UNIVERSITEIT TWENTE.

Assessing Germany's Care Act

(Pflegestärkungsgesetz I)

From a gender mainstreaming perspective

Bachelor Thesis in European Public Administration

Monika Blum-Khayati

Supervisors

Prof. Dr. Joy S. Clancy

Dr. LL.M.Victoria I. Daskalova

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1 INTRODUCTION

An important part of all policy considerations and policy making in the union should be Gender Mainstreaming (GMS in the following) according to the European Communities (2008) in order to achieve the goals for growth and employment. GMS on the one hand is an ideological concept, and on the other hand a tool or process for achieving Gender Equality (GE in the following). In 1996 the European Communities (p. 67) defined GMS:

"GMS involves not restricting efforts to promote equality to the implementation of specific measures to help women, but mobilizing all general policies and measures specifically for the purpose of achieving equality by actively and openly taking into account at the planning stage their possible effects on the respective situation of man and woman (...). This means systematically examining measures and policies and taking into account such possible effects when defining and implementing them."

Lately the visibility or consideration for gender issues in the national reform programs (Rubbery, et al. 2006) has been decreasing. This includes Germany as well, and stands in contrast with German legislators repeatedly stressing the importance of GE as an ideological imperative and a fundamental value of German society. For example Angela Merkel in a speech in 2009 declared GE to be a key issue of society (Hamburger Abendblatt, 2009) or Dennis Gladiator Speaker of the CDU in Hamburg declaring "that it is time for standing up for our fundamental values and our open way of living. The equality of man and woman is non-negotiable " (Die Welt, 2016). The Minister of Family Manuela Schwesig (Bild der Frau, 2016) announced that it not only her wish but her declared goal to achieve "real GE for all men and women."

Not only does the German constitution declare men and women equal, but also states that the state should actively work against inequality. Furthermore Germany is obliged under EU-Law to use GMS as a tool (European Communities. 2008, 1996), from the Federal down to the communal level. The Federal Government, as well as the state governments, have passed specific GE laws (Gleichstellungsgesetzte) that among other provisions instate so called equal opportunity officers and councils on communal level, as well as in state and in federal ministries. As well as creating an obligation in all level of public administration in Germany to use to GMS.

The German Pflegestärkungsgesetz I (2014) address the issue of elderly care in a broad angle involving changes for all stakeholders involved, this includes changing care-levels and financial matters for the person in need of care as well as changes for family members providing informal care.

When it comes to care, great differences between the genders exist: Not only is the majority of care givers, professional as well as informal, female (Schneider, et all., 2001) but also the majority of care receivers (Schärpler et all, 2015). Two-thirds of all elderly patients in need of care, are cared for by family members, who in 72% of all cases are female (Schmidt & Schneekloth, 2011). This makes the care act, and especially the provisions concerning informal care interesting from a GMS perspective.

If GMS considerations were applied, or to a minimum considered, indicators of that would be visible within the act itself, or in the discussion and explanation leading up to it.

1.1 Research Question

My question therefore is:

To which extent does the German Care Act (Pflegestärkungsgesetz I) meet GMS standards in relation to informal care provisions?

To answer this question properly a set of sub questions needs to be answered first:

What are GMS standards and how do we evaluate compliance with such standards?

What are the Gender Specific differences in providing informal care, and how can they be explained?

What is the Goal of the Care Act?

To what extend were GE considerations relevant in the introduction and designing of the Bill?

To what extent was there concern with GE in the stage preceding adoption of the law?

2 THEORETICAL BACKGROUND

Before the topic of GMS can be discussed, some basic concepts need to be defined.

Firstly it is important to distinguish between sex and gender. There is some confusion between the way the term is used in 'public' and the way the term is used by experts. Gender encompasses more than just the box ticked on a form. JämStöd (p.15, 2007) summarizes the definition of gender as:

"Gender is our 'created' identity as opposed to our biological sexual identity-the sum total of what we perceive to be male or female."

GMS is often confused or used interchangeably with GE. While one cannot exist without the other, GMS and GE are two distinctively different things. GE, equality between men and women, is a fundamental EU core value and right, and the Union sees it as a necessary condition for the achievement of the EU objectives of growth, employment and social cohesion (European Communities, 2008). Because "GE is an issue that challenges traditional attitudes, highly personal values and also the established power hierarchies" (Berquist-Mansson, p.6, 2007) it is met with resistance and contempt from parts of society and the political spectrum. When German rightwing politicians are talking about the "Gender Mania" their contempt is directed towards the concept of GE. In its most basic form the objective of GE Policy is for women and men to have the same power to shape society and their own lives (JamStöd, 2007).

The European Communities (later Union) as well as Germany, and many member states have adopted equality between men and women into their constitutional and general legislation. The German constitution for example states in Article 3 (2):

" Men and women have equal rights. The state shall promote the actual implementation of equal rights between women and men and works towards the elimination of existing disadvantages."

This article not only proclaims legal equality but also obligates the German State to employ active measures and actions to combat any disadvantages that might exist on the basis of gender. GE is seen by the Union not only as a fundamental right, but also a necessary condition for the achievement of its goals of growth, employment and social cohesion (European Communities, 2008).

2.1 Gender Mainstreaming

GMS is more of a tool or a method to achieve GE. In its most basic form GMS "implies that the policy takes the unequal position of men and woman into account." (European Communities, 2008).

JämStöd (2007) identifies three major strategies in attempting to create GE. Strategies for GMS can be classified by their outcomes. The oldest and most frequently used strategy, Tinkering, consists of measures that formally and legally establish equality. An example for this would be Article 3 Paragraph 2 two of the German constitution, stating that men and woman are created equal. Tailoring is used to describe strategies that suggest women should adapt to the Status Quo. Most reconciliation policies, like parental leave programs, and positive action programs fall into that strategy. The most radical strategy is Transforming. It questions the status quo and

deems a transformation of institutions and organizations necessary. This approach is rarely ever used, and does play a minuscule role when it comes to policies.

GMS is a process that approaches achieving GE from a different angle and is applicable to all above mentioned strategies. It aims at integrating the gender perspective into external and internal activities and ensures that provisions and decisions have the same consequence for men and women (Bergquist-Mansson, 2007). GMS is not to confuse with specific action. Specific Action in the area of GE are specific initiatives that target specific areas of gender inequality and try to ameliorate them. That is why the European Communities (2008) suggest a Dual Stack approach: GMS and Specific Action.

The Council of Europe (1998) defined GMS as: " the (re)organization, improvement, development and evaluation of policy process, so that the GE perspective is incorporated in all policies at all levels and at all stages by the actors normally involved in policy making."

This is done in four stages of GMS as proposed by JämStöd (2007) and the European Communities (2008):

I. Getting organized: The first stage sets the basis for working on GE. Without a structural and cultural basis, as well as a real commitment externally and internally to the issue working towards GE would be futile (Bergquist-Mansson, 2007). This step not only includes the formulation of objectives and targets, but also budgeting, allocating and defining duties, obligations and responsibilities. It is a stage where the securing of external or internal competence in the area should be considered. It is important for GMS that all Stakeholders involved should be considered and be aware of issues considering equal opportunities. Not only does that require a certain level of knowledge on gender related issues, but also that the actors involved take 'ownership' of the issue. A possibility for that is having a designated responsible for considering the questions of GMS (JamStöd, 2007).

II. Learning about Gender Differences: The raising and compiling of relevant data, that registers gender (many of older surveys did not record the gender of the participants) is of utter most importance when it comes to assessing actual gender inequality. It is also important in order to be able to prioritize areas of focus. By monitoring the development over time trends on gender inequality can be identified. The European Communities (2008) has determined for areas of Gender inequality:

    a. **Participation**: participation is about the configuration of male to female ratio in the target group of the policy. It evokes the need for gathering basic information on the group about how many women, disabled, men, or certain ethnicities are touched by it (European Communities, 2008).

    b. **Resources**: there might be a difference in access to resources such as time, space, information and money, political and economic power, qualifications, transport, use of public services based on Gender (European Communities, 2008).

    c. **Norms and values**: the norms and values of society are fundamental in shaping gender roles and with that the division of labor. They do also play a distinctive role in value attached to personal characteristics(European Communities, 2008) and to choices for the genders. Without a question it is therefore of uttermost importance to examine the impact a policy measure has in reinforcing existing (harmful) gender roles.

    d. **Rights**: rights refer to discrimination on the basis of gender, whether indirect or direct, human rights, access to justice system, political and socio-economic life. Here it is essential to note, that while formerly equal rights

might be in place, but a lack of chance, or perquisites prevents either of gender to participate fully (European Communities, 2008).

III. Assessing the Policy Impact: The potential impact in relation to GE of a policy should be assessed on the basis of its influence on the four dimensions of gender inequality (see above). Does the policy influence these inequalities in a positive or a negative way? Does it reinforces them or ameliorate them? (JämStöd, 2007).

IV. Redesigning Policy: When the assessment of the policy impact is considered, or found out to be negative, the policy needs to be redesigned in a way that it does not do that any longer, and with that restarting the process from Step I.

Following this four step process is the ideal or fastest way to advance GE and to carry out the process. But it is not the only, way, and not all things must be done in order to achieve some sort of advancement.

2.2 Gender Mainstreaming Standards

Is established before, GMS is not a goal in itself, but a mean to an end, a tool in order to achieve equality. That in its most basic form means the application of the gender perspective to all policies and public administration actions. Because GMS is a requirement for member states, an agreement about what constitutes GMS is necessary.

In European Union Terminology a Standard is “a publication that provides rules, guidelines or characteristics for activities or their results, for common and repeated use” (European Committee for Standardization, 2015). This deviates slightly from the way the word standard is normally used. The Oxford Dictionary defines standard as a “required or agreed level of quality or attainment” and this will be the meaning of standard used within the thesis.

What can be considered as the GMS Standard is contested. There is already an ideological contestation to the usage of it in feminist theory. Walby (2005) describes it as Agenda Setting versus an Integrationist approach to GMS. Agenda Setting entails the transformation and reintegration of existing policies in order to change the process and prioritizing gender objectives to the level of rethinking policy ends. The Integrationist approach, is “selling” GMS as a way to better achieve existing objectives without challenging the existing policy paradigms. The Integrationist approach is less likely to be rejected, but also is less likely to have a noticeable impact (Walby, 2005).

The European Union has, according to Walby (2005) and Verloo (2005) chosen the Integrationist Approach to GMS which leads to a technocratic understanding of the issue.

This translates to GMS Standards: The Consideration of the gender perspective is to be integrated into all policy considerations in order to make them more effective, yet it does not require gender objectives to take precedent over the existing policy objectives.

This leads to the existence of a grey-area in terms of GMS Standards. There are no harsh legal rules or requirements. There are recommendations and manuals that set a standard – technocratic- modus operandi on how the tool works and looks like. “Over recent years a variety of manuals ‘how to gender mainstream’ have been developed, often focusing at specific areas and/or directed at certain target groups” (European Communities, 2008). All of these Manuals have the four steps of GMS (as described above) in common. From which it can be derived that these four steps are considered standard elements of GMS if used as a tool.

2.3 Evaluating a policy

All four Steps need to be completed in order for a policy to meet the GMS standard fully. Yet, as the European Community of Practice on Gendermainstreaming (2014) points out Member States are at different starting points when it comes to GMS. When a law is decided on, to a minimum Steps I: Getting organized and Step II: Learning about Gender Differences should have been completed. And if Step II reveals great Gender Specific Differences, also Step III: Assessing the Impact should be considered. If it has been concluded in Step III that the impact is negative, Step IV: Redesigning the policy should be ideally initiated. Yet the assessment can be wrong, and Step III and Step IV require Monitoring, and investigation even after bill has been passed.

In order to evaluate the policy the completion of the Steps needs to be assessed. Step I getting organized will not be discussed in the thesis in depth. As mentioned in the introduction Germany has signed relevant treaties in the Union, has made GE and the active combat of inequality part of their constitution, passed equality legislation and instated in all areas of public administration equal opportunity officers and committees. More so they have their own GMS Guideline that needs to be applied when making laws, if the policy is found to be relevant from a Gender Perspective (BFSJF, 2007). Also, if Step I was not adhered to, evaluating the other steps would be futile, because it can be assumed that, if there is no commitment to GMS on a structural and legal basis, certainly GMS will not be used.

When evaluating whether a policy is adhering to the standards of GMS Step II and Step III should be in focus.

For the second Step it should be investigated whether there is gender specific difference in all four areas of inequalities. Whether step II has been completed should be evaluated in a two step process. In the first step it needs to be investigated independently whether gender specific differences exist. And in the second step it should be examined whether these are noticed or discussed in context of the policy by the law makers. Evidence for this can be in the explanation and reasoning to the law, this can be in parliamentary debates or in other publications. If no evidence of an investigation or discussion about gender specific differences can be found, and in the first step it was determined that there is a difference, the standard was not met. The Standard is also not met, if no proper assessment of gender specific differences was made.

A perquisite for assessing whether Step III of the process was completed is that Step II of the process was completed as well. Since no assessment of implications of a policy for gender can be made by the law maker, if they failed, or omitted, to investigate gender specific differences in the first place. The assessment of the policy impact needs to examine how the policy will influence the genders in all four areas of inequality. This leads to four main questions. These can be adapted with little changes, to make them less specific, from the GMS Manual that was focused on employment policies (European Commissions, 2008):

a. Does the Policy affect men's and women's financial situations differently?
b. Does the Policy affect women's and men's opportunities and conditions for paid work, education and self-employment differently?
c. Does the policy affect women's and men's opportunities to share unpaid care work differently?
d. Does the policy affect norms and values concerning the role of men and women differently?

In order for Step III to be completed and meet the standard, they do not need to be answered negatively. It is sufficient if they were investigated. In case the conclusion is positive, meaning that there are unequal consequences, the law should be adapted. An Indication for planned changes or for an ongoing process should be made, either within the debates, the law text, or other publications. They do not necessarily need to be completed at the point of investigation for Step IV to be met.

2.4 Gender System Model

Yvonne Hirdmans (1996) Gender System Model (GSYM in the following) is the theoretical foundation of the Swedish GMS policies (JämStöd, 2007) and with that the theoretical background for their GMS Manual. The European Communities (2008) manual is adapted from the Swedish Manual and therefore, and the GSYM indirectly becomes the theoretical background of the Commissions Manual.

The Gender System is described as the pattern of gender in society and their relationship, to the entire societal system and themselves. According to Hirdmann (1996) the predominating pattern in the Gender System is Segregation.

Genders are scrutinized and separated on the basis of pure types or *Idealtypus* of man and woman. The organization of the male and female Idealtypus works on the same binary as dark and light, or dry and wet, with set characteristics and allocations. This stresses the existence of gender on a very basic level of orientation and underlines the aspect of segregation. And this segregation can be and is used as “a mean of subordination” (Hirdmann, p.8, 1996).

In western modern society there are very little people that would sign the idea that a woman should not have the same rights as a man, or oppose GE. Yet most individuals “both criticize and participate in the reproduction of the unequal gender-system”(Hirdmann, p.21, 1996). Hirdmann (1996) relates that back to the Gender Contract, a societal agreement that determines the positions, rights and duty of men and women within the public, private and work life.

The basis of our –western- gender contract stems from the Bible (Hirdmann, p.26, 1996): “Man (by God) has the rights and responsibilities of the provider and woman the duties and responsibilities of the pro-creator and care provider.”

This division continues to exist. Even though the ethics of works, the idea that in modern society being human is identical with being a worker, becomes more predominant as woman become wage earners as well, the segregation and basic structures of the gender contract continue to exist. “One could rather say that the strongly segregated labor market underlined the masculinity of male work, as the contrast to female work was so easily seen in every aspect” (Hirdmann, p.38, 1996).

It requires great effort to change the parameters of the contract and the gender roles, because it upsets the equilibrium in the system, that is uphold by both societal partners.

GMS as a process makes the gendered nature of assumptions, processes, roles and outcomes visible (Walby, 2005) the corner points of the gender system, and enables to question and change the patterns of segregation.

Caring for children or the elderly is still widely considered to be the responsibility of women in Germany (bpd, 2013). This also falls in line with great part of scientific literature simply declaring that “intergenerational care is predominantly a women’s task” (Conen, 1998, Schmidtke 1987, as read in Schneider, et all., 2001).

[1] A SOCIAL CONTRACT BASED ON THE SOCIAL CONTRACT THEORY.

Adhering to GMS Standards on a conceptual basis when it comes to informal care, would transform the gender contract, create new gender norms and blur the lines of segregation. In order for that to happen the new norms would “have to fight their way into institutionalized thinking in competition with traditional norms” (Walby, 2005).

Therefore it is unlikely that the informal care act will adhere to GMS Standards, because the established goals of the care act of more people providing informal care would compete with the prioritization of the GE aspect. Staying within the given parameters of the GSYM will making reaching the main goal of the policy more attainable, questioning the status quo of gender relations would complicate things.

2.5 Methodology

In order to answer the sub-question ‘What are the Gender Specific differences in informal care, and how can they be explained?’ will be answered. It is important to see whether actual gender specific differences in providing care exist. While the initial look on the statics would suggest that the care providers are predominantly female, a further more in dept examination is needed. This will be done through a literature review, examining previous research done on the topic. The assumption can be made that everything that will be found in this paper, was available and attainable to the Government when drafting the policy, meaning that it is fair to assume that any gender specific differences existing and noted by this thesis could be and should be know. This corresponds with the first part of the evaluation whether Step II of the Process has been completed.

To complete the second part of the evaluation as outlined above the Draft of the Bill, and the Plenary discussions will be examined. The Two main Research Questions here are: `To what extend were GE considerations relevant in the introduction and designing of the Bill?` and To what extent was there concern with GE in the stage preceding adoption of the law?

To answer the first one the Draft of the Bill, together with its reasoning will be examined. What are the goals of the law, does it mention gender specific differences, and does it perhaps even contain an impact assessment.

In order to answer the second question the two discussion of parliament preceding adoption will be manually coded. To see whether there is evidence that indicates that the issue was viewed from a gender perspective and whether the four areas of inequality: Participation, Norms and values, Resources, and Rights are discussed. To do that for one it will be differentiated between Opposition and Government Fractions in Parliament. It will be looked for the direct (and indirect) use of the words: “Man, Woman, Gender, Sex, GE” and for sentences that indicate “Financial Situation; Reconciliation of Care, Work and Family; Negative Consequences of providing care for the provider; Change of Family Structure, division of care work”. When comparing that to the findings from Part I about the existence and cause of gender specific differences, it will give a good indication whether the Gender Perspective was considered, and whether the impact of the policy on GE was considered.

In the final step a conclusion whether the Pflegestärkungsgesetzt I is adhering to GMS Standards will be given. If the situation will present itself, recommendations about how it could be improved to include the Gender Perspective will be given.

3 INFORMAL CARE PROVIDERS

Based on the level of care need of a dependent person, the German care insurance pays benefits to the care-dependant in order to help covering the costs of care. It is not meant as a comprehensive system, but as an added help. The other half of the costs or tasks are expected to be covered by the care-dependant or their family. Due to various reasons, that will not be discussed here, the most common form of care is informal or family care, providing for two thirds of all persons in need of care. Making the family the biggest care provider in Germany (more on that in Appendix II).

This of course has strong implications for the consequences of policy on care for the elderly. In at least two-thirds of all care cases the family of the care-dependent is directly influenced by the legislation as providers and in the rest of the cases at least indirectly. Since informal care-providers are pivotal to the system, any sort of impact assessment, and with that also gender impact assessment, cannot be limited to care-dependents alone.

Therefore the question 'What are the Gender Specific differences in providing informal care, and how can they be explained?' needs to be answered. In the first part of this section the Gender Specific differences among care providers will be discussed and in the second part, theories and their ability to explain the gender specific differences will be explained.

3.1 Gender Specific Differences

In total between 4 to 5 million people in Germany, 8,7% of all women and 4,7% of all men, are in some way care-providers (Schmidt & Schneekloth, 2011). Most informal care providers do not receive any remuneration for their work, because family care is expected to be unsalaried or voluntary.

A quarter of all persons receiving nursing care are cared for by two persons, and another quarter is involving 3 or more persons. When only one Person is care-provider the probability for the help of a professional caring service is increasing (GVK Spitzenverband, 2011).

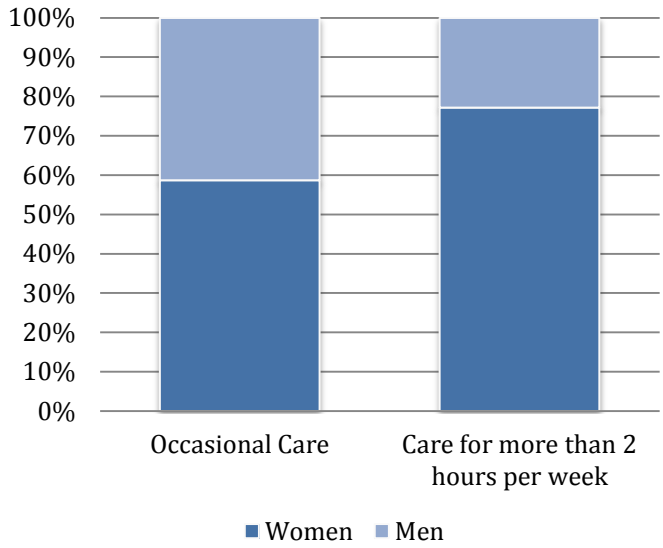

FIGURE 1: CARE FREQUENCY BY GENDER (WETZENSTEIN, ET ALL., 2015)

Nursing Care is, even though there are a successively increasing number of men involved, still predominantly provided by women. Two thirds of all care providers at home are women (Schmidt & Schneekloth, 2011), Wetzenstein (et all, 2015) shows the difference proportion of women in care providers. As Figure 1 illustrates, the percentage is even higher for women if the care work is not only occasional.

As Schneider et all (2001) point out, “while men and women do provide family care, in 80% of cases the main responsible is female.” If men are the main responsible of care they call in for professional help far more frequently (Gößel, 1998).

The General consensus in the scientific discourse is that providing informal care, puts the care giver at a greater health risks and risks of social exclusion (e.g. Wetzstein et all. 2015, Bundesministerium für Gesundheit 2010, Schneider et al. 2001, Schmidt & Schneekloth 2011) compared to people who do not. While some argue that this is due to the large socio-economic differences between the two groups, Wetzstein (et al., 2015) show that the difference in health risks remains, even if the socio-economic differences are accounted for. Interestingly enough though, this is only the case for women, for men the differences did not remain. Wetzstein (et al., 2015) has no conclusive answer to that. They assume that due to ingrained gender roles, women have more trouble separating their care work from their job if they work, as well as feeling greater societal pressure to be fulfilled by their care work. Another factor in this could also entail that care often requires heavy lifting of patients.

For care-providers a job beside the care seems to be a positive resource (Schmidt & Schneekloth, 2011; Wetzstein et all., 2015). Schmidt & Schneekloth (2011) found that persons holding a job seem to be better at handling the emotional aspect of the situation, as well maintain a social network. Social networks are an important factor in receiving social support, and maintaining an identity away from being a care-giver. Schneider et al. (2001) looked at the employment behaviour of married women and found out that “women are orienting, contrary to men, their decision about a carreer continously strongly towards the needs and tasks within the family”. Meaning that women are more likely to quit, or restrict their day job in order to provide care. Figure 2 illustrates the employment behaviour of married women.

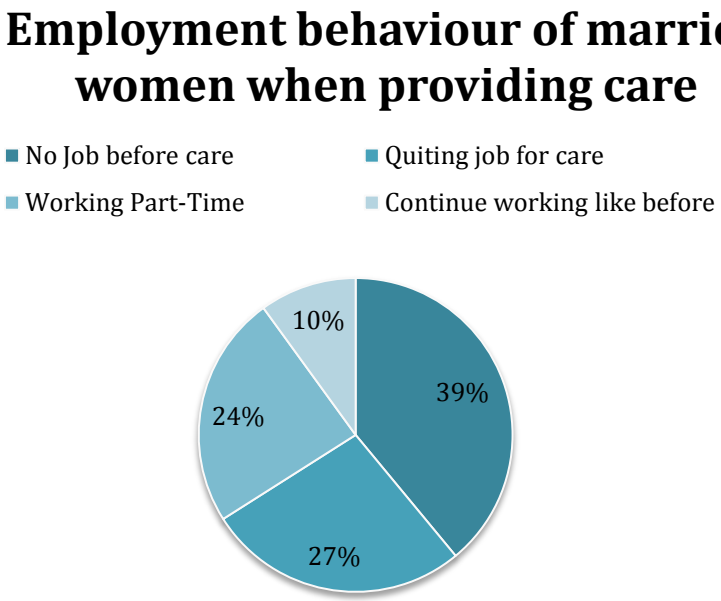

FIGURE 2: EMPLOYMENT BEHAVIOR CARE PROVIDER (SCHNEIDER ET ALL. 2001)

In total almost 50% of women do not change their employment status due to providing informal care, 10% of married women continue working like they did, before they started providng care. And the other 39% were already not employed when they decided to take over care responsibilty. The other 50% of married women alter their employment behaviour in order to take over care responsibilty. Slightly more than half of women altering their behaviours quits working a day job completely, while the other decided to work part or half time.

Obviously an increasing employment rate of women, will lead to a surge conflict between care provision and working. Since the majority of married women providing care is not working.

Apart from the risk of social exclusion on a personal level, women who did take time of to provide care for a family member, have greater difficulties finding a job afterwards. These women usually are over 40 years old, the average of a woman providing care being 54 years (Haberken & Szydlik 2008), making it more difficult for them to find employment. A longer period of time not being employed generally lowers the employability of a person.

Another issue when it comes to employment is, that persons who provide care, tend to have a lower productivity at work, missing important in work training programs, as well as showing a lack of concentration, being late, and missing work more frequently. Again, these issues seem to be more prevailant for women than for men according to Schneider et all. (2001).

As Wetzman et al. (2015) remarks, women also have to more frequently explain or justify their decision to continue working in case of care situation within the family, while men do not. Summarized we can say, that the majority of care providers is women, and that the negative consequences of providing informal care seem to be more negative for women.

3.2 Theoretical explanation of reasons for providing care

After establishing, the gender specific differences in providing informal care, I am interested in possible explanations for these differences. There are several options in trying to explain the differences. While surveys can probe into motivations, there is the need for understanding the decision on a more conceptual basis. In the following I will explore theories that are frequently used in order to explain why a person is providing care.

3.2.1 Social Exchange

The concept of social exchange is one of the theories used by for example Holstein and Brilla (1998) and Schneider et al. (2001) to explain why persons become care providers.

The Social exchange is a form of exchange that differs from the economical exchange. The economical exchange requires an immediate and specific exchange for a service or a good given. In contrast to that the social exchanges is marked by a so called “generalized reciprocity” (Blau, 1984). Generalized Reciprocity means, that the payback for the service given is not expected to be given immediately or equally. With the time for payback not being determined, the giver knowingly takes the risk of not being paid back at all. Therefore this sort of exchange will only happen or be conducted if the relationship between the exchange partners is characterized by a high level of trust. Not only trust has a high importance in the social exchange, but the relationship between the participants as well, as Schneider et al. (p. 365, 2001) puts it: “the relationship has that high of a standing, that the payback is considered natural”.

It is very compelling to apply this theory to elderly care provided by family members. In the last couple of generations, more children receive transfer contributions from their parents way past their childhood (Schneider et al. 2001). These transfer contributions involve, living with their parents, direct monetary support, responsibilities in the area of child care. Meaning children receiving support from their parents, in a time where they rightfully can be considered equal exchange partners. Holstein and Brilla (1998 as read in Schneider et al. 2001) therefore consider the care provided as a reciprocal reward for the support given beyond childhood.

“The children are especially evaluating a biographical balance sheet, of their parent’s contribution, whereby the existence of a positive emotional relationship between the grown-up children, is not a necessary condition for the willingness of children to provide care for their parents.” (Schneider et al. p.366, 2001).

This theory has one major shortcoming when applied to informal care for the elderly: It is not able to explain the gender specific differences.

Hollstein and Brilla (1998, Schneider et al. 2001) do not discuss those differences at all, and Schneider et al. (2001) points out that the general consensus in the Literature is that “intergenerational care is a woman’s task”.

With care-work being in its overwhelming majority done by women, an explanation or theory that fails to explain the difference in gender is less than satisfactory. It is not to be disregarded though in describing the motivation.

3.2.2 Neoclassical Labor Market Theory

According to the Neoclassical Labor Market Theory individuals strive to maximize the positive outcome for themselves when balancing leisure time and work. Free Time in itself is considered as a pleasure.

Becker (1993, as read in Schneider et al. 2001) defines leisure time a bit differently than most. He introduces the idea of 'Householdproduction'. Cleaning, raising of children, taking care of elderly, etc. are products produced by the household. This means that what the household produces needs to be added to the equation when trying to maximize the positive outcome. When applying Beckers (1993, as read in Schneider et al. 2001) theory to elderly care two options in organizing elderly care within the household become possible (Schneider et al, 2001).

First option being the reorganization of the production of household goods. By reducing or cancelling time intensive free time activities, as well as the production of time intensive household goods, these can be swapped for market-goods (like a professional care services), not influencing the employment behavior of individuals within the household.

The second option is that work time will be given up, partially or completely in order to provide care, if the overall household income is high enough to sustain the members of the household.

Just from Beckers (1993, as read in Schneider et al. 2001) theory of household production, no definite hypothesis can be made whether free time is reduced or employment time is reduced. If the money from the care insurance is given to the care-givers in the household, this increases money from non-work and with that lowers the cost for producing household goods. Which in turn would likely lead to a lower employment rate of individuals within the household (Schneider et al. 2001).

According to Schneider (2001) gainful employment within a household is always in relation to what is cheaper for the members of said household. Using the time of a person to produce household goods, becomes more likely in the light of the high costs for market goods. The "strain on the family budget" will take precedent over the individual preference or need of the individual with the lowest income.

Becker (1993, as read in Schneider et al. 2001) also states that the individual that has mainly focused on producing market goods will continue to do so. His theory as such is gender neutral and totally ignores non-monetarily motivations for providing family care. The Theory is compelling, and certainly offers great value in explaining reason, but it also is unable to explain the gender specific differences.
Since as Schneider et all. (p. 367, 2001) point out: "even if wives have a much higher earning potential than their husbands, husbands will normally work full-time and their wives adjust their paid work according to family demands." While the Data is older, the Schmidt & Schneekloth (2001) study found similar results. Yes, more men are starting to provide informal care, yet the average age of informal care givers is 54 for women. In this particular age bracket, the division of care level is still very similar to 2001.

3.2.3 Rational Choice

The rational choice theory states that all persons involved have preferences and make decisions based on previous choices and available information. The decider anticipates consequences of the decision as far as possible. But since actors have limited resources, they will decide on the option with the biggest "use" for them. Structural circumstances (class, education, money, knowledge about the topic) might make certain options for the deciders impossible.

For providers of informal care the one of the biggest decision points is the anticipated high cost of nursing homes (Schneider et all., 2001) which is increasing the probability for providing care at home. The Higher the income of a person, the higher the conflict between staying at home and hiring help becomes.

The rational choice theory is a compelling theory when trying to explain the difference between migrants and locals in terms of registration within the care system. As Kohls (2015) points out there seems to be a lesser knowledge about provisions and the system. Meaning Migrants have less access to information, making certain options for deciders impossible because they have no knowledge about them.

Yet when it comes to explaining gender specific differences, the rational choice theory is not enough to explain them. Previous choices, like a previous child-care leave, or a lack of knowledge of the system, or a lack of money for nursing care, is still not sufficient in describing the motivation.

3.3 Sub-Conclusion

There are great differences when it comes to providing informal care. And they are noticeable in three out of the four areas of gender inequality. When trying to explain the differences in terms of participation, the examined theories that bring forward economical or semi-economical arguments are unable to explain the differences to a satisfying degree, strongly suggesting that the system of separation is playing an important part.

When it comes to participation the configuration of the male to female ratio is heavily skewed towards women. The majority of (informal) care-providers are female, therefore any policy touching the area of informal care directly influences more men than women.

There can be a difference observed when it comes to resources. Informal care has negative consequences for the person providing it, in terms of health, risk of poverty and risk of social exclusion. While that can be said for every person providing informal care, as outlined above women are influenced more negatively than man by providing care, and those negative effects also remain standing for women, when socio-economic differences are accounted for, while they do not for men.

Arguably the biggest gender specific differences can be found in the area of norms and values. As described above, one of the major deciding factors in determining who out of a family or a household will take over care duties is apparently gender. While the rational choice, social exchange, and the neo classical labor market theory are able to explain general reasoning factors, and great parts of the gender specific differences, they do not manage to do so exhaustively. The gender system model, gives a theoretical insight into the general notion that ‘care is a woman’s job’. Care is part of the tasks of the woman within the gender contract, making it seem “natural or normal” for a woman to complete care duties. This also explains why the majority of professional care personnel is female. Care work is generally considered woman’s work.

There are no recognizable gender specific differences in terms of rights.
With the gender specific differences in informal care being so great, any legislation concerning informal care should examine and assess the possible impact the policy has on GE, in order to ideally ameliorate or at least not deepen them any further.

4 THE BILL

In this part the question `*To what extend were GE considerations relevant in the introduction and designing of the Bill?*` will be examined as well as describing the content goal and purpose of the policy.

The German Care Act I is only the “working” title of the bill, as it is an amendment to the 11th Book of the Social law that regulates (elderly) care.

The bill itself is part of bigger reform package that includes 4 more bills up to date. The overall content of the reform package was decided after the federal election in 2013 in the coalition-contract between the two parties in government: CDU and SPD. This law was introduced by the government into parliament, and its wording was drafted by the Ministry of Health.

The draft law brought in for discussion consists of five parts: An Introduction to the Problem and the Goals, a letter to the President of Parliament by the chancellor asking for the law to be put onto the Agenda, the proposed wording, the reasoning, and a statement to be provided by the Nationaler Normenkontrollrat . Normally a statement of the Bundesrat, and an opinion of the Government to that statement would be included (§42, GGO), but they were not yet available when the draft for the law was submitted to the President of Parliament. Since only minimal wording changes were made to the draft, and not in the area of informal care, the draft will be discussed in the following.

4.1 Introduction

The Bundesregierung (2014) explains in the first part of the draft of the law the issue at hand and what the goal of the law is. They start off with a general bigger goal or ideal, then listing five concrete issues that this particular law is aiming at resolving to achieve the bigger objective.

The overall objective, of this law and the entire reform packet, is “securing the quality of care, in the light of changing societal parameters, while taking the personal needs of persons in need of care into account, because this is regarded as an expression of a humane society” (Die Bundesregierung, p.2, 2014).

The first problem pointed out is about the provision of informal family care. The Bundesregierung (2014) acknowledges that two-thirds of all persons in need of care are being taken care of at home. And that it is family and relatives that ensure that care is provided to most people in need of it. This would according, to the Bundesregierung (2014) not cause a issue itself, but due to the change of occupational biography of individuals and the change in family structure measures are needed to stabilize and make informal nursing care more flexible, in order to achieve a notable improvement in the reconciliation of care, family and job and further ensure the supply of care.

Other issues mentioned are the concept of support personnel in nursing homes, the redefining of care-levels and the assessment process to include dementia patients, and the adjustment of the benefits to actual costs.

As a solution to solving the first issue, the Bundesregierung (2014) wants to increase flexibility of informal care, in particular through the addition and increase of opportunities for short-term care, temporary replacement care, and night care as well as broadening the definition of family.

4.2 Changes to the Original Law

The Bundesregierung (2014) proposed (and later passed) the following changes to the existing legislation in order to improve short-term and temporary replacement care.

A complete Re-write of §39 SGB XI (Die Bundesregierung, 2014) stating that, if a caregiver is unable to provide care due to vacation, sickness or other reasons, the care insurance will cover costs of the necessary care replacement, for a maximum of six weeks per year. The amount that will be covered is also increased. Perquisite for that is that the person providing informal care is a second-degree relative by blood or by marriage or cohabitating with the care receiver, and has provided care for a minimum six months prior. The Replacement care-giver can also not be a family member of second degree or cohabitate with the receiver in order for the care-insurance to cover the costs. Unused time from the short-term care contingent can be used to extend the time period.

There were also changes to short-term care provisions in §42 SGB XI suggested by the Bundesregierung (2014). Unused time/money from the replacement care can be used to increase time of short term care to a maximum of 8 weeks and overall amount of money available for short-term care was increased.

Another provision aiming at enabling greater flexibility in care, is the additions and changes suggested to §45 SGB XI concerning low-threshold respite services. A clarification for the aim and what they entail is given in the to be added section 3 (a). The respite services are to grant support to patients in the household, in particular with practical domestic help and organization of individually needed aid delivery. These activities also fall under respite services if it lightens the care burden for relatives.

These changed provisions can be attributed as classical examples of reconciliatory polices. They are supposed to enable care-giver to combine family life and care in a better way, by ensuring that in case of emergencies, or vacations the care-depend person is provided for.

As Walby (p. 325, 2005) points out: “policies to support the reconciliation of work and family life have the potential to constitute a transformation of gender relations and GE in the domains of both care and employment, but some interpretations of these policies may merely integrate women into the labor market.” And the Bundesregierung has in instances before done the first. When it comes to childcare for example the full amount of paid parental leave (14 Month) can only be received if both parents are taking time off from work. If only one parent takes parental leave, only 12 Month will be supported. This provision is supposed to encourage, mainly men, to take part in childcare and with that is trying to transform gender relations and equality in the domain of child care (Bundesministerium für Familien, Senioren, Frauen und Jugend, 2014).

In the case of care for elderly, no such provision, as shown above, has been made. This is a strong indicator for a tacit acceptance of the gender specific differences, and supports the thesis that a adherence to GMS Standards is unlikely.

4.3 Reasoning of the Law

The reasoning of the law directly follows the proposed changes. It consists of two parts, a more general one, which includes assessments of financial and other consequences of the law, as well as specific part explaining the reasoning behind every change.

The general part is of greater relevance for the thesis. Therefore no further assessment of the costs reasoning will be done, since the cost reasoning discusses questions as how much more

[1] THE NATIONALE NORMENKONTROLLRAT IS AN INDEPENDENT BODY FOUNDED IN 2006, WHICH IS SUPPOSED TO CONTROL AND ADVISE THE FEDERAL GOVERNMENT ON BETTER LAW-MAKING AND REDUCING BUREAUCRACY

per patient the care-insurance will have to pay, and how the costs will be divided among the federal state, the states, and the communes.

The first part is a further development of the goal setting and the necessity of the new regulations. As stated before in the introduction to the introduction of the bill, the Bundesregierung (2014) sees it as necessary to develop the care insurance further in a way that caters to the need of both the patients in need of care, and their relatives. At the same time the demographical development of Germany makes it necessary to take financial precautions in order to continuously be able to fund the care insurance, if the expected imbalance between contributors and receivers will come into full affect. This is to be done in a form of an investment fund.

The anticipated increase of care-dependent persons by 40% until the year of 2030 (Bundesregierung, 2014) along with expected continuously low birth rate, is not only going to lead to financial problems with the care insurance, but it is also predicted to lead to a low supply of potential care givers, professional as well as informal.

In order to combat this expected shortage, the Bundesregierung (2014) sees it as necessary to stabilize the informal home care, because informal home care is less "personnel and financially intensive" than inpatient care. They assume that, by enabling more flexible possibilities for organizing care at home, they can cater to the changed occupational biographies and therefore encourage more persons to take over care responsibilities.

Informal care is not only continuously discussed first and in greatest length by the Bundesregierung (2014) in the reasoning and introduction to the law, but it presented to be the pivotal solution to the challenges brought by the demographic change in the future. There is an expected increase needed in hours in care, and the solution to that is primarily, an increase of persons providing informal care. Like the Minister of Health said in his introductory speech in parliament goal of the policy is "to motivate more persons or giving them the means to (…) practice informal family care".

There is no discussion or acknowledgment about the gender specific differences in this part, of the reasoning. The Goal is to increase the amount of persons providing informal care, whether this is going to reinforce existing gender patterns, meaning even more women taking time of work to provide care, or not seems to be irrelevant to the policy consideration. As stated above, the Government did take opportunities to use reconciliatory policies in order to transform gender relations and more equality in the domains of care and employment. There can be no evidence found that this was the case here. There is not even evidence that any consideration to gender specific differences was made.

4.3.1 Gender Equality Relevance Test

In the final part of the general reasoning, the Bundesregierung (2014) talks about the expected impact of the law, and costs for the federal state, the states, and the communes, as well as in the small under section about other impacts. This also includes a test to see whether the policy is touching on gender relevant issues. This so called GE test is outlined in the "Arbeitsshilfe Geschlechterdifferenzierte Gesetzesfolgenabschätzung „Gender Mainstreaming bei der Vorbereitung von Rechtsvorschriften" (BFSFJ, 2007).

In the Working Guideline a two step approach is suggested. First a pre-testing is supposed to be performed. This Pretesting is the so called GE Relevance Test. This incorporates two questions. The first questions is whether the policy provisions have a direct effect on men and on women, and the second question is whether they have indirect effect on them. The Working Guideline

(BFSFJ, 2007) in particular points out that the four areas of gender inequality are considered when the questions are answered, and asking for listing the important sources. If the relevance test finds that men and women can be unequally affected by the law, a full gender impact assessment should be carried out. For this the Ministry writing the policy should contact the BSFJ and work together with them on the assessment and any possible changes to the law. This Guideline follows Steps I and II of GMS: Learning about differences and Assessing Policy Impact.

The actual assessment within the Bill is kept very short, and the government concluded that because women tend to have a higher life expectancy than men, there is a “particularly large share” of women among the persons in need of care. Therefore more women are affected directly by all new regulations then men. Meaning, according to the Bundesregierung (2014), they will profit, both on the side of the care receiver as well as care provider, more by the improved services/benefits.

Statistics are listed in order to point out the relevance of the law in the area of GE politics. The table in the Bill (Die Bundesregierung,p.25, 2014) shows the share of women in overall care dependent persons, and then listing the share of women in care personnel (88% in mobile services, 85% in nursing homes) and also the share of women among informal care providers (72%). The Bundesregierung (2014) cites a Schmidt & Schneekloth (2011) study.

No further analysis of gender specific differences in the four areas of inequality was done, and only the aspect of participation was mentioned. The Bundesregierung (2014) is quoting a study that explicitly points out the negative consequences of providing care, in relation to mental and physical health, social exclusion and the lowered employment rate of people providing care (Schmidt & Schneekloth, 2011), and that these negative consequences are more prominent among care providing women. This definitely excludes the possibility that there was no knowledge about the gender specific differences when it comes to providing informal care. It can be only speculated as to why no proper gender impact assessment as called for in the working guideline was made. The lack of harsh legal requirement certainly plays an important role in that, since involving another Ministry certainly is more “hassle”. Like Walby (p. 323, 2005) points out that “the issue is not articulated as opposition to the goal of GE, but rather the prioritization of some other goal”.

4.4 Sub Conclusion

The Policy was designed with a concrete goal: to ensure that a qualitatively high care standard is guaranteed, today and in the future. The pivotal aspect or tool in achieving this is informal family care. Therefore there are provisions in this bill, that aim to make informal family care more flexible and with that a more appealing option to families of care-dependent persons and aiming at increasing the amount of people providing informal care.

And while the gender specific differences in providing informal care were acknowledged to some extent, no real assessment of impact on GE was done. Gender specific differences were mentioned, but it was concluded that the law only brings benefits, and women therefore will benefit more. As explained in Section 3the Gender Specific differences in the area of informal care are significant in three out of four areas of inequality. The reasoning and the content of the bill, underlines the initial thesis that because changes in informal care distribution would be changes to GSYM no proper adherence to GMS Standards will be made.
Only discussing the difference in one area –participation- is not sufficient to meet GMS standards of Step II.

5 THE PLENARY DEBATES

While the bill and the reasoning for it does not discuss and assess gender related differences to a satisfactory extent, the discussion and the assessment of GE related topics can also be carried out in the legislatives debates in parliament. Therefore the parliamentary debates will be analyzed to answer the question 'To what extent was there concern with GE in the stage preceding adoption of the law? '

The German Federal Parliament had two major discussions on the Pflegestärkungsgesetz. The Draft of the Law was introduced, formally on the 23rd of June 2014, and was discussed the first time in the plenary on the 04th July 2014, and the second time in the plenary on the 17th of October 2014, on which day the bill was also decided on and approved. Between those two plenary discussions, the law was discussed in the committee on health. Both debates in plenary were 96 Minutes long. The amount of time each party can talk is dependent on the size of their faction within parliament. Due to its current composition, the government factions (SPD und CDU) combined have almost three times as much talking time as two opposition parties (Bündniss 90/Die Grünen and Die Linke).

Both times the debates were opened by a speech of the Minister of Health by Herman Gröhne(CDU).

5.1 First Debate

The parts of the bill attaining to informal care provision are only a part of it. Like outlined before, the law changed other aspects of elderly care as well. In both public plenary debates the point of greatest debate was the oppositions reproach that the government is doing 'too little too late' and expressing their doubt for future planned reforms. The form of financing of the care insurance also played in both discussions a major role. In the first plenary debate the discussion about informal care provision only played a minor role, but important indicators about awareness or use of gender perspective can be observed.

Hermann Gröhe (CDU), German Minister of Health, makes some statements about informal care provision in his speech during the first debate about the care law (4th July 2014) that indicates the goal of the policy in regarding to informal care provision. He states that "informal care in the family should not be replaced by professional nursing care" and that the goal of the policy in regard to informal care provision is "to motivate more Persons or giving them the means to (…) practice informal family care".

During the entire speech he constantly uses the gender neutral family pronouns like children, grandchildren, parents, and family. The only time he uses the word 'man' or 'woman' is in combination, not indicating gender specific differences. There is no indication whatsoever that gender perspective did play a role when the policy was drafted.

The only mention of the unequal distribution of the care-load was by opposition member Pia Zimmerman (Die Linke), in an interceptive question to Dr. Georg Nüßlein (CDU) speech. In his speech, Dr. Nüßlein states his conviction that care should be provided as long as possible at home, and preferably by the family. And continues to describe how the reconciliatory policy aspects will aid informal care-providers to find time do so and aid them in doing so.

Zimmerman's questions the provisions specifically from a gender perspective, regarding participation and resources, and addresses the gender inequality present:

"How can we, in regard to the person providing care (…) find a solution that prevents, what is for the most part the case: that women quit their jobs or are forced into part-time (…) because they have to provide care tasks?"

Nüßlein's answer reinforces the Health Ministers notion that "family care is preferable to professional care" and that more people should be encouraged to provide informal care. He does not address the point of gender inequality and fails to answer the question as a whole. He claims understanding the question in a way, that critiques the quality of informal care compared to professional care, and when informed differently by members of parliament, still does not address the question about the gender inequality in informal care.

Table 1 shows the word or issue frequency divided by opposition and government. The most important topics for the Opposition were gender, reconciliation of work and family and the negative consequences of informal care. They even mentioned these issues more frequently than the Government Factions, even though their speaking time is only a third of the speaking time of the Government Factions. This is an indicator that questions of GE did play a greater role for them.

	Goverment	Opposition
Woman/Sister/Daughter/Granddaughter /Sister-in-Law/ Daughter-in-Law in a 'gender' context	2	3
Man/Son/Brother/Grandson/ Brother-in-Law/Son-in-Law in a 'gender' context	0	0
Gender	0	0
Change of family structure	5	0
Reconciliation of family, care and work	4	4
GE	0	0
Making providing care at home easier	3	1
Negative consequences for informal care providers	0	3
Providing Care at home better than in a nursing home	7	0
Flexibility for informal care providers	5	0

TABLE 1: 4TH JULY 2014 WORD COUNT 2ND DEBATE IN THE BUNDESTAG

For the Government the advantages of informal care, or care at home in contrast to care in a nursing home as well as making care at home easier were mentioned the most frequent. This fits in with the focus of the policy: making care at home easier, so that more persons provide care.

The first debate underlines the impression from the Bill and the reasoning: Challenging the status quo of gender relations is not a priority to the government. Not acknowledging or ignoring gender specific differences is therefore the easier solution.

5.2 Second Debate

The second debate in plenary, together with the vote on the bill, was held 3 Month later on the 17th of October. While issues of financing the law, were still in the foreground, more was discussed in the speeches about informal care providers. Since the plenary debates are

mirroring the discussions in the committees, the assumption that the issue of informal care providers was discussed (heatedly) can be made. The overall mentioning of issues connected to the provision of informal care greatly increased on the governmental side compared to the first discussion (compare table 1 vs. table 2).

There are two very direct indications that there was awareness and knowledge about the existence of Gender Specific differences. The first by a member of the opposition party, Katja Kipping (Die Linke):

"We know, that informal care is mainly provided by daughters, wives, daughters-in-law – in short: by women – women that are taking burdens for that: salary cuts, cuts in their pension rights, sacrifice of leisure time. They have deserved more than well meaning words of praise in Sunday speeches."

She not only acknowledges that there are gender specific differences, but also directly touches on two gender inequalities: Participation and Resources. Yet there is no questioning this difference from a gender perspective.

The second statement is by a member of the government, Mechtild Rawert (SPD): "Furthermore we want more GE. The apparent self-evidence, that also in the future women will be carrying the majority of the load when it comes to care, is deceptive – not due to a lack of love towards their families, but due to the increased amount of gainful employment and higher mobility."

While she does mention the issue of participation, the unequal division of care labor, and she does speak about gender inequality, there is no conclusion or solution to it, nor is there an explanation how the law is a positive influence on GE.

	Government	Opposition
Woman/Sister/Daughter/Granddaughter /Sister-in-Law/ Daughter-in-Law in a 'gender' context	0	3
Man/Son/Brother/Grandson/ Brother-in-Law/Son-in-Law- in a 'gender' context	0	0
Gender	0	1
Change of family structure	1	0
Reconciliation of family, care and work	6	3
Gender Equality	1	0
Making providing care at home easier	16	1
Negative consequences for informal care providers	1	4
Providing Care at home better than in a nursing home	17	0
Flexibility for informal care providers	17	2

TABLE 2: 17TH OCTOBER 2014 WORD COUNT 2ND DEBATE IN THE BUNDESTAG

While the gender perspective was mentioned by a member of government, it is not connected to the provisions in the bill and does not constitute a real analysis of the situation. The overall word count of the debate shows the same again. Gender related issues or words are mentioned far more frequently by the Opposition than by the Government.

5.3 Sub-Conclusion

When examining both plenary debates, it becomes evident, that the legislators were aware of gender specific differences in the provision of informal care. But it becomes also evident, that no or little attention was paid to the gender perspective on the issue, and the impact the policy would have on gender inequalities.

Even though they have significantly less speaking time, on issues like negative consequences for care providers and indicating the gender of the informal care providers, the opposition raised in both debates more issues concerning gender , and in the first debate also on the topic of reconciliation of family work and care. This is a strong indication that either, the opposition was more aware of these gender related issues, or measured a higher importance to them.

The analysis of the debate underlines the conclusion from the analysis of the draft of the bill: The Gender Specific differences in informal care were known, but they were neither examined properly, nor was the law significantly acknowledging them in neither the process nor the result. This reinforces the thesis, that a proper adherence to GMS standards was not made.

6 CONCLUSION

After answering the sub-question it is now possible to answer the main research question:

To which extent does the German Care Act (Pflegestärkungsgesetz I) meet GMS standards in relation to informal care provisions?

Existence of Gender Specific Differences

In three out of the four areas of gender inequality great gender specific differences can be found in informal care provision.

When it comes to participation the configuration of the male to female ratio is heavily skewed towards women. The majority of (informal) care-providers are female; therefore any policy touching the area of informal care directly influences more men than women.

There can be a difference observed when it comes to resources. Informal care has negative consequences for the person providing it, in terms of health, risk of poverty and risk of social exclusion. Arguments that these differences are caused by the socio-economic background alone can be disputed. The effects remain standing for women only, when socio-economic differences are accounted for.

Arguably the biggest gender specific difference can be found in the area of norms and values. One of the major deciding factors in determining who out of a family or a household will take over care duties is gender. This cannot only be explained, with the often lower earning potential, or household specialsiation of women.

While the rational choice, social exchange, and the neo classical labor market theory are able to explain general reasoning factors, and great parts of the gender specific differences, they do not manage to do so exhaustively. Only the GSYM is able to explain the underlying pattern of care work distribution. Care work is regarded as a “female” job and is therefore still mainly performed by women.

Examination of Gender Specific Differences –Step II

With the gender specific differences in informal care being so great, any legislation concerning informal care should examine and assess the possible impact the policy has on GE, in order to ideally ameliorate or at least not deepen them any further.

Obviously the policies goal was not to achieve GE among informal care providers. The main goal of was: to ensure that a qualitatively high care standard is guaranteed, today and in the future. And while the gender specific differences in providing informal care were acknowledged to some extent, no real assessment of impact on GE was done. Gender specific differences were mentioned, but it was concluded that the law only brings benefits, and women therefore will benefit more. Only discussing the difference in one area –participation- and not analyzing them in the slightest is not enough in any way to meet GMS standards, or to conclude that women will only benefit from this law.

The plenary debates, underline the notion that legislators were aware of gender specific differences in the provision of informal care, but paid no or little attention to them or the policies impact on them.

Summarized it can be concluded, that the awareness about gender specific differences was present in the administration when designing the law yet little or no assessment of the consequences of the law on GE were made. Even though the focus of the law was not on GE that does not discharge government under GMS from having to examine or assess the effects. Since Step II of the process was not concluded, Step III was not concluded as well.

These findings support the initial Thesis that, because adhering to GMS standards would change the relationship between Genders and therefore change the parameters of the gender contract, it is unlikely that the standards were adhered to when designing the Pflegestärkungsgesetz I.

Even though Germany publically internally and externally committed to GMS, it is very unlikely that the GMS process was followed when designing the care policy.

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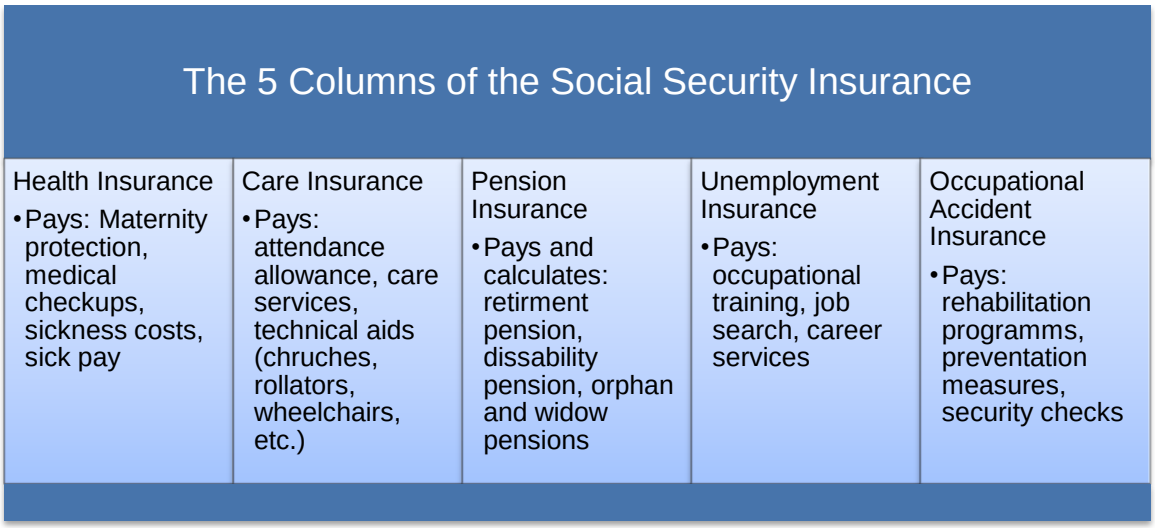
APPENDIX I –SOCIAL SECURITY INSURANCE



APPENDIX- II STRUCTURE OF THE GERMAN CARE SYSTEM

In the following section the German Care system will be summarized and explained, in order to be able to show how the German care system is structured and what are the pivotal points of it.

I. Care Insurance

Persons depended on care, receive the benefits and support through the so called Care Insurance.

The German Care Insurance (Pflegeversicherung) is a fairly "new" part of the German social security system, and constitutes the 5th column of social security (see Apendix 1.1) complementing the basic security benefits. It was seen as a necessary step, because the prolonged life span of people, in combination with a lower birth rate, lead (and is still leading to) a constantly aging population, with a significant increased need for elderly care. It became effective in January 1995. Since „in principle everyone can be in need of care, care insurance has been made mandatory from the beginning" (Bundesministerium für Gesundheit, 2015).

The Insurance is financed by premiums paid by the employer and the employees in even parts, while childless people have to pay a slightly higher premium then persons with children. The Insurance is a partially comprehensive, covering half of the estimate costs of care, dependent on the care-level, while the other part is paid by the patient themselves.

This underlines that the care-dependents persons financial means, and in many times their families play an essential role in guaranteeing that care is paid for. But this also underlines an inequality: poorer care-dependents or care-dependents with poorer families have less options available when choosing what kind of care the care-dependent will receive.

II. Care-Levels

The German Care-System knows three kind of Care-Levels, the so called "Pflegestufen (I,II &III)". The Care-Levels are allotted to patients depending on the amount of help the person

needs in managing their daily activities. This determines the amount of financial support the patient will be receiving from their Care-Insurance.

When the patient, or their care-givers, apply for care-support from their care insurance, the insurance commission the “Medzinischer Dienst (MDK)” assess the need of care support of the patient. They assess the time-need based on assessment guidelines (Begutachtungsrichtlinien) in the home of the patient, and then allocate him into one of three care-levels (Bundesministerium für Gesundheit, 2015).

The first level is care-level I which signifies a substantial need for care. The patient is at least once per day in need of aid, for two tasks in the area of principal care (Personal hygiene, nutrition, mobility). As well as weekly need for care in terms of household tasks, with a total average daily need for care for a minimum of 90 minutes per day.

In care-level II, the amount of care is significantly higher. The care dependent is heavily reliant on care. Care is needed at least three times per day for principal care, as well as weekly need for help in household tasks. Overall an average daily care time of a minimum of three hours is necessary.

Care level III is allocated to persons with the largest care need. The patient needs care around the clock, for all things concerning personal as well as household tasks. On average five hours per day minimum need to be spend on care, as well as several hours per week to complete household task.

Apart from the three care levels, the system also knows a so called hardship provision. This provision is granting more money for cases that fall into care-level III, but for which the amount of care is „in quality and quantity beyond and above the basic conditions of care-level III care effort needed” (Bundesministerium für Gesundheit, 2015).

As mentioned in point 3.1.1 the care levels assess, based on the expected amount of time need for care, the amount of money/benefits the care-dependent person will be receiving.

III. Types of care

In the following part the different types of care are going to be explained. This is not an exhaustive list, but covers the main types discussed in the law and with that sub sequentially in the thesis.

The German system differentiates between 5 major types of care. The first type being informal or family care. This is care provided by friends or family members on an unsalaried basis. In order to receive benefits, or be applicable for short-term or temporary replacement care, the provider needs to be a close family member.

The second type is inpatient care, the patient is living full time in a care facility. Often inpatient care is seen as the ‘opposite’ of informal care. Typically there is a distinction between three types of care facilities. In a classical nursing home the patient lives in a single or double room and all household tasks as well as care tasks are completed for them. Then there are two types of retirement homes, where the patient usually lives in a small apartment, or room with their own kitchen and varying degrees of help in the household as well as in care tasks (Bundesministerium für Gesundheit, 2015).

Ambulatory Care can be defined as care ‘at home’ where the person in need of care, or the family members are supported through outside professional care providers. That can be in the

form of a professional care service, or individual nursing staff (Bundesministerium für Gesundheit, 2015)

A forth type is short-term care. Like the name suggest, short-term care is a temporary stop-gap measure. That covers the cost for temporary inpatient care. There are many patients that are only in need for in-patient care for a limited amount of time (Bundesministerium für Gesundheit, 2016). This is often the case after a hospital stay, when the patients cannot live by themselves for some time, and the family care providers is unable to either provided the care needed due to time or skill constraints. One can also apply for short-term care if, permanent inpatient care is planned but no proper place is found yet, or if the care need arose suddenly and preparations and changes need to be made at home to accommodate the new status.

Similar to short-term care, temporary replacement care is not a permanent solution. In case the main care provider is sick, or on holiday, or for other reasons is not able to provide care for the patient, the care insurance will cover the cost for replacements costs for up to six weeks per year (Bundesministerium für Gesundheit, 2015).

IV. What is the most common type of care?

In order to be able to see what kind of role informal care plays in the system, it is important to have an overview over the care recipients and what kind of care they are receiving. There were a recognized total of 2.6 Million people in need of care in Germany in 2013 (DStatis, 2015).

The estimated number of persons dependent on care is estimated to be around 4.6, significantly higher than the amount of people receiving money out of the care insurance (Wetztstein, et all 2015). The majority of persons depended on care are female (64%) which corresponds with the higher percentage of women in the age group of 60 and above.

There are several possible explanations for the discrepancy between the estimate and the recognized number. One important factor is the guidelines that are being used to assess the care-level. They focus mainly on the amount of time the care-giver needs to complete certain physical tasks, which leads to an assessment with regards to persons with mental or cognitive issues viewed by many in the public discourse as unjust.

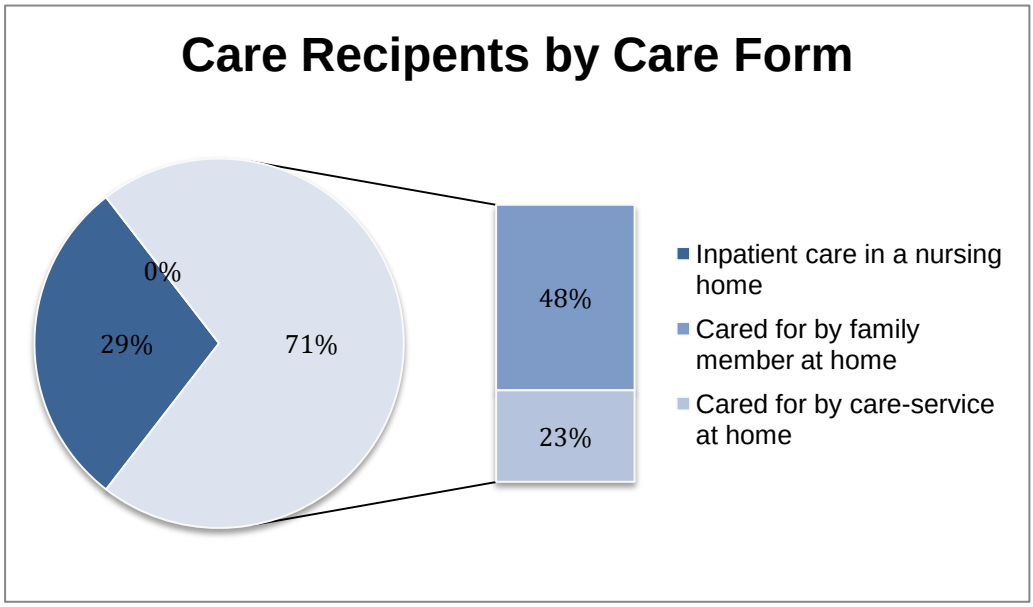


FIGURE 1: CARE RECIPIENTS BY CARE TYPE IN PERCENTAGE (DSTATIS, 2013)

Another factor in the discrepancy is persons that could receive care-aid but do not apply. One of the groups is migrants. Migrants in need of care are the fastest growing demographic. As many of the former “guest” workers start entering into retirement age. Currently Migrants are, in comparison to Persons without migration background, using care aid significantly less frequently (Kohls, 2015).

Kohls (2015) offers two explanations for this. The first being that migrants are more likely to rely on the family as a support system, and secondly that at the same time the knowledge level about options and aids available is less spread.

More than two thirds of all patients in need of care are taken care of at home (see Figure 1) with a total of 1,25 Million being cared for by family members alone, and 616 000 being cared for at home with the aid of a professional care agency. The remaining 764 00 are receiving inpatient care in a nursing home.

This makes the family “the biggest care organization in Germany” (zeit.de 2015).

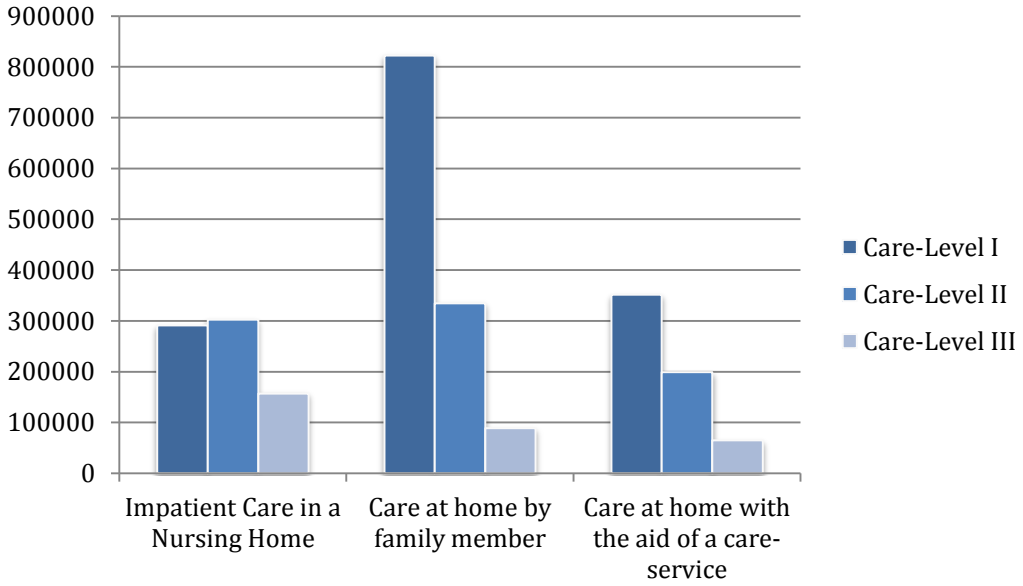


FIGURE 2: DISTRIBUTION BY CARE TYPE (DSTATIS, 2013)

While overall informal nursing care provided by family is the most frequent form. The share is decreasing with increasing care intensity, as illustrated in Figure 2. While for care-level I & II the most frequent form is family care. For care-level III the most common form is inpatient care. Care at home with the aid of a care-service is the least frequent form on all care-levels.

Germany is one of the countries with the highest percentage of care being provided at home, only topped by a few South-European Countries. In Scandinavian Countries only 50% of persons are being cared for at home, compared with Germanys 71%. This difference is equally obvious in the percentage of persons being exclusively cared for by family members (Haberkern& Szydlik, 2008). This is not surprising because as Haberkern & Szydlik (2008) point out, the German care-insurance was designed explicitly as an addition to informal-care within the family.

With informal family care being the most common care type, any legislation aimed at the care-system, does not only touch the care recipients, but directly influences the families as care givers as well. Making informal care and it’s providers an important aspect of all policy considerations.