Elderly Care Policies of Germany and Austria: Lack of Innovations Towards Migrants’ Special Needs

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Abstract

How strong is the awareness of migrant-related problems and inequities in elderly care in Austria and Germany? And how do health policies of both countries respond to this issue? My investigation covers a field research of migrants’ aspects in the health care policies of both countries and provides a qualitative analysis of the discourse on elderly care and migrants. The focus is on elder Turkish and former labor migrants in Berlin, Hamburg, Munich (Germany) and Vienna (Austria).

As a result of the field research, the discourse about and the projects within health care for migrants is decisively governed by two interests: political interests of integration policies and any kind of economic interest. Views of elderly care for migrants range from commercial product design to integrative capacity and shape the respective health care policies in distinct ways.

We can find the paradigm of Intercultural Opening as a German-wide consensus affirming actions against inequity in elderly care. This policy implies that migrants face different access barriers to standard elderly care facilities. Inequity in the access to elderly care offerings is thus seen as a problem of elder care facilities and services.

The Viennese approach of a Diversity Management in health care emphasizes equal and qualitatively the best treatment for all members of the society. This policy implies that migrants generally disfavor the standard elderly care facilities. Inequity is thus seen as a problem of migrants’ individual request or preference.

Finally, I will analyze why innovative migrant-related measures in elderly care are only sparsely found.

I. Introduction

Elderly care for migrants is discussed in welfare since the late 1990s in Germany but only slowly becomes an issue in Austria. We are thus faced with the quite interesting situation of comparing two countries that strongly share similarities in their health care systems and also in the history of labor migration, whereas their policies, practices and discourses towards migrants in elderly care are strikingly different, and, even opposite awareness about the need of a special treatment of migrants in elderly care is recognized.

Social needs are more and more justified by demographic development and statistics and less by democratic considerations as the following example demonstrates. In Germany 16.4 million inhabitants have a so-called migration background, and 9.7% of them are older than 65 years with a

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II. Methods

A field research was carried out in three different cities of Germany (Berlin, Hamburg, Munich) and in the capital of Austria (Vienna). Activities and offerings in intercultural, transcultural or culturally specific elderly care were searched and monitored. German activities are found in the political sector, in the academic sector, in welfare work, in the networking of organizations, and in civic engagement. Elderly care offerings are found in the non-profit (welfare care) sector and in the for-profit (private) sector. Compared to Germany, the spectrum of activities in Austria is narrow and the academic, political and health care sectors were analyzed.

Data collection was carried out by visiting elderly care offerings and carrying out interviews with patients, care-givers, care providers, discourse participants, nursing educators, politicians. Furthermore the discourse and the development of activities was followed in newspapers, information folders, radio and television, and in the internet. First results were analyzed according to a Grounded Theory approach that helped to categorize the notion of culturally sensitive (or culturally specific) elderly care in both countries. The categories were further analyzed. A content analysis of the observed discourse was added that helped to identify the risk-chance-duality. All following results are qualitative in nature.

1The migration background represents a modern category of population and is strongly politically charged. A history and critical summary is found in [Perchinig & Troger 2011]. It should be noted here that the definition of a migration background is different for Austria and Germany. Roughly speaking, since 2008 the Austrian census speaks about a migration background of citizens when both parents are born outside of Austria. In the German census since 2004-2005 a migration background is given with immigration to Germany after 1945, with a foreign citizenship or for native Germans with at least one parent born outside of Germany. In both countries deviations from the national definition are regionally in use. For example, the Viennese definition is similar to the German definition.
III. Paradigms in Elderly Care

A. Germany: Intercultural Opening

The term *Intercultural Opening* has experienced a shift in its meaning and content with time (see Table 1). It strongly depends on who is using the term in which context, thus *Intercultural Opening* has been used in different fields, ranging from pedagogy and sociology to welfare policy, and, finally to integration politics. A shift in meaning can be found whenever a new community (individuals and organizations) discovers the term in order to represent themselves or their concepts.

In order to shortly describe the transformation of the term *Intercultural Opening*, one should remember that the term was coined in the 1980s by social workers, educators and sociologists as a demand for equity at a time when culturalization of concepts became fashion: Higher school education and training/employment opportunities should open for adolescents with a background in migration.

The application of the term *Intercultural Opening* was further broadened to administrative agencies, employment policies and social services with the meaning of equity in recruitment. In this sense, the idea of *Intercultural Opening* bears also the notion of *Diversity* since the ethnic composition in recruitment of the public service, for example, did not reflect the ethnic composition of the population. *Intercultural Opening* is strongly related to the emergence of migrants of the so-called second-generation.

During the 1980s welfare organizations were increasingly criticized because of their paternalistic position upon migrants. Counseling of migrants in Germany has been performed since ever by welfare organizations in special agencies running parallel to regular information centers for the German population. The special agencies were claimed to create a doubling of costs for social services in general: the German welfare system sensed the afterpain of the economic crisis from 1974. It was further argued that this separation in counseling between migrants and the German population would lead to an enhanced segregation in society. Furthermore, migrants of the second and third generation could easily use the regular social services, certainly nourished by a critical report of Nestmann and Tiedt in 1988. The special services for migrants were possibly well-intentioned but did not effectively support the inclusion of migrants into society. The demand developed in the context of *Intercultural Opening* led thus inevitably to a criticism of welfare organizations in their mentoring of migrant issues. *Intercultural Opening* aspired towards a transformation of organizations and society.

In a subsequent stage, the term *Intercultural Opening* was absorbed by welfare organizations. The previous criticism was turned into a mission statement in the late 1990s for administration, social and finally elderly care activities of the Workers Welfare Federal Association (AWO), and both main Christian social welfare institutions, Caritas and Diakonie. It was a repeated demand for equity, a cloned version of previous concepts developed in education. The newly started activities of welfare organizations in elderly care can be described as pilot projects or regional joint-programs in migrant counseling.

Around 2000 an established *Task Force Memorandum* (*Arbeitsgruppe Memorandum*) with different participants mostly from welfare institutions installed a proposal for how elderly care for migrants should look like and coined it a *culturally sensitive elderly care*. One of the main aspects of their working paper was that elderly care of migrants is in the need of time. In a sort of a manifest, the main welfare organizations in Germany agreed to implement strategies for an Intercultural Opening of their services. However, a transformation of conservative structures like the ones appearing in social welfare organizations has never found a real support by their top management. Instead, any necessary
process of transformation was labeled with slowness and infeasibility. Simultaneously, in order to channel emerging activism within their own institutions, a simple model picture of access barriers for migrants to their services was promoted with the idea that their removal will solve all problems. The simplified picture contains social services and organizations, a favored group (native Germans) and an excluded group (migrants), where exclusion is a result of barriers. Thus, the discourse driven by members of social welfare organizations was mainly focusing on the description of access barriers for migrants to social services and elderly care and it was linked to the demand for their reduction. In contrast to a transformation of the whole organization, for which nobody provided a realistic concept, projects for migrants could be funded much easier. Unfortunately, social issues were still not treated in a holistic way, and migrant issues in elderly care were separated from general elderly care (also in order to attract attention and funding). Not surprisingly, Intercultural Opening is sometimes regarded as ineffective, as failed or without notable progress because of its inconsistencies.

Finally, the term Intercultural Opening was absorbed by federal integration policy. Around 2005, Intercultural Opening has become a commonly used term in the discourse about elder migrants. The notion of providing culturally sensitive health care was directly linked with the idea of reducing access barriers to regular social and health care services, nursing homes and hospitals, as described above. For example, the term Migrant-friendly hospital and the correspondent project denotes such an activity. More importantly, Intercultural Opening was understood as a reduction of access barriers for migrants and became synonymous to the inclusion of migrants, and therefore, a German-wide consensus. Intercultural Opening became a key-phrase in political strategies in integration. It is mentioned in the National Integration Summit (2006), the National Integration Plan (2007) and the National Action Plan (2011). The absorption of Intercultural Opening into political strategies finally has again shifted its meaning towards common aspects of integration politics, predominantly integration of migrants into the labor market and their education in health professions. Implementation and quality of health care offerings (not only) for elder migrants play a subordinated role, although the increasing number of elder migrants is commonly mentioned as ingredient in recommendations for the funding of more migrant-related activities.

The intellectual concept of Intercultural Opening in elderly care for migrants in Germany today is congruent with other descriptions of health care for minorities, for example, the Hispanic minority in the United States. An entry about Hispanic and Latino Elders in the Encyclopedia of Elder Care provides the summary: Optimal health care for the Hispanic population requires that health care providers embrace the cultural diversity of the population they serve. Elder Hispanics are the fastest growing segment of the minority population and they share many common cultural links. Unique barriers exist, and their solutions will often involve not only the individual and family’s efforts but sustainability of the actions will also require community and national efforts. Understanding culturally specific characteristics of Hispanic elders can enhance the quality of health care services, facilitate meaningful and culturally appropriate interventions, and ensure a mutually healthy relationship. One-to-one correspondences with the frames of Intercultural Opening could read as

- health care providers have to embrace the cultural diversity in reducing the access barriers for the migrant population,
- elder migrants are one of the fastest growing segments of the total population,
- elder migrants share many common cultural links,
- unique access barriers exist,
- structure of migrant families change and result in decreasing support for elders, therefore community and national efforts are required, and,
- understanding culturally specific characteristics of elder migrants enhances the quality of
health care.

In addition, there is also the common notion of access barriers and their description as language barriers and cultural barriers. Actually however, changes in the perception of migrants and especially refugees have an increased impact on the established immigrant-friendly policy (Willkommenskultur) that must be observed in future investigations.

Since around the year 2000 elderly care for migrants is also a field for private (for-profit) providers. The culturally specific offerings differentiated from the intercultural opening program, because latter was strongly developed from and for welfare organizations. A battle about migrant patients between welfare organizations and private providers started that finds itself in the mutual denial of success or quality. In the meantime culturally specific home care services seem to attract more attention that is caused by a more aggressive advertisement and in successful networking within politics and science. The image of elderly care that for-profit providers offer is highly biased and must be treated carefully.

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B. Vienna (Austria): Diversity Management

Vienna’s policy towards migration has a schizophrenic touch. The municipality of Vienna boasts today with the status of being a city of immigration (Wien ist eine europäische Einwanderungsstadt) [Vienna Government 2016], gladly putting the city into the heart of Europe or referring to the nostalgic past of a fin-de-siècle. As pointed out in [Perchinig & Troger 2011] the Viennese census defines migration background in a much broader sense than the overall Austrian census resulting in an increased percentage of people with migration background, especially among the oldest seniors (because they easily have one of their parents born outside of today’s Austrian borders in other parts of the former Austrian-Hungarian monarchy). Census figures can be easily used for the design of a self-portrait of the city, as it can be seen also, for example, in the classification of Vienna as ‘german city’ in 1900 based on disputable data about a (single) colloquial language. Simultaneously there is, however, a strong tendency for xenophobia, stereotypes and an aversion for segregation [Moser & Leidinger 2010]. Integration is more understood as assimilation and regarded rather as an individual duty than a collective one. Special treatment for migrants/minorities is regarded as unjustified privilege. As pointed out by Perchinig, integration became a container concept in the political discourse, that can absorb any meaning [Perchinig 2010].

In contrast to Germany, welfare organizations in Austria did not establish counseling services for labor migrants (so-called guest workers) divided by confession and origin. In December 1971 the Viennese municipality and the social partners[^2] have established a fund (Fonds zur Betreuung

[^2]: the social partners are the Chamber of Labour (Arbeiterkammer), the Austrian Federation of Trade Unions (Österreichischer Gewerkschaftsbund), the Austrian Federal Economic Chamber (Wirtschaftskammer), and the Federation of (Austrian) Industries (Industriellenvereinigung)
und Beratung von Zuwanderern nach Österreich) for a legal and social counseling of about 60,000 immigrants in Vienna. Six counseling services with translators were established as immediate action opened for 2 hours in the evenings. The service was, however, accessible for all immigrants to Vienna, independent of their citizenship and continuously transformed in their content from counseling to renting cheap accommodations.

Other tasks such as counseling or the support of integration by providing information, especially for the so-called guest workers from former Yugoslavia and Turkey, were not properly fulfilled. In addition, finding a first accommodation was not a major problem for the migrants, because in most cases they were provided by the employers. The immigration fund did further not prevent the discriminatory housing situation of migrants in sub-standard flats and the exclusion of migrants from subsidized low-cost housing (Gemeindewohnungen) in Vienna. In the 1980s drug addicted people were partially resettled into apartments of the immigration fund. Today, the fund for immigrants (Zuwanderer-Fonds) was recently criticized in the report of the Austrian Court of Audit, that it developed practically into a building and apartment management with unclear practices. In 2012 only 7% of apartment renters were foreign citizens, 45% of the renters migrated to Vienna within Austria. All other renters are Viennese individuals or enterprises.

Health care for migrants has never been a central topic in the Austrian public discourse and is only marginally represented in research, especially in health care studies (see figure in [KMI ÖAW 2012:12f]). The lack of studies is typically referred to a lack of statistical data (see for example in [Hofbauer 2004:57]), an invalid argumentation that easily constitutes a short-circuit because the lack of data in turn is caused by a lack of studies. The establishment of target-group-specific health services, research and prevention measures (for example, for elder migrants) was demanded by, for example, Baldaszti already one decade ago but is still not on the political agenda today. Arguments that target-group-specific offerings would not be necessary, because migrant families would take care of their elders, can be heard until today. Diversity is an emergent term in the health care policy of Vienna and often connected with the term monitoring. As stated in an encyclopedic work: Diversity management is known as resource management in a global economy and in first instance applied to the recruitment and motivation of staff within an enterprise. Diversity management has two dimensions: First, the ambition to display a positive picture of the organization to the outside world - a picture that showcased individuals with different identities. In practice however, the prevailing climate within the organization was one of conformism. Second, motivation of the staff is enhanced by rejecting discrimination and empower employees by accepting their identity.

The Diversity Management in Vienna’s health care policy is based on the conviction that a diversity in staff and a high technical quality standard is able to provide the best possible elderly care for anybody. Equal treatment is claimed, however, equivalent treatment can be questioned and there are no specific offerings for migrants. The interest in establishing a specific elderly care service for migrants (for example a day care center or a nursing home) was phrased sparsely by some doctors and nursing scientists scholars during the past two decades without success: a proposal for a separate nursing station for migrants from Ex-Yugoslavia integrated in a welfare organization was fizzled out, a proposal for general offerings for elder migrants for the 10th district in Vienna was blocked, a proposal for a day care facility for Persian migrants to the Vienna Social Fund (Fonds Soziales Wien) was bureaucratically crushed and applicants were demotivated, a proposal for a culturally sensitive activity for migrants within the Diakonie was blocked by the Vienna Social Fund as well. A well running counseling service (called Beratung am Eck) for elder people in the

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3 An ‘extensive’ treatment of the topic of migrants’ health as mentioned in [KMI ÖAW 2012:12f] sounds exaggerated according to their presented statistics.
15th district of Vienna was closed by the Vienna Social Fund under contradictory statements. Regularly, informants of the above cases want to stay anonymous and mention to be afraid of consequences as long as they either are employed by or have to collaborate with the municipality of Vienna. Only the latter case was reported in one local newspaper. The counseling service (Beratung am Eck) was founded in 2000 and reckoned for its important activities.\cite{Sterkl2007, Schloegel2009} It included intercultural meetings for elder women, a special health promotion for Turkish elder women and multilingual offerings.\cite{FSW2007} Towards the newspaper the Vienna Social Fund argued that the number of interested persons was decreasing and counseling would not be their main task.\cite{Gantner2012} Head of the service until 2011, Elisabeth Ettmann, however, stated that the number of interested persons with migration background increased resulting in complaints by non-migrants using the counseling facility. Towards Ettmann the Vienna Social Fund complained about the running costs of a copy-machine and too many forms would have been copied and printed. In fact, the copy machine was only one tool for the counseling service in helping persons to fill out forms for authorities. This example demonstrates not only the perverted argumentative strategies, when a social service becomes more frequented by migrants than by non-migrants, but also the obvious meaning of Diversity Management, that aims to regulate the use of their services by the population category migration background. One can speculate that with a majority of native users, the counseling service would be still financed.

The context of diversity in Diversity Management should not be misunderstood: Social diversity should be managed and channeled into the health care services, but it does not necessarily mean to provide culturally diverse elder care services or specialized offerings. The actual practice of the Diversity Management in Vienna’s health care policy facilitates the exclusion of minorities with special needs.

IV. Results and Discussion

A. Care about Special Needs and Equity

Elderly care for migrants or culturally specific as well as culturally sensitive (transcultural, intercultural, etc.) offerings in elderly care are commonly decoded as special needs care in the German discourse.\footnote{For the purpose of this study the subtle differences between transcultural, intercultural, and culturally sensitive care are neglected. The concepts are however well distinguished from culturally specific offerings that - in contrast to the previous concepts - focus on a single specific origin or cultural background of the patients.} The Anglo-American term special needs care, that describes primarily educational and health care for children with special disabilities, is not installed as officially used expression in context of elderly care for migrants. Nevertheless, migrants in elderly care are experienced as a minority group in Germany and Austria who have special needs that deviate from a host society generated standard.

Special needs of elder migrants in health care are ranging from a language-based intervention to the respect of cultural habits, tastes and religious backgrounds in day care centers and elderly care services. In most cases these needs are described as culturally specific ones, where culture stays a hazily defined term and is reduced to a minority speaking a specific language, originating from a specific country, sharing a similar experience of migration or to members of a specific religion. Communication among elder migrants in their first (mother) language is viewed as important promoter of well-being. Language-based treatment in health care, for example, becomes extremely important, especially for patients suffering from dementia, Alzheimer’s disease and an impairment of memory as shown in various studies.\cite{Ekman1994, Fabbro2001}
The counseling of migrants in elderly care in Germany was described in a first analysis as preferential practical oriented and without theoretical foundation. Among the discourse participants it is jointly accepted that due to their migration experience and situation migrants face additional specific problems that result in special needs. Main topics in the discourse concentrated around the term stranger, the dilemma between staying and returning, and ethnicity as resource. From these topics we can already experience a shift from culturally charged terms via an individualistic approach to the disposition of risks and chances, where ethnicity as resource favors a positive connotation of migration and a chance for society and/or individuals. Latter aspect will be discussed below in more detail.

The acknowledgment of elder migrants’ special needs provides the basis for argumentation pro culturally sensitive or specific elderly care. The process of Intercultural Opening among welfare organizations in Germany is, for example, directly triggered by migrants’ special needs where the adaption of health care offerings according to the needs as well as a reduction of access barriers for migrants in health care are demanded. It has to be emphasized here, that the original meaning of Intercultural Opening as demanded by social workers, in education and later in pedagogy opposed the special treatment of migrants by welfare organizations and the doubling of counseling services. However, the awareness about migrants’ special needs in elderly care is explained with social justice and equity, integration and social inclusion and sometimes as a feature of quality. Simultaneously, culturally specific elderly care offerings founded by for-profit-providers in the private sector highly utilize the special needs argument as motivation and also as their supposed right to employ and recruit special staff, i.e. predominantly staff with the same migration background as their patients (clients). Their specialization towards a specific group of patients is stronger argued as an issue of quality, and is externally categorized as ethno-marketing. The awareness about migrants’ special needs is sometimes also argued to serve social justice and integration of migrants into society.

With the acknowledgment of special needs the inequity of migrants is understood to originate from structural deficits of the elderly care services, and, there is the expectation that a properly adaptation of the service or a culturally specific offering would help to decrease inequity in the access of elderly care services. Rhetorically, this image is strongly transported by the demand of the identification and removal of access barriers for migrants in elder care services.

In contrast, elder migrants’ special needs stay unaddressed for example in Vienna’s Diversity Management approach, a policy that does not favor culturally sensitive or specific offerings, however special needs were even indirectly claimed in the recently released Austrian dementia report. In chapter 6.7.2 of Austrians dementia report the authors concluded that although if information and structural support [for dementia patients] would be created [in the care of migrants, the migrants] would not accept them and migrant families ... would [continue to] care about their elders at home. Such a future scenario can never be empirically founded and is in contradiction to experiences from other countries but obviously should serve as confirmation of the actual policy and prevents already in the forefront possible necessary developments towards multilingual or language-based treatment in the care of migrants suffering from dementia.

Based on this view, inequity is understood to originate in the migrants’ deficit to accommodate with or to accept existing standard elder care offerings. Equal treatment of all patients is claimed, however, services in elder care are unequally accepted, or, migrants have individual requests that cannot be covered or would not be economically feasible. As a consequence, inequity could only be reduced if the migrants’ behavior changes. Simultaneously, as the above quotation of the Austrian dementia report proofs, it is pretended by policy makers that a change of migrants’ attitude towards professional elderly care cannot be expected - even if special structures would be
generated. Rhetorically, differences between migrants and the host population in elderly care or special needs are not stressed and better not mentioned.

B. A Problematic Discourse with Risk-Chance Duality and the Problematic Role of Social Science

There is a problematic discourse about migrants in health care (and also in elderly care) that is based on a risk-chance duality. This risk-chance-duality can be found in the rhetoric of the public discourse, in the social sciences about elderly care of migrants, in lobbying and finally in political and economic discussions. Risks and chances can be phrased for the individual or for a community (or the society). The risk-chance argumentation can be viewed as a product of neoliberal ideology. Within this ideology social welfare is reduced - according to Macnicol - to charity. Pensions and in a wider sense elderly care should be only rights for those who can afford it, which makes pensioners the most economically vulnerable group.\[Macnicol 2015:5\]

It is talked and written about access chances or more about access barriers to health care offerings or the health care system, latter poses the risk to fall through the social net of benefits. Ethnicity is often highlighted as a resource (chance), as well as participation, that is regarded as chance for social justice. Special services in health care for migrants pose a risk whenever they are blamed of supporting segregation or the formation of a parallel society. Economically, the establishment of a special care offering for migrants is viewed either as financial risk or as chance in a market niche. Diversity is positively regarded as a chance. Demographically, the migrant status is regarded as risky when vulnerability and marginalization are analyzed, however, migration is described as a chance in the discussion of labor markets, for example.

The coloring of statements on elderly care for migrants with risks or chances depends on the predominant policy and is charging the discourse with emotions resulting in a gradual loss of fact-based arguments. The philosopher Byung-Chul Han relates the observed increase in emotions with neoliberalism: emotions support the sense of freedom, should be consumed and act as the resources of a neoliberal regime.\[Han 2016:64f\] Social and emotional competences\[Ibid. 66\] of employees become importantly discussed in the frame of cultural competence in elderly care. As a result political decisions and social welfare are based more and more on emotions generated in a discourse of stakeholders and less on actual needs within the society. Such a development opens the way for the development of myths and fictions. As a dramatic consequence for the social system stakeholders with the most effective emotions succeed and determine the policies for years instead of more balanced solutions that are based on facts.

Social scientists play an important role in the foundation of policies and the generation of images of the society. A newspaper title promises 'olives for breakfast' (Oliven zum Frühstück) \[Lindner 2015\], but should elderly care for migrants be reduced to a fruit? Especially the romantization of for-profit elderly care services in good-practice examples is highly critical. The so-called 'good-practice' is neither a quality nor a moral testing. In neglecting scientific standards a fatal cooperation result between scientists and private providers. In the case of shared living arrangements that have to be classified as 'under the regime of' by a private elderly care provider in Berlin the information provided by the owner is directly transferred into an expertise for the ministry without any scientific investigation by the researcher.\[Tezcan-Güntekin2015\] In the expertise one can read: 'Aliacare

The term was coined by Klie in order to express the power structure between care provider and patients \[Klie & Schumacher 2009\].

The first author of the expertise confirmed that she never visited the elderly care facility (Aliacare) personally and the information was provided by the owner. The private provider has practically dictated the text in the expertise.
stands for assisted living for dementia patients in the need of care. [Ibid.:17] It certainly does not. Aliacare (or alia care) is only the name of a private care provider. The naive copying of narratives and advertising texts without background information leads to a biased image that is recommended by the researchers to the politicians and the press (see the article by [Lindner 2015]). The problems that appear in reality in assisted living units are completely masked: the exploitation of care givers, the strong hierarchical system of employees subordinated to family members of the owner, delivery of medicine by unskilled staff, the hunting for migrant patients in other elderly care facilities, the restrictions that patients experience or billing fraud. [Altıntop 2015b] In the case of private care providers that run assisted living units (’under their regime’) the legal situation is, in addition, pushed deeply into a gray area [Klie & Schumacher 2009]: logically they should be treated legally like nursing homes, in actuality they have enormous freedom and many possibilities for grants. The privatization of elderly care is the favored policy in Germany, and therefore, not objected by the recent expertise. The unquestioned advertisement instead of an analysis in the expertise by some social scientists can trigger a snowball-effect that deteriorates the situation of patients and care givers and strengthens the lobby of employers in the private sector of elderly care. Articles and reports with nearly no or only superficial analysis and hidden advertisement unfortunately can be increasingly observed. The advertisement of private elderly care services for migrants in the journalistic and scientific landscape unintentionally operate in an emotional sense as legitimization and quality certification as so-called good-practice. This leads to a further enlargement of the legal gray area in which private providers operate - especially when they start to run assisted living units very similar to home care facilities. Besides, the often (even of the same researchers) evoked transcultural or intercultural approach is opposed by culturally specific care providers that fall into the category of ethnomarketing. The success of ethnomarketing is founded in a construction of one (single) defined ‘home’ or ‘culture’ in this business. [Kullina 2007:157] Advertisement and uncritical adoption by gerontologists follow the wrong - but neoliberal - idea that culturally specific offerings by private providers would be the only option in elderly care for migrants and that welfare services would fail in the elderly care of migrants. The in reality existent poor conditions for health care workers, a lack of quality as well as corruption in the health care sector are only rarely mentioned. The power that elderly care providers have over their patients (clients) is disregarded, profit-making is downplayed. The pretended freedom of choice for patients (clients) reduces after detailed analysis. Patients seldom change an elderly care service even when they have made bad experiences, and if they change a service too often, they become branded by the providers. Patients are much more strongly dependent than the public discussion is aware of. Social research has been undermined and exploited by private elderly care providers in various ways: private providers act as participants in conferences and meetings where they can advertise for free, they may arrange visitations of their care facility for researchers or journalists that act as promotion, they enter collaborations in publications where they have direct access to monitor the output. As a result, a strongly biased view on culturally specific elderly offerings is established at present.

V. Conclusions

Depending on the awareness of migrants’ special needs in elder care equity is differently understood and this view is also rhetorically transported. The German policy of an Intercultural Opening that is propagated mainly by welfare institutions acknowledges migrants’ special needs, finds unequal access of elderly care services by migrants compared to non-migrants and locates the origin of inequality in the structure of the services. Similarly, for-profit providers in the private
health care sector use the argument of migrants’ special needs in order to legitimate their practices. The Viennese policy based on a Diversity Management approach distances from migrants’ special needs in a particular way and does not like to stress differences in the elderly care of migrants compared to non-migrants. Vienna’s health care service wants to provide a *one-size-fits-all* solution. The unequal access of elderly care services is thus explained by unequal preferences, regardless of the fact that special counseling and elderly care offerings for migrants are effectively demanded. Assisted living could be an innovative solution when it is implemented in its original meaning of higher self-determination of patients. Unfortunately in the care of migrants, the newly established assisted living units have the strong tendency not to be organized by patients but by private providers. In perverting the original idea this development correlates with an increase in legal gray areas within elderly care with the result that an increased dependence of patients to private care providers, who also overtake the function of the lessor, is found. The regulations for elderly care homes that apply from a certain number of nursing home residents are easily bypassed when constructing an assisted living unit and renting shared flats to patients. Within the dual risk-chance discourse, the German policy has preferentially accented the chances of diversity, ethnicity and migration. Access barriers in health care are understood as a risk for migrants. In contrast, the Viennese Diversity Management preferentially stresses social and financial risks for the establishment of special social and health services for migrants. Special offerings would support segregation leading to a parallel society and the formation of migrant ghettos. The charging of the discourse with emotions in either direction bears the risk of decoupling the policies from a more balanced and fact-based analysis. The role of social scientists on the topic of elderly care for migrants must be critically addressed. The naive and superficial reporting without critical assessment easily leads to a hidden advertisement especially for elderly care offerings of private providers. This development is unfortunately observed with increased intensity in social sciences that cover the topic of elder migrants and health care. As exemplary shown for a recent report the counseling of the government and state administration by social scientists is directly dictated by private providers. Apart of the lack of scientific rigor in the transfer of advertisement for for-profit providers of elderly care facilities (including an assisted living unit) to the government or a ministry, it can be noted that reports with a programmatic style appear on the topic of migrants in elderly care that facilitate legislation processes in favor of more privatization in the elderly care sector and violently ignore the need of improving the situation for elders and low paid care-giving jobs.

Government consultancy follows a critical pattern: a report is ordered from a selected institution that has to provide a written statement within a few weeks. The singular and often less well grounded opinion is often not based on facts. Two examples have been given that demonstrate the singular opinion in two recent reports (Austrian Dementia Report and a German expertise) that should influence the governmental decisions for the next years. Reports become less critical and do not tend to object established policies in their recommendations. The programmatic orientation of policy makers towards neoliberal arguments does not support equity in elderly care. In Germany, the trend of treating elderly care for migrants as a business model is grown with the appearance of political and economic support of private providers, the application of *Intercultural Opening* in integration policy and the decreased sense of responsibility of the state to invest in social welfare. In Vienna, any specific elderly care or elderly care for migrants is driven by the Diversity Management into a private matter of the patient which is another method of reducing social welfare. In conclusion, the strategies of an elderly care for

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7In contrast to health care recommendations for special car companies, supermarkets, textile companies or travel agencies by researches and finally by the government or in ministries have not been found yet and would probably be questioned.
migrants are largely left to migrants: migrants should care for migrants, with the difference to Austria, that in Germany an additional business in ethnomarketing is supported by the politics that is included in the labor market.

References


[Destatis] www.destatis.de


[Statistik Austria] www.statistik.at


