# Long-Term Care Insurance in Germany and Japan: A Comparative Comment

*Thomas Klie*

The following remarks will comment on long-term care insurance in Germany and Japan in three steps. First, I would like to point out what the Japanese and German efforts to offer social insurance against the risk of needing long-term care have in common. As a second step, I wish to draw attention to what I perceive as substantial differences between the two systems. Finally, I will pose a few questions which appear to be of considerable importance for future discussions in both Germany and Japan.

## 1. Similarities in Long-Term Care Insurance in Germany and Japan

Both Germany and Japan are confronted with demographic aging – in Japan at the proverbial Shinkansen [bullet train] speed, in Germany somewhat more slowly. This means that fundamental changes in the system of social security and its financing are becoming necessary. In Germany, the system of care for the elderly is in special need of reorganization.

In addition to the demographic challenge, developments that may be subsumed under the fashionable term of "modernization" are constantly reshaping both societies. As a consequence, traditional forms of private solidarity – which constitute the basis of social security for those who need care in both countries – are under pressure and will not be maintained for much longer in their current form. Nevertheless, social security will have to rely on private solidarity which up to this day remains the central pillar when care is necessary.

Strenuous efforts in each country to rationalize its cost-intensive health care system in connection with the critical situation of public finances can be witnessed. In both countries, the health care system, hospitals in particular, has taken part in the provision of long-term care. In Japan, this process is exemplified by the recent expansion of geriatric rehabilitation facilities, even though patients were often not specifically rehabilitated in the strict medical sense.

In both countries, social security for those who need care has been taken up as a national task that is not supposed to be dealt with at the welfare level. Taking into account their lifelong contribution to society, the elderly are thought to be entitled to social security when they require care, without becoming dependent on social assistance. Reliance on social assistance is ill-regarded socially in both countries, an recipients are stigmatized. In Germany, long-term care insurance was introduced partly in order to provide noticeable relief to local authorities, who are heavily in debt, not the least due to their assistance-providing function.

Every model of long-term care insurance that has been developed so far envisages only partially funded care when it is needed. Protection when care is needed is generally based on a combination of funds. In the Japanese model, there are even more participants than in the German one. In both cases, the range of possible aids and services is broad – ranging from home care to fully integrated institutional care. This is done with the aim to build a need-oriented infrastructure of help nationwide; in Germany, responsibility for this infrastructure is divided between the federal government, regional governments, *Pflegekassen* [long-term care funds], and local authorities. While responsibilities for planning are more clearly defined in Japan in accordance with a more traditional concept of planning, they still lie with authorities on various levels.

Both countries make use of market forces to encourage the expansion of services and facilities available as well as to guarantee choice for those in need of care and their relatives. As a result of such an economy of demand rather than a policy of public subsidies, both countries hope for improvements in the development of their infrastructure, especially with regard to home care. In Germany, a narrow regulatory framework for institutions and services offers strict criteria for each type of institution, resulting by and large in the future disappearance of many of the currently numerous kinds of homes, for example the *Altenheim* [home for the elderly]. In both countries, it is not a free, but a heavily regulated market.

These similarities show that problem-solving strategies are comparable despite cultural differences. They also show that there are global influences: the Japanese, for example, have collected information about the different systems of social security for long-term care across Europe. What they have learned from the European discussion, or rather, what conclusions they have drawn, is evident from the differences between the German and the Japanese model.

## 2. Differences Between the German and the Japanese Model of Long-Term Care Insurance

Even though the Japanese use the term "long-term care insurance", it is not an insurance proper according to the German understanding of statutory social insurance. On top of insurance premiums, the Japanese government allocates tax funds for the financing of long-term care insurance. The prefectures as well as local authorities retain some freedom to act, but also carry certain responsibilities for contributions of their own, including a financial one. Concerning future developments in Germany, the question is how the model of a statutory social insurance system can be developed in the context of a changed age structure, in order to guarantee the funding of health care and social security in the future. Long-term care insurance in Germany was implemented at a time when the ability to finance, for example, the public pension scheme, was becoming the subject of intense debate. In addition, some do not consider the need for long-term care as a typical social risk in the model of social security. That is because the concept of social insurance is based on the protection against risks inherent in the work environment and assumes the equal division of contributions between employer and employee. As the labor market is being globalized, high marginal costs of labor are regarded as a disadvantage in the face of international competition. In Germany in particular, this leads to an unprecedented tightening of expenses in care insurance, exemplified by the introduction of the principle of stable contributions.

While in Germany the *Pflegekassen* – organized partly on a national, partly on a regional scale – support long-term care insurance, in Japan local authorities must fulfill this function. In Germany, local authorities were to be largely relieved of the cost of social assistance for those in need of long-term care, but they have also lost some control in securing long-term care provision. In Japan, in contrast, local authorities play a central role in this area. Local authorities are entrusted not only to implement care insurance but also to finance additional and more extensive institutions and services, this process being subject to discussion of social policy measures at the local level. This reflects regional demographic and cultural differences as well as the importance of local policies in support of private solidarity vis-à-vis those in need of long-term care.

In Japan, the group of people entitled to receive benefits was deliberately defined differently from Germany. Thus, one difference can be seen in the entrance level, which is lower in Japan. Not only those in need of physical long-term care, but also those who simply need help at home are entitled to receive benefits in certain cases. In determining the criteria for

the need for care, the special needs of elderly people with senile dementia were also taken into consideration. In Germany, recognition of the need for care of those with senile dementia constitutes a special problem (Klie 1998: LPK-SGB XI, § 14, Rz 7).

In Germany, the health care system on the one hand, and that of long-term care insurance on the other, are kept strictly separate. While health insurance remains responsible for acute medical care, the care for the chronically ill lies in the hands of long-term care insurance. The principle of "rehabilitation before care" is almost invalidated due to this division of financing depending on the particular case, which is impeding the integration of medical and long-term care (Igl 1995: 289). In Japan, attempts are being made to integrate geriatric rehabilitation and acute medical care into the long-term care insurance system – although not without resistance from the medical sector. The best solution is still open to discussion between policy and care experts.

While the Japanese model assumes that services and institutions support those who require care and their relatives in securing care, the German long-term care insurance leaves a choice between financial aid and service provision – cash or care. Experience with long-term care insurance reveals that people in need of care and their relatives are far more inclined to financial support, than to aid in the form of services. In Germany, around 80% of people receiving care at home choose financial aid, while only 20% prefer service provision. As far as we know, the cash benefits have little influence on care behavior. Those receiving care and their relatives use care payments according to their own cultural predisposition concerning care; it does not lead to alterations in care arrangements (Evers 1997; Blinkert and Klie 1998). Traditional motives for providing care to relatives are supplemented by modern expectations of reciprocity. Cash benefits are especially relevant for those households in which a somewhat "traditional" way of life is pursued, i.e., being married, having more than one child, and showing low mobility during the life cycle. In such cases the benefits of long-term care insurance lead to a high degree of satisfaction of those requiring care. With regard to disabled people with unstable social relationships, satisfaction with the benefits of long-term care insurance decreases perceptibly (Blinkert and Klie 1998).

In Germany, assessment of care need is undertaken by the Medical Services Authorities of the health insurer, which serve as an expert committee of the *Pflegekassen*. Assessment in Japan, by contrast, is integrated into a model of care management, for which local authorities are responsible. Its explicit aim is to guarantee coordination between the different services and care-providers. In Germany, such a consistent model of care

management in the context of implementing long-term care insurance is lacking.

## 3. Common Problems for the Future Development of Long-Term Care Insurance

Finally, I would like to pose a few questions which are of concern to both long-term care insurance systems. First, there is the question of the relationship between care organized in a private context and professional care as provided by specialized services and institutions (Braun and Schmidt 1997). The differences in the organization and conceptualization of care in the private and professional contexts must not be underestimated. It is a great challenge for professionals to utilize their skills for care that is otherwise organized on a private basis and, in the process, to culturally develop it further in order, for example, to prevent stress situations and possibly violent behavior as a consequence, without giving orders to the families in question (BMFSFJ 1996). In both countries, long-term care insurance is a modernization project that can be regarded as no less important than the introduction of public education for children. The reservations concerning public interventions into private life – education and nursing care – are presumably different in both countries due to different cultural backgrounds.

Related to the problem of privately organized care in relation to care that is professionally controlled and provided is the central question of the relationship between cash and service benefits (Evers 1997). Due to the limited resources provided by long-term care insurance, the contribution, which services and institutions can offer with the help of long-term care insurance toward securing the care needed, remains small. It is important to further develop the infrastructure, including services and institutions, for securing the provision of care. However, doing this is still largely a task which can only be solved adequately by a combination of various contributions from private solidarity networks, market forces, and social benefits guaranteed by the state. Cash benefits offer the option of more flexible care arrangements, which can fall back on the specific resources of each network but also of a society that is turning service-oriented. I think that in Germany, as in the Netherlands, the normative predominance of service provision will disappear in the medium-term in favor of the promotion of supervised cash benefits.

In the context of securing long-term care provision, we may consider whether a care profession independent of medicine will emerge, which would not be characterized by the medical paradigm of ill-health but

develop a health-oriented concept of care and support for those in need of care. The German long-term care insurance was developed in the context of, and influenced by, the health insurance system. Consequently, the concept of the need for care is defined predominantly according to medical criteria. Long-term care insurance still has a long way to go before it can offer its own concept of need for care, rooted in a science of care. Only the diagnosis of the need for care caused by ill-health justifies the receipt of benefits from the care insurance. Securing long-term care when required offers a major challenge for the largely hospital-oriented provision of care. Despite a number of cautions and criticisms concerning the model of long-term care insurance from the point of view of a science of care, it is clear that professional care gains considerably in importance through the care insurance system, since care professionals assume equal responsibility together with medical practitioners, both in establishing a need for care and in tasks such as care advice and examination. In order to be able to fulfill these functions adequately, the care profession is subject to major demands concerning its qualification (Klie and Steppe 1996; Entzian and Klie 1996). In both countries, the science of care as an independent science is still in its beginnings. At least in Germany, it is receiving a great boost through long-term care insurance.

As a third question, I would like to discuss the fair distribution of the limited resources available for securing long-term care in social terms. This raises the issue of inverse redistribution which is linked to that of care insurance. The beneficiaries of long-term care insurance in a clinical context, for example, are those with a net income of around 1,530 Euro per month. They are the only ones to remain without welfare payments, while those earning less are still dependent on social assistance (Rothgang 1997: 191–219). On the international scale, procedures of assessment and classification are sought to help ensure that (1) different backgrounds and forms of care need are considered on equal terms, (2) those services which people in care wish to receive are also recognized, and (3) the time required by family helpers and professional personnel for the various care tasks can be measured in a suitable manner (Équippe de Recherche Operationelle en Santée 1996). This task has just been taken up, especially with regard to private care. By and large, home care is still a black box – at least from a scientific point of view.

The fourth and last question to be raised is that of the future role of local authorities. It is at the local level where help is provided, social culture gains or loses cohesion, and new as well as traditional social networks can successfully be supported and created. In Japan in particular, local differences appear to be noticeable and are taken into account in the model for long-term care insurance. The model of the German care

insurance is a unified one and theoretically covers the Federal Republic of Germany with a uniform pattern of institutions and services without leaving room for contributions at a local level. It is doubtful whether this model is a suitable one in the context of limited benefits from care insurance and the central role of local networks, since it removes the issue of need for care from those responsible for social policies. From the point of view of demand, however, securing the provision for care at a local level ought to be integrated into a concept of local provision for the elderly and the disabled (Klie and Spiegelberg 1998).

## 4. Summary

Both the initial situations and the models for the introduction of long-term care insurance in Germany and Japan offer numerous similarities. It is also possible to discover striking differences. The definition of the need for care, the role of local authorities in the implementation of care insurance, and the availability or non-availability of the choice between cash benefits and services in the private context are examples for this. It is the comparison of the models in these two countries that allows us to pose questions central to the development of a future care insurance, which can be summarized under the following headings:

- the relationship between care organized in the context of private life and professional care;
- the emancipation of securing care provision from the medical sphere;
- the fair distribution of scarce public resources for the welfare state; and
- the role of local authorities in a future "welfare mix".

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