Six Years of Long-Term Care Insurance in Germany: An Overview

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1. Introduction

In Germany financial security for dependent persons has been a topic of much discussion for almost thirty years. However, it was only seven years ago – in 1995 – that it became a main social-political issue or a significant aim of the government. The main reasons for the growing importance of ensuring financial security for persons in need of care are of course the well-known demographic developments. Worth mentioning first is the significant increase in a) the absolute number of elderly people, b) the proportion of elderly people within the whole population, and c) the absolute number and proportion of people aged 80 years or older within the population 65 years or older. In this context it must be kept in mind that very old age is closely related to the need for care; while the risk of becoming dependent on long-term care averages 3.5% for people aged between 60 and 80 years, this percentage increases to 30% for those aged 80 years or older. An important trend which contributes to the aging of the German population is the fact that fertility rates remain far below the replacement level (Deutscher Bundestag 1998).

In addition, shifts in the family structure (e.g., the number of persons living alone is rapidly increasing, people are marrying later, marriages do not last as long as they used to and are often childless) and an increase in the number of women participating in the labor force are aspects which challenge the availability of care and support given to the elderly by family members. Against this background problems connected to the provision of long-term care for an increasing number of elderly people have become a major concern for Germany and led to the introduction of the Long-term Care Insurance (LTC-Insurance) in 1995 as the fifth pillar of the social security system (the other four pillars are health, unemployment, pension, and accident insurance).

Before the LTC-Insurance came into force there was no real social security that dealt with the risk of long-term care. For example, older persons who lived in a nursing home had to finance the cost of care by themselves. If the individual had no financial resources he/she had to rely on private family support or resort to the means-tested social assis-

tance scheme to cover the cost of residential care in institutions (BÄCKER *et al*. 2000). Keeping in mind that residential care is very expensive in Germany – the average cost amounts to approximately 3,000 Euro per month for a person who needs intensive support and care – this meant that more than 75% of elderly people living in nursing homes were dependent on social assistance in order to be able to cover the cost of care shortly *before* the introduction of the LTC-Insurance (KRUG and REH 1991).

Within the socio-political discussion concerning the necessity of introducing the LTC-Insurance a second "cost factor" was important, which is connected to the one just mentioned: the financial burden on local authorities due to their expenditure for long-term care for an increasing number of elderly people. Although the cost of care had to be financed by those concerned in the first place, the local authorities still had to pay huge amounts of social assistance benefits, because in Germany they are the carriers of the social assistance provisions. These costs – which to a great extent reflect the expenditure for residential care – increased from 1.5 billion Euro in 1975 to nearly 9 billion Euro in 1995 – the year the LTC-Insurance came into force. Therefore, local authorities badly needed relief to ease the financial burden of long-term care and increasingly applied pressure to find ways to cover the cost of residential care (ROTHGANG 1997a, 1997b).

2. THE LTC-INSURANCE: SOME GENERAL INFORMATION

The LTC-Insurance has the following *aims*:

- To reduce demands placed not only upon the personal finances of people in need of care and their families, but also upon local authorities' social assistance budgets;
- to generally improve the life situation of care recipients and caregivers;
- to promote home or family care instead of residential care by improving the quality of life of care recipients *and* caregivers;
- to promote preventative health care and rehabilitation measures for persons with care needs;
- to control the public cost of care;
- to promote the implementation of a highly qualified professional care system (EISEN and SLOAN 1996; ROTHGANG 1997a, 1997b).

The German LTC-Insurance scheme *includes* all people employed in Germany as well as pensioners and non-employed family members. It is based on the principle "LTC-Insurance follows health insurance". The

LTC-Insurance is similar to health insurance which can be either mandatory (social) or private (voluntary). It is a *statutory scheme* which combines two branches: a social care insurance scheme and a private care insurance plan. Currently, approximately 92% of the German population is covered by the mandatory scheme and 7% by the private LTC-Insurance. In all, about 82 million Germans are insured.

The LTC-Insurance is almost entirely *financed* as a "*pay-as-you-go-system*" by equal contributions from employers and employees, including the self-employed and pensioners. Non-employed spouses and children are also covered without having to pay contributions. The strong opposition from employers who refused to pay greater ancilliary labor costs was compensated by a reduction in the cost of paid vacation leave: one of Germany's public holidays was abolished and thus employees lost out on the equivalent of one day's paid vacation leave. By "dealing" with the problem in this way they enabled a greater part of the cost to be shifted to employees, a novel aspect in the history of the German social insurance system.

The *rate of contribution* amounts to 1.7% of the individual gross earnings or the qualifying pension. In sharp contrast to the traditions of the social insurance system in Germany, the contributions are *limited* by law to 1.7%. As a result, the benefits of the insurance are also restricted to a certain amount or, in other words, these amounts are neither indexed to prices or income, nor is there any provision for regular increases.

In this context it should be mentioned that the social insurance model was the only model that could rely on a vast majority of votes in the *Bundestag* (German Parliament). At an earlier stage of the discussion, though, other possibilities were taken into consideration such as:

- case-mix reimbursement;
- capitation financing;
- a market model financed completely private – encouraged, for example, by tax reliefs – and run by private insurance companies; or
- a transfer model, administered and financed by the state.

Important reasons, however, led to the preference of the social insurance model, which may be considered as a compromise between a transfer model and a market model (Naegele 1992). These reasons are:

1. The German tradition of organizing social security is regarded as successful by the vast majority of German citizens.
2. The need for care is regarded as a general social risk comparable to other social risks which are covered by the remaining four pillars of the German social security system.

3. Within the social insurance model it was possible to *organize* the LTC-Insurance as its own branch under one roof with the statutory health insurance. In other words: the carriers of the health insurance – the insurance funds – are now the carriers of the LTC-Insurance as well. This in turn means that the implemention of new institutions was not necessary.
4. It was obvious that a model financed by taxes had no chance of success because of the existing financial burden accompanying German unification. In addition, those who were in favor of a social insurance model also believed that the adaptation of provisions would be easier within the social insurance model than within a model financed by taxes.
5. By using the social insurance model, those already in need of long-term care could be included right away.

In the past, and in accordance with constitutional law in Germany, the provision of all public and social services and facilities was a task carried out by the local authorities which – following the *principle of subsidiarity* – worked closely together with welfare organizations. However, in order to realize the aims of the LTC-Insurance and to safeguard the provision of long-term care, three aspects have been changed in this system.

- First, the LTC-Insurance funds now *enter into contracts* with the providers of home and institutional long-term care facilities and other organizations providing services and benefits. Through so-called supply contracts, these long-term care facilities are integrated into public benefit systems with legally defined rights and obligations. The providers of services and institutions are obliged to provide nursing care for the insured and in return, are eligible for remuneration from the LTC-Insurance funds.
- Second, the LTC-Insurance law explicitly encourages *privately run providers* who work on a profit basis to enter the market – provided they guarantee qualified care. As a result, three groups of providers are now operating within the care market:
  - Local authorities;
  - welfare organizations;
  - privately-run providers as new participants in the market.

  Whereas the last group mainly operates in the home care sector, the local authorities and the big welfare organizations dominate the market for residential care, day and night care as well as short-term care.
- The third aspect refers to the *responsibility the LTC-Insurance concedes to the 16 German Federal States* with regard to the efficiency, quantity, and economy of the "caring infrastructure". To realize this task most of the

federal states implemented their own laws which – although they may differ from state to state – grant care services and facilities, including the cost of investment they might incur. The provision of the LTC-Insurance can be regarded as an incentive for the professional care providers to enlarge and to improve their services and facilities. To better understand the importance of this goal, a look into the past is helpful. Before the implemention of the LTC-Insurance there was a great discrepancy between the need for professional care and the quantity of professional home care services and facilities that were available to satisfy this need. Only one-third of those concerned could draw upon adequate care services and facilities or, in other words, two-thirds were without any kind of professional support or were completely dependent on the help of family members or on other informal caregivers. Therefore, an improvement of the "caring infrastructure" was unavoidable.

Persons – no matter whether they live in their private homes or in institutions – *qualify for benefits* from the LTC-Insurance for more than six months if he/she has – regardless of age – a physical or mental illness or disability which makes him/her dependent on the help of others in performing "activities of daily life" (in the areas of personal hygiene, nutrition, and/or mobility). In addition, individuals must also require assistance a few times a week with "instrumental activities of daily life" (grocery shopping, cooking, cleaning, dishwashing, changing and washing bedlinen and personal clothing, heating the home).

In order to determine the extent of benefits and services, the beneficiary will be assigned to one of *three care levels* according to the severity of care requirements and the resulting extent of help needed.

- *Care level I* is accorded to persons in *considerable need* of long-term care. They would require assistance at least once a day for two activities at the minimum in the areas of personal hygiene, nutrition, or mobility. They would also require assistance several times a week in carrying out household chores. Individuals must need at least 90 minutes of assistance, from which personal care must take up at least 45 minutes.
- *Care level II* is accorded to persons in *severe need* of long-term care. They require assistance at least three times a day with personal hygiene, nutrition, or mobility. They must need at least three hours of assistance, from which personal care must take up at least two hours.
- *Care level III* is accorded to persons in *extreme need* of care. They need help all the time in performing at least two activities of daily life. They

must need at least five hours of assistance, from which personal care must take up at least four hours.

The assignments are based on a professional assessment. If a person applies for care benefits, a qualified nurse or a physician (from the medical division of the health insurance fund) will visit the applicant at home to determine whether and to what extent he/she will require long-term care.

The benefits of the LTC-Insurance which are designed to assist people who need care can be described as follows (see Table 1):

1. Benefits for *home care:* Depending on his/her care level the care recipient may be entitled to the following benefits for home care: *Benefits in kind* of the value of 384 Euro per month for persons with care level I, 921 Euro for persons with care level II, and 1,432 Euro for persons with care level III. In exceptional cases benefits in kind to the value of 1,921 Euro can be paid. *Benefits in cash* amount to 205 Euro per month for persons with care level I, 410 Euro for persons with care level II, and 665 Euro for persons with care level III. The care recipient can use this money to "buy" informal help. It is possible to combine benefits in kind and benefits in cash in order to get a highly individualized care program.
2. *Additional* benefits of the LTC-Insurance for home care are:
   - payment of day or night care up to 1,400 Euro per month;
   - payment of short-term care (up to four weeks per year) up to 1,400 Euro;
   - stand-in care (up to four weeks per year) up to 1,400 Euro;
   - subsidization of the improvement of housing according to the special needs of the care recipient up to 2,500 Euro;
   - subsidization of certain technical care aids and appliances (e.g., wheel chairs);
   - contributions to the pension fund on behalf of the carer in case he/she gives up paid work in order to care for a dependent person;
   - free nursing care courses.
3. Benefits for *residential care*: Regarding institutional care, the LTC-Insurance only covers the cost of nursing care. The monthly care rate is paid directly to the nursing home. The amount depends on the care level of the beneficiary. The present care rates for persons with care level I are up to 1,023 Euro per month, care level II up to 1,279 Euro, and care level III up to 1,432 Euro. To avert hardship the benefits in care level III can be increased up to 1,688 Euro. Accommodation and food still has to be paid for by the care recipient or – if

he/she has no financial resources – by close relatives or the social assistance fund.

Table 1: **Benefits of the LTC-Insurance (per month in Euro)**

	Home care		Residential care
	benefits in *kind*	benefits in *cash*	benefits in *kind up to*
care level I	384	205	1,023
care level II	921	410	1,279
care level III	1,432 *(in exceptional cases 1,921)*	665	1,432 *(in exceptional cases 1,688)*

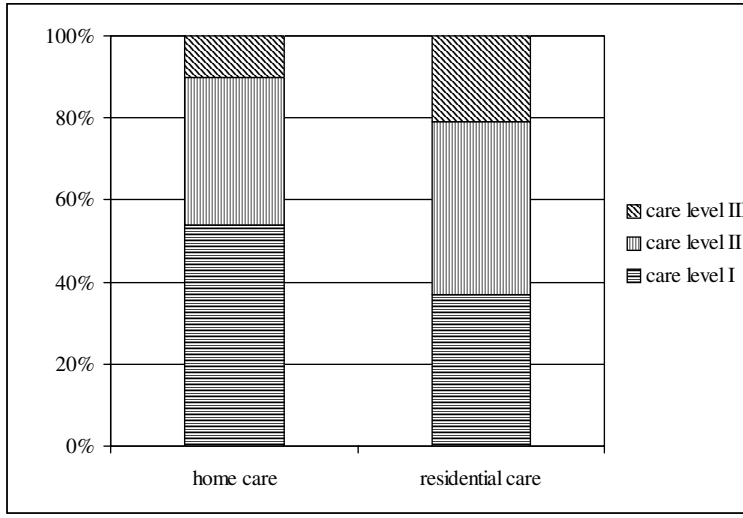
Although the list of benefits provided by the LTC-Insurance seems to be impressive, the risk of being in need of care is *not* covered completely – the LTC-Insurance is a so-called "Teilkaskoversicherung" (part-comprehensive cover). In contrast to the statutory health insurance – which in principle does not know a limitation of benefits – the benefits of the LTC-Insurance *are limited*. Therefore, it can be assumed that the social risks which might be linked to care are recognized as less important than those social risks which might be linked to illness.

3. Some Important Data

Let us examine data on how many individuals receive benefits from the LTC-Insurance and how they are distributed with regard to the different levels of care. At the end of the year 2000, about 1.4 million persons living in private homes and about 553,000 persons (2.5% of the whole German population) living in institutions received benefits from the LTC-Insurance.

With regard to home care 54% of individuals entitled to benefits were assessed as being in considerable need of care (care level I), 36% were assessed as being in severe need of care (care level II), and only about 10% were assessed as being in extreme need of care (care level III). With respect to institutional care we obtain the following figures: care level I = 37%, care level II = 42%, care level III = 21% (see Figure 1).

Figure 1: **Proportion of persons receiving home or institutional care by care level in % (2000)**

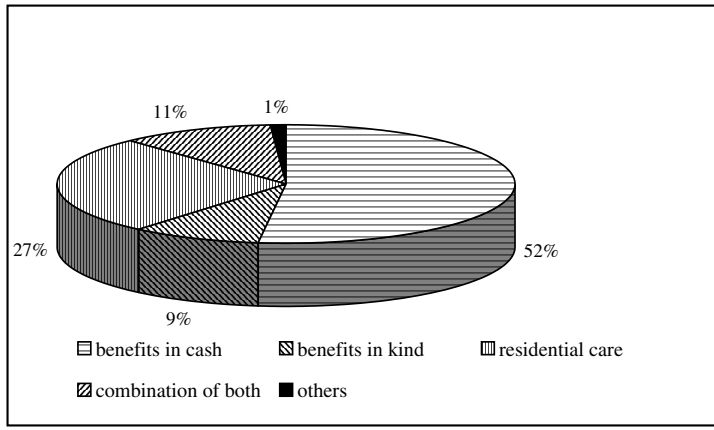


Source: Based on http://www.bmgesundheit.de/themen/pflege/finanz/pflegestufen. Downloaded June 28, 2001.

An interesting question refers to the *distribution* of benefits that are offered by the LTC-Insurance. Data from the LTC-Insurance fund reveal that of those who receive provisions for *home care* the vast majority decided to take benefits in cash. Shortly after the introduction of the LTC-Insurance 80% instead of 50% – as predicted by the German Ministry of Social Affairs – did so as compared to 20% who chose benefits in kind (EVERS 1997). In the meantime, however, more people have decided to take benefits in kind or a combination of both. Currently, we estimate a ratio of about 70% receiving benefits in cash, 20% receiving benefits in kind and about 10% receiving a combination of both. In general, it seems that those who are assessed as "care level III" show a higher willingness to take benefits in kind or a combination of benefits in kind and in cash. In this context, it has to be kept in mind that benefits in cash are "cheaper" for the LTC-Insurance fund than benefits in kind.

When we look at it from a different perspective we see the proportion of different benefits – for home care as well as for residential care (see Figure 2).

Figure 2: **Distribution of benefits of the LTC-Insurance in % (2000)**

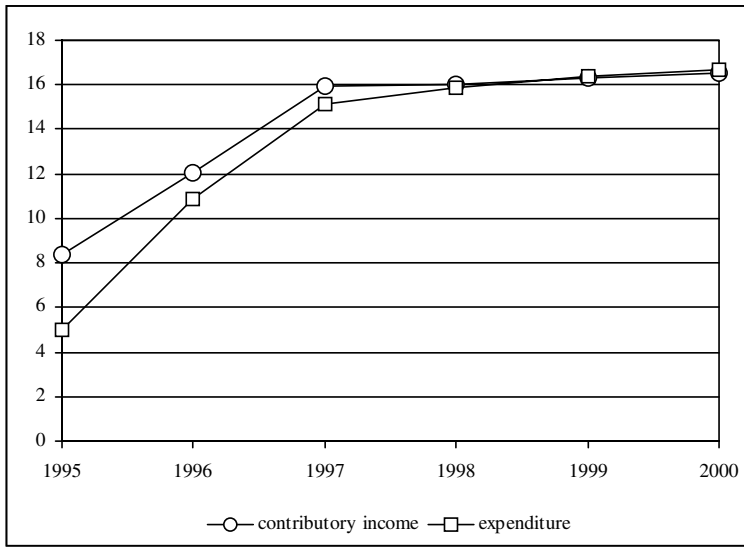


Source: Eildienst Landeskreistag Nordrhein-Westfalen, May 2001.

With regard to the distribution of expenditure for the different benefits of the LTC-Insurance we see that benefits in cash amount to 25%, benefits in kind to 13%, residential care to 46%, social security for caregivers to 6%, and other benefits to 10% of all costs. Thus, it is important to note that although residential care covers only about 27% of all benefits of the LTC-Insurance, it still amounts to 46% of all costs. This fact is due to the high cost of residential care as mentioned earlier.

Since the LTC-Insurance has been introduced in 1995, we can observe the following development of contributory income and expenditure. From 1996 until 1998 contributory income was higher than expenditure, however, as Figure 3 shows, after this period expenditure exceeds contributory income. For the year 2000 contributory income amounted to 16.55 billion Euro, whereas the overall expenditure was 16.68 billion Euro.

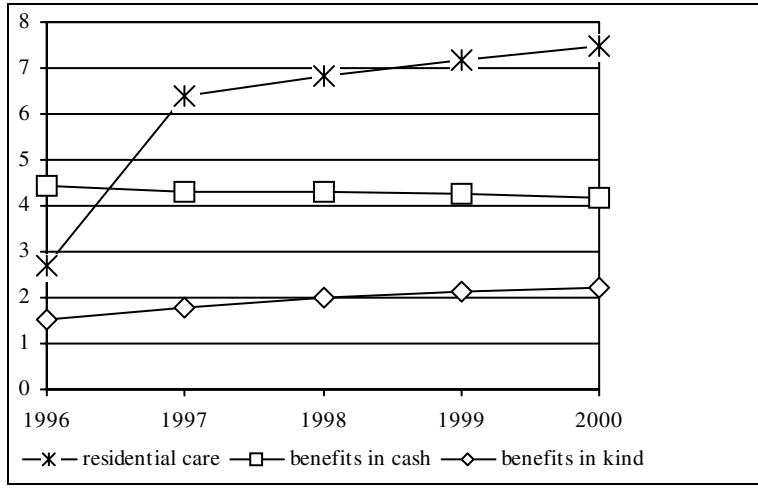
Figure 3: **Contributory income vs. expenditure from 1995 until 2000 (in billion Euro)**



Source: http://www.bmgesundheit.de/themen/pflege/finanz/dv-ergebnisse. Downloaded June 28, 2001.

The main reason for this development is that expenditure for residential care and for benefits in kind have increased, whereas the expenditure for benefits in cash slightly decreased (see Figure 4). In 1997 the LTC-Insurance fund spent 6.41 billion Euro for residential care, whereas in the year 2000 it spent 7.48 billion Euro, which equals an increase of 16.5%. The responsible factors for this shift towards professional care, which will become even stronger in the future, were mentioned earlier.

Figure 4: **Expenditure from 1996 until 2000 for different kinds of benefits (in billion Euro)**



Source: http://www.bmgesundheit.de/themen/pflege/finanz/dv-ergebnisse. Downloaded June 28, 2001.

4. Evaluation of the LTC-Insurance

After six years the *success* of the LTC-Insurance can be described with regard to the following main aspects:

First, the number of individuals in need of care who are depending on social assistance has declined by 20% to 33%. This particularly refers to persons who receive residential care. In consequence, local authorities are less burdened and there has been a remarkable reduction in costs of local social welfare funds. However – as already mentioned –, in some cases the provisions of the LTC-Insurance do not cover all expenditure related to care, particularly residential care. It is estimated that about 40 to 50% of those who live in nursing homes still receive social assistance benefits (Bundesministerium für Arbeit und Sozialordnung 1998).

Second, data show that between 66% and 75% of those entitled to benefits of the LTC-Insurance are satisfied with the provisions (Runde *et al.* 1996; Bundesministerium für Arbeit und Sozialordnung 1998; Klie 1998). It can also be observed that there has been a change in the self-definition and self-esteem of persons in need of care; from a recipient

of social insurance provisions to a "client" on the "care market" (Igl 1999).

Third, the number of care services has increased substantially, leading to the introduction of competition and plurality on the "care market". Over the past nine years the number of nursing homes has doubled from around 4,300 (in 1992) to 8,600 today, and the number of home care agencies has risen from an estimated 4,000 (in 1992) to almost 13,000 today. In consequence, those in need of care and their families now have better access to professional support. This is not only true for the different kinds of home care services available but also for day/night and short-term care facilities.

Fourth, at least up to now (see below), it can be observed that the number of persons entering nursing homes is declining, or in other words, more persons receive care within the community for a longer period of time. This development is seen as a result of the financial incentives, i.e., the benefits in cash, that the LTC-Insurance provides for home care. However, the implications of this development for the quality of life of the care recipients and caregivers is yet to be examined. Although it can be assumed that the growing number of professional home care services have many positive effects for caring families, some of these effects might be offset by the fact that persons in need of intensive care might not always receive the kind of support they need (Bundesministerium für Arbeit und Sozialordnung 1998).

Although the introduction of the LTC-Insurance was a step in the right direction, experience with this new scheme has also revealed some *deficits*:

First, according to all available predictions the number of elderly living and being cared for in institutions will increase. In addition, it is also expected that the number of persons in need of intensive care (care level III) will rise more rapidly than the number of persons with lower care levels. By the year 2050, forecasts assume that nearly 3.9 million (Rückert 2001) or even 4.7 million (Deutsches Institut für Wirtschaftsforschung 2000) individuals will receive benefits from the LTC-Insurance – or, in other words – up to 2.5 times more people than today, with an above-average increase after 2020. All these changes challenge the financial resources of the LTC-Insurance (Rothgang 2001). As we have already seen, expenditure already exceeds contributory income (see Figure 3).

Second, since the introduction of LTC-Insurance, the definition of "dependency" has come under much criticism. It was seen and continues to be regarded as too narrow and too much oriented toward physical limitations. Therefore, not all persons in need of care are covered by the

LTC-Insurance. Certain groups of disabled persons – for example, people with dementia or younger disabled persons who can perform most "activities of daily life" but still need supervision and/or some support – are not covered by the insurance or, in other words, they do not "fit" into the categories of defined "dependency". Therefore, the problem of financing the care for these persons remains unsolved and is currently subject to much discussion (Borosch and Naegele 1998).

Third, there has been some criticism that the quality of care provided is suffering since the LTC-Insurance came into force. The reasons for this assumption are that care is provided under time pressure and that the "care market" is confusing for people in need of care or for their relatives. In addition, quality control measures are seen as being underdeveloped. The same applies for effective forms of user involvement, user empowerment, and consumer protection (Schnabel and Schönberg 2000).

Fourth, a further weak point is the organization of the LTC-Insurance which legally confirms the separation between illness and needing care within the German social security system. This is contradictory to the fact that being needy of care – in general – is a consequence of chronical illness and not of decreptitude. Therefore, logically and systematically long-term care should have been covered by the health insurance.

5. Recent Developments

In September 2000 the "Parliamentary Enquete Commission on Demographical Change" carried out an expert meeting in order to evaluate the effects of LTC-Insurance. In general, the arguments were repeated that have been mentioned above. However, the following proposals were made to overcome the deficits already listed:

- In order to guarantee the financial stability of the LTC-Insurance, *a rise in contribution levels* is regarded as unavoidable already shortly after the year 2005. The respective predictions range from 2.6 to 3% in 2030 and from 3 to 4% in 2040 (Rothgang 2001). Thus, a controversial debate on how to financially secure the LTC-Insurance in the future has begun. The proposals range from raising contributions to reducing the benefits to implementing a new (or additional) financial basis, following a capital-stock system. All experts – apart from those representing the employers side – also agreed on the proposal to adjust benefits in line with the cost of care in order to avoid its slow devaluation. At least the provisions for those with care level III should be adjusted and raised substantially.

- Many experts referred to the fact that there are still gaps that must be filled by the LTC-Insurance. This particularly refers to a *broader concept and definition of dependency* which should at least cover dependency caused by dementia. The experts regarded it as very important to make the benefits of the LTC-Insurance available to persons suffering from this illness, too. In the meantime, the German government reacted to this proposal, and at the end of 2001 a bill was formulated. There are plans to improve the situation of informal care providers of dementia patients by offering them special counseling and by financing a number of days in day care centers. These plans are regarded as a first step toward tackling the problem on a broader scale.
- Currently, the German Federal Government is preparing two laws which explicitly aim at a) the improvement and the broadening of quality assurance, and b) the user-participation in developing quality management in the care sector. To develop the quality of care, the so-called "*Quality Assurance Law" (Pflegequalitätssicherungsgesetz)* comprises a range of tasks which primarily refer to internal quality assurance and control (e.g., to improve existing quality control instruments). In terms of user participation, the law not only demands the involvement of user organizations but also of organizations which look after the interests of professionals in the caring sector when quality measures and respective guidelines will be developed in home and institutional care.

Other important proposals to improve LTC-Insurance can be found in a recently published report of the of the "Parliamentary Enquete Commission on Demographical Change". Apart from other aspects, the Commission proposes facilitation of a better cooperation between health insurance and LTC-Insurance, further development of the care infrastructure, a stronger differentiation of the three existing care levels, and an increased flexibility with regard to the provision of different benefits of LTC-Insurance according to the individual needs of beneficiaries (DEUTSCHER BUNDESTAG 2002).

In conclusion, it remains to be seen whether all these suggestions will be realized in the near future. If this indeed happens, the German LTC-Insurance will be a highly appropriate socio-political measure to ensure quality and equality of care and, thus, can be a model for other countries.

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