Discussion Paper No. 10-012

The Social Long-term Care Insurance in Germany: Origin, Situation, Threats, and Perspectives

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Non-technical Summary

This paper gives an overview of the German Social Long-term Care Insurance (*Soziale Pflegeversicherung*, SLTCI). In the current state, Germany provides a universal, non means-tested contribution-financed social insurance for long-term care. This insurance should partially cover the care needs of the benefit claimants. Similar to the other social insurances in Germany, it is organized as a pay-as-you-go system. The benefit scheme allows for some flexibility in the provision of services due to recognition of different levels of care dependency and there are different types of benefits available; types of benefits comprise, e.g., cash allowances and benefits in-kind for home care, and financial support for institutional care. Today, most claimants apply for cash allowances which enable to maintain home care arrangements with the help of informal caregivers.

The ageing of society will increase the number of persons in care dependency and will reduce the number of potential informal caregivers. Both developments challenge the sustainability of German SLTCI. A number of reform options have been suggested by several authors and are reviewed here. Some of these reform options suggest to only slightly adjusting the status quo system to take account of the changed demands, whereas other proposals postulate a radical reform of abolishing the pay-as-you-go system in favor of a system with funding principle. Despite the availability of options and the concerns about the status quo, the German legislator introduced a first reform of the SLTCI system in 2008. Although remarkable innovations were adopted like the nominal adjustment of benefits to maintain constant real values, the reform has to be criticized as being non-sustainable already in the medium-run. Therefore, further reforms will be necessary in the near future.

Das Wichtigste in Kürze

Das vorliegende Papier gibt einen Überblick über die Soziale Pflegeversicherung (SPV) in Deutschland. Neben einer Beschreibung des Aufbaus und der Finanzierung der SPV werden die Reformvorschläge der letzten Jahre und die Reform im Pflegeweiterentwicklungsgesetz betrachtet. Die SPV unterstützt pflegebedürftige Personen, in dem ein Teil der Kosten zur Deckung des Pflegebedarfs direkt oder indirekt übernommen wird. Wie die übrigen Sozialversicherungen ist auch die SPV im Umlageverfahren organisiert. Anspruchsberechtigte Pflegebedürftige können entsprechend der vorliegenden Schwere des Pflegebedarfs unterschiedliche Leistungstypen (z.B. Pflegegeld oder Pflegesachleistungen) in verschiedenen Leistungshöhen (sog. Pflegestufen) erhalten. Die Anspruchsberechtigung ist dabei unabhängig vom individuellen Einkommen oder Vermögen der Person. Der Großteil der Leistungsbezieher wird gegenwärtig häuslich versorgt und erhält ein Pflegegeld.

Durch den demographischen Wandel und eine alternde Gesellschaft wird die Zahl der pflegebedürftigen Personen weiter ansteigen, gleichzeitig reduziert sich die Zahl der Personen, die insbesondere die häusliche Pflege übernehmen können. Beide Entwicklungen gefährden den Status Quo der SPV im Hinblick auf eine nachhaltige Teilabsicherung der Pflegebedarfe. Zur Fortführung und Stabilisierung der Absicherung von Pflegerisiken wurden eine Reihe unterschiedlicher Reformvorschläge von verschiedenen Autoren vorgelegt. Die Bandbreite der diskutierten Optionen reicht dabei von einer graduellen Anpassung des gegenwärtigen Systems durch Ausweitung der Gruppe der Beitragszahler über hybride Modelle aus Umlageverfahren und Kapitaldeckung bis zu einer vollständigen Abschaffung des Umlageverfahrens und Ersatz durch eine kapitalgedeckte Versicherung. Der Gesetzgeber hat mit dem Pflegeweiterentwicklungsgesetz einen ersten Reformschritt vollzogen. Obwohl die Reform einige lange kritisierte Einschränkungen der SPV verändert hat, z.B. wurde eine schrittweise Anpassung der Leistungshöhen zum Ausgleich der allgemeinen Teuerung beschlossen, bleibt insbesondere die mittel- und langfristige Finanzierbarkeit im gegebenen institutionellen Rahmen unklar. Eine zeitnahe Fortführung der Reformierung der SPV erscheint notwendig.

The Social Long-term Care Insurance in Germany: Origin, Situation, Threats, and Perspectives*

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Abstract

This paper describes the Social Long-Term Care Insurance (SLTCI) in Germany. Based on a short review of the history of long-term care organization and the preceding laws in Germany, the implementation of the SLTCI as a self-standing pillar within the system of social insurances in Germany and its set-up with regard to eligibility criteria, service provision and financial budget are presented. Since SLTCI is a universal, contribution-financed insurance the ageing society and the corresponding shifts in the number of persons in need of care and the number of persons potentially providing informal care are challenges for its sustainability. Therefore, recently suggested reform options are discussed at the end of the paper showing potential pathways to a sufficient provision of care services in the future.

Keywords: Social Long-term Care Insurance, Germany, Financial Situation, Sustainability, Reform Options

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1 Introduction

This paper describes the organization of long-term care in Germany as part of the welfare state. Therefore, we will focus on the Social Long-Term Care Insurance (SLTCI) introduced in 1995 which is one of the main pillars of the German system of social insurances besides, e.g., unemployment insurance, health insurance, and the pension system. As most (western) societies, Germany faces a demographic transition that will more than double the number of elderly individuals in need of long-term care and at the same time will decrease the number of informal caregivers. As a consequence, public responsibility for the provision of long-term care will continue to grow. In light of the current and expected changes the sustainability of the SLTCI has to be questioned. In particular, maintaining the real values of benefits with an increasing number of benefit claimants, on the one hand, and a decrease in revenues due to shifts in the population of contributors, on the other hand, emphasize the reform pressures on the current system.

To organize the presentation of the paper, we will order the discussion chronologically. We will start in section 2 with a characterization of SLTCI including the discussion and organization preceding its introduction. Before 1995 when SLTCI was implemented, long-term care was considered within welfare assistance. However, this approach had two severe shortcomings. On the one hand, receiving welfare assistance is not without stigma for the eligible persons. On the other hand, welfare assistance is administered by municipalities. Thus, raising numbers of benefit recipients lead to financial strains. The introduction of SLTCI augmented the system of social insurances. Similar to the other types of insurances, financing is organized by contributions from gross income subject to social insurance contributions. SLTCI therefore covers almost everybody in Germany, except groups that are allowed to privately insure against long-term care risk. In the current state, Germany therefore provides a universal, non means-tested contribution-financed social insurance for long-term care that is intended to provide a partially comprehensive cover of the benefit claimant. Similar to the other social insurances in Germany, it is organized as a pay-as-you-go system.

The benefit scheme allows for some flexibility in the provision of services due to recognition of different levels of care dependency and different types of benefits available including cash allowances, on the one hand, and support for institutional care, on the other hand. In the current situation, most claimants apply for cash allowances that should enable to maintain home care arrangements with the help of informal carers. Details with regard to the benefit scheme, the administration of services, the financial situation and the shares of persons opting

for the different types of benefits available will be presented in section 3.

The sustainability of the system has to be questioned given projections of the number of future benefit claimants and the number of future contribution payers. Several authors have analyzed the threats of the German SLTCI system, and we will review the major aspects and the corresponding reform proposals in detail in section 4. Recognition of the options proposed for Germany could also be helpful for other countries facing a similar situation. Despite the array of reform options, the German legislator has recently adopted a first reform in 2008. The main changes as well as an evaluation will be provided at the end of section 4.

2 The German Social Long-Term Care Insurance (SLTCI)

2.1 Background: The Situation Until Introduction of SLTCI in 1995

The foundation of the German welfare system is laid out in the German Constitution (*Grundgesetz*) that guarantees living in dignity.[1] The welfare system today comprises unemployment insurance, welfare, health insurance, retirement pensions, and long-term care insurance. Despite its comprehensive nature, the single facets of the system were introduced at different points in time during the last decades. Long-term care insurance is the most recent augmentation introduced in 1995 as a self-standing pillar of the welfare system; however, consideration of support for care requirements was not new within German welfare.

Support for long-term care was first regarded in the federal law of welfare assistance (*Bundessozialhilfegesetz*) adopted in 1962. Besides the rules for social welfare it contained a section defining so-called special public long-term care assistance (*Hilfe zur Pflege*) and long-term care was organized as a part of welfare assistance. This special public long-term care assistance provided a means-tested allowance in order to support people in need of help. At that time, the notion of being in need of care was not explicitly defined further but every "helpless" person has been eligible for allowances. Allowances were administered on the state level and differed between states due to the federalist system in Germany. The majority of processing and funding was allocated to local providers of welfare, e.g. counties or independent cities.

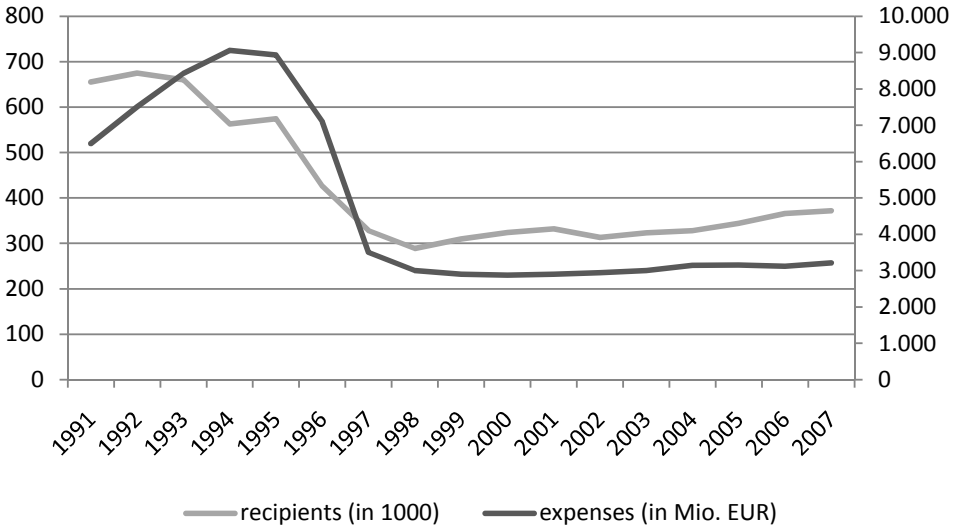
By the mid 1970s, an important debate on the prospects of people in need of care was initiated by a report of Kuratorium Deutsche Altershilfe (1974). The report illustrated how people in need of long-term care were "deported" to institutional care seen as cases of irreversible illness along the lines of care instead of cure. It demonstrated (and postulated) that health insurers should be obliged to account for expenses of institutional care by arguing that care cannot be separated

from the definition of illness in terms of the insurance-legal definitions. At that time, people had to pay expenses for institutional care themselves and, therefore, a rising number of older persons became welfare dependent. This development also stressed the financial situation of the local authorities who were in charge of providing the special public long-term care insurance. The number of people eligible for benefits more than doubled from 165,000 in 1963 to 335,000 in 1973 and peaked in 1992 with 675,000 (now including the reunified Germany).

Both, on the one hand, the growing number of elderly becoming welfare dependent even if they had worked their whole lives (which induced a kind of stigma effect) and, on the other hand, the imbalance between welfare grants and costs for stationary care and the associated financial pressures for municipalities were the starting points of the discussion of adopting a self-standing long-term care insurance. Nevertheless, both arguments were important but not the only ones put forward. As emphasized by Götting, Haug, and Hinrichs (1994), in addition, the strain of doing informal care with a shrinking supply of informal carers and concerns about supply and quality of professional care for increasing demands were mentioned. An early proposition for a self-standing insurance in Germany was made by the Association of Public and Private Welfare in 1981 (Deutscher Verein für öffentliche und private Fürsorge, 1981). They suggested to integrate long-term care into the social insurance system using the argumentation that being in need of care is a general risk of life. Furthermore, they criticized that the principle of subordination – applicable for welfare – was constantly violated since special public long-term care assistance claimed the largest part of welfare payments and therefore was not paid for exceptional circumstances of life. This early proposition was resembled in the later implemented social long-term care insurance, but it took another fourteen years to pass the law.

According to Campbell (2002) there are two main alternatives to implement long-term care provision: 1) Direct service provision financed by taxes or 2) social insurance financed by contributions. The choice between those extreme alternatives is mainly influenced by the already existing structure of the insurances and tax system.[2] Both alternatives were part of the discussion in Germany as well, but in addition two insurance solutions were discussed: A private and a social insurance.[3] While Liberals, the employer-oriented Christian Democrats and the employers' association clearly favored a private insurance, the employee-oriented Christian Democrats proposed a social insurance. In contrast to that, trade unions, the Social Democrats and the Greens together with smaller interest groups (physicians association, representatives of handicapped, self-administered bodies of sickness funds and small white-collar unions) first favored a tax-transfer scheme, but at least the Social Democrats and the trade unions later switched to support the idea of a social insurance.

Figure 1: Special Public Long-term Care Assistance: Recipients and Expenses (1991 to 2007)



Source: Federal Bureau of Statistics (2009a), p. 37, own representation

After a long debate (that was delayed due to German Unification in 1990) finally a universal, non means-tested, contribution financed long-term care insurance being part of the German social insurance system was adopted. On May 26th, 1994 parliament passed the associated law. However, in contrast to health insurance, SLTCI was not intended to fully cover the risk of being in need of long-term care. The new insurance was a partially comprehensive insurance with the aim to cover only the basic needs. Therefore, special public long-term care assistance as part of social welfare was not abolished but its relevance decreased significantly (see Figure 1). As from June 1st, 1994 long-term care insurance funds were installed at every health insurer and from January 1st, 1995 contribution payments started. Benefit payment did not start before April 1st, 1995 for out-patient care and from July 1st, 1996 for in-patient care. Therefore, an initial stock of savings could be set up (more details of the financial structure of SLTCI will be presented below in section 2.3).

2.2 Institutional Framework

As indicated above, SLTCI is part of the social insurance system which consists of five pillars: unemployment insurance, health insurance, pension insurance, accident insurance and long-term care insurance. They all follow the principles of solidarity, self-administration and funding by social insurance contributions. Social insurance is generally compulsory for all employees, for health insurance and SLTCI respectively up to a certain income threshold, the so-called social insurance ceiling. There is no such threshold for the other social insurances. Contributions

are calculated as the given percentage rates up to the so-called social insurance contribution assessment ceiling. This is the maximum gross income up to which income is subject to social insurance contributions. If income exceeds this level only the social insurance contribution assessment ceiling is considered for deductions. In 2003, it was set to €45,900 and is increased by the ratio of per capita gross salary in the preceding year and the pre-preceding year.In 2008 it amounted to a yearly gross income of €48,600. Some groups are exempted from compulsory coverage: Civil servants, soldiers and people older than 65 years are exempted from unemployment insurance. Self-employed are exempted from health and SLTC insurance, and civil servants from pension insurance in addition.

Table 1: Development of Contribution Rates for Social Insurances (in %)

	1995	**2000**	**2005**	**2009**
Unemployment Insurance	6.50	6.50	6.50	2.80
Health Insurance*	13.20 (12.80)	13.60 (13.80)	14.20 (14.00)	14.00
Long-term Care Insurance	1.00	1.70	1.70**	1.95**
Pension Insurance	18.60	19.30	19.50	19.90
Employees subject to social insurance contribution (in 1000)	28,118	27,826	26,178	22,560

* values in brackets apply to East Germany

** employees' contribution is 0.25%points higher for childless people

Source: Federal Ministry of Labor and Social Affairs (2009)

Except for accident insurance where financing is exclusively provided by employers, all other social insurances are financed by contributions on the basis of parity.[4] Table 1 shows the development of contribution rates for the four insurances where financing is shared and the development of the number of all employees subject to social insurance contributions.

Unlike the other four pillars the SLTCI does not have an independent administrative organization. It is co-administered by the existing health insurance funds. In June 1994, SLTCI funds have been installed at every existing public health insurer. To compensate health insurers for taking over administrative tasks there is a fiscal equalization scheme obliging the SLTCI funds. According to Arntz, Sacchetto, Spermann, and und Sarah Widmaier (2006) there are about 250 SLTCI funds in Germany.[5]

The general funding of SLTCI is organized as a pay-as-you-go scheme. Private LTCI funds instead rely on prospective entitlements. This means that provisions are kept from each person insured and for employees private LTCI funds also receive a grant from employers to the same amount as for social LTCI.[6] The federal states are responsible for providing an adequate infras-

tructure for long-term care. The SLTCI funds have to ensure that the benefit claimant receives the requested and entitled benefits. Therefore the SLTC insurers contract with ambulatory and institutional suppliers to guarantee provision of long-term care.

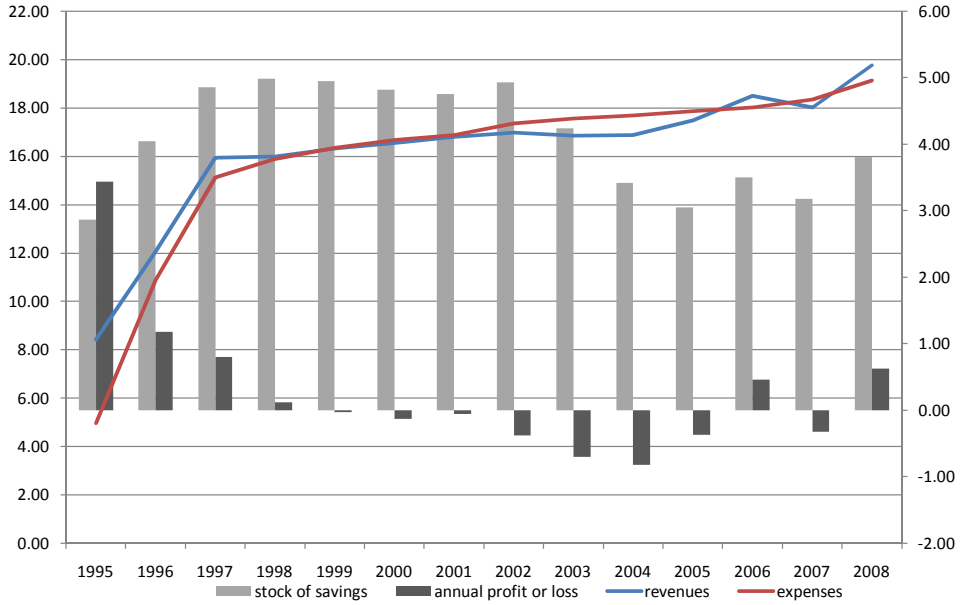
2.3 Funding

When payment of contributions started in 1995, the rate corresponded to 1% of gross income. In July 1996, the premium was increased to 1.7%. To account for the fact that childless people will on average receive higher benefits from the SLTCI funds compared to people cared by their own children, in 2005 an additional premium to be paid by childless people of 0.25%points of gross income subject to social insurance contributions was introduced.[7] In consequence, childless employees also contribute more than their employers and financing is no longer based on parity. Exempted are childless persons born before 1940, persons younger than 23, and recipients of unemployment assistance or persons in military or alternative service. Another increase of premia is in effect since July 2008. In the course of a novel of the SLTCI law (*Pflegeweiterentwicklungsgesetz*) to finance adjusted benefits, contributions were further increased by 0.25%points so that premia for people with children are now 1.95% and for childless people 2.2% of gross income subject to social insurance contributions (see below for a more detailed discussion of this recent reform).

At the time of introduction of SLTCI, employers where not in favor of adding another social insurance due to higher labor costs. However, employees agreed to resign a public holiday (the day of repentance) in order to prevent the non-wage labor costs to rise. The economic activity of an extra working day (the abandoned public holiday) was thought to finance the employers' contributions.[8] Thus, SLTCI has in fact never been a social insurance on the basis of parity. Although contributions were shared mathematically equally, employees indeed compensate the share of employers by working an additional day per year. Residents in the federal state of Saxony voted against this split and kept the public holiday in return for higher contributions of employees: In 1995, employees with children paid 1.475% and employers only 0.475%, 0.5%points less than on a basis of parity.[9] The later adjustments of contribution rates took account of this initial difference.

As contribution payments started before benefit payments a stock of savings has been built. However, in 1998 the positive difference in revenues and spending vanished and expenses exceeded revenues from 1999 to 2005 and again in 2007 (see Figure 2).[10] Higher contribution rates due to the recent reform in 2008 (see below) will temporally mitigate this development. SLTC

Figure 2: Revenues and Expenses of SLTCI from 1995-2008 in billion €



Data source: Federal Ministery of Health (2009b)

insurers are obliged to withhold a stock of savings that consists of at least 50% of the monthly benefit spending designated in the budget. Therefore, on average the stock of savings at the end of each year corresponded to about two to three months of benefit spending.

An important facet of the long-term care insurance system in Germany is that insurance is compulsory. Members of social health insurance are automatically insured for SLTCI. Every person earning less than the social insurance ceiling is a member of this system. It covers all additional-insured persons like spouses and children; altogether there are around 70 million people insured. Persons voluntarily insured at social health insurance are also automatically insured at SLTCI. Furthermore, there are another 9.25 million persons insured at private LTCI funds (associated with the private health insurance funds). Thus, despite compulsory coverage there are approximately 3 million persons not insured for the risk of being in need of care.

3 Eligibility, Care Levels and Provision of Services

3.1 Eligibility and Assessment

Persons are eligible for SLTCI payments when they are frail.[11] This applies to "a person who requires for a minimum period of approximately six months, permanent, frequent or extensive help in performing a special number of 'activities of daily life'(ADL) and 'instrumental activities of daily life' (IADL) due to physical, mental or psychological illness or disability", see Arntz,

Sacchetto, Spermann, and und Sarah Widmaier (2006). ADL consist of abilities necessary for fundamental functioning like bathing, dressing and undressing, eating, using the toilet, or walking. Next to it, IADL comprise besides others "telephoning, shopping, food preparation, housekeeping, laundering, use of transportation, use of medicine, and financial behavior", see Lawton and Brody (1969). These tasks provide the basis of an independent life and are affected in an earlier stage of disease or disability.

Table 2: Assessment Guidelines of Medical Review Board

Domain	**Examined activities**
Personal Care	washing, showering, bathing, dental care, combing, shaving, micturition and defecation
Nutrition	preparation of bite-sized meals and assistance with ingestion
Mobility	getting up and going to bed, changing the position independently, dressing and undressing, walking, standing, climbing stairs, leaving and entering the accommodation, (e.g. for consulting a physician)
Housekeeping	shopping, cooking, cleaning, washing up, changing and laundering clothes, heating the apartment

On behalf of SLTC insurers the Medical Review Board of health insurers (*Medizinischer Dienst der Krankenkassen*) is responsible for assessing the individual level of required care. The four basic domains of activities evaluated by the Medical review Board are personal care, nutrition, mobility and housekeeping. The assessments guidelines enumerate a number of special activities examined in every domain (see Table 2).

Apparently, the notion of being in need of care is clarified with the help of assessing ADL as well as IADL. The actual assessment of the individual is undertaken by physicians and nurses mandated by the Medical Review Board. According to the Federal Ministry of Health (*Bundesministerium für Gesundheit*) the probability of being in need of care is 0.7% for persons younger than 60, 4.4% for persons between 60 and 80 years, and increases to 28.6% for persons older than 80 years.

After having evaluated a person's level of care required, the corresponding demand of time for provision of services is assessed. Three different care levels are assigned according to the tasks and time needed. Care levels are differentiated with regard to severity of care dependency. Table 3 shows the respective attribution of care level, need for help, and time necessary for provision.

Table 3: Care Levels and Care Needed

	Care level I (need for considerable care)	**Care level II** (need for intensive care)	**Care level III** (need for highly intensive care)
assistance for personal care, nutrition or mobility	at least once a day for at least two tasks in one or more areas	at least three times a day at different times of the day	assistance around the clock
assistance for housekeeping	several times per week	several times per week	several times per week
time needed*	at least 90 min./day on average thereof no more than 45 min./day for housekeeping	at least 3h/day on average thereof no more than 1h for housekeeping	at least 5h/day on average thereof no more than 1h/day for housekeeping

* time exposure is calculated for non-professional carers.

3.2 Provision of Services

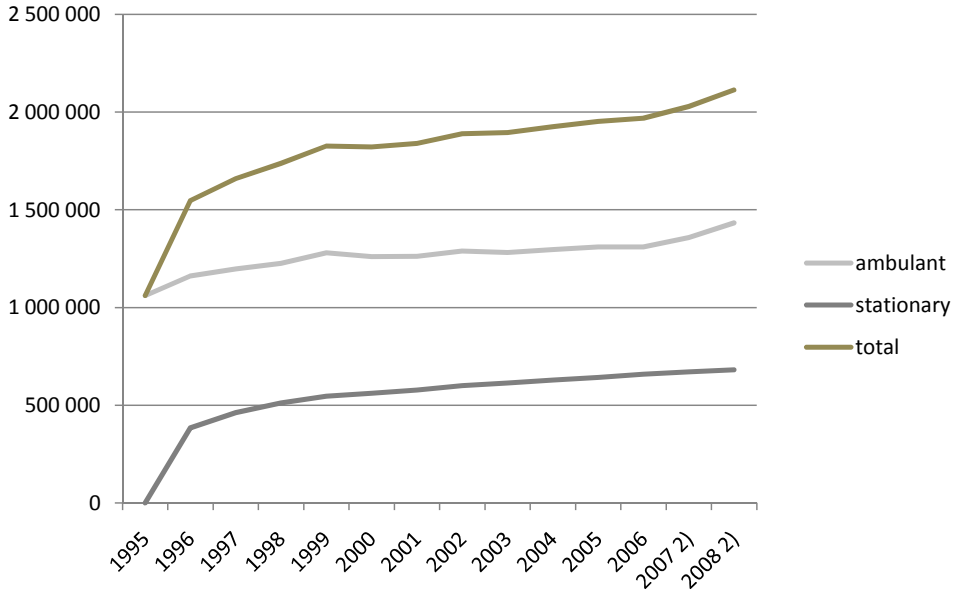
Services could be provided in three different ways. Home care (family members or non-professional private persons), home help service (professional staff for ambulatory help) and institutional care. The latter can be provided in different kinds of institutions like old age homes, residential care homes and nursing homes (Lundsgaard, 2005) where the care dependency of residents is highest in nursing homes. Since the introduction of SLTCI in 1995 the number of benefit claimants increased steadily. Figure 3 shows the development of benefit recipients in total and for recipients of home (home care and home help service) and institutional benefits respectively. When assuming constant probabilities of becoming dependent on care, expected demographic development will lead to an increase of 50% in need of care, or, in absolute values, one million additional claimants for benefits (Federal Ministery of Health, 2009a).

SLTCI favors home care (including home help service) compared to the more expensive institutional care. This order of preference is also reflected in the variety of benefits trying to facilitate flexible care arrangements. The following numeration shortly characterizes all available kinds of benefits. The first five kinds of benefits apply to home care and home help service respectively.

Benefits in Kind

Benefits in kind consist of help for personal care, nutrition, mobility, and housekeeping and is carried out by professional care providers. Providers have to be licensed by the SLTCI funds

Figure 3: Benefit Recipients 1995-2008



[2]) Increase 2007 and 2008 due to improved registration methods.Source: Federal Ministery of Health (2009a)

and sign provision contracts. The amount of care provided depends on the actual needs of a person but is limited in value according to the assigned care level and to services included in a pre-defined catalogue. Table 4 shows the respective monetary amounts which can be spent for benefits in kind for each care level.

Additional benefits can be allocated for persons at care level III in cases of hardship, but only up to a maximum value of €1,912 per month if extraordinary effort is necessary (e.g. at the end-stage of cancer). Moreover, these extra benefits can only be granted to 3% of all insured persons at care level III.

Table 4: Benefits in Kind According to Care Level (Monthly Values in €)

Care Level	Before 07/2008	From 07/2008	2010	2012
Care Level I	384	420	440	450
Care Level II	921	980	1,040	1,100
Care Level III	1,432	1,470	1,510	1,550

Cash Allowances

Alternatively, persons can opt for lump-sum payments, so-called cash allowances. With this kind of benefits, care can also be provided by other persons than the contract partners of

SLTCI funds, namely personal care assistants or informal carers (family members or other non-professionals). The person in need of care can decide whether to purchase services from a provider of choice, to use the cash allowance to remunerate informal care givers, or to spend it on something completely different. Thus, lump-sum transfers are not bound to the purchase of care but in turn are smaller than benefits in kind as Table 5 shows.

Table 5: Cash Allowances According to Care Levels (Monthly Values in €)

Care Level	Before 07/2008	From 07/2008	2010	2012
Care Level I	205	215	225	235
Care Level II	410	420	430	440
Care Level III	665	675	685	700

It should be noted that cash allowances can only be granted when services for the caring needs are provided by a third person, i.e. not the person herself. Compliance with this eligibility rule is checked by regular visits from agents of an information center licensed by SLTCI funds and takes place at least once in six months for persons with care levels I or II and at least once in three months for persons with care level III.

Combination

If benefits in kind are not exhausted, the rest of the entitlement could be paid proportionally as a cash allowance. These combinations of benefits in kind and cash allowances do not alter the overall level of benefits. The allocation is binding for the next six months and can only be changed afterwards.

Auxiliary Care Products

Benefit recipients are entitled to auxiliary care products that facilitate care but only for basic equipment. Technical products like wheelchairs are provided without additional costs. Consumer goods as disinfectants are provided up to monthly costs of €31. Measures that enable a person to live more independently in his or her own accommodation can be supported up to a value of €2,557 but with co-payment of the insured depending on income.

Respite Care

When care is provided informally there may be need for a substitute of the carer, e.g. in cases of illness or leave. Therefore, the person in need of care could be entitled to so-called respite care for a maximum duration of four weeks per year. Requirements for receiving respite care are that the person taking over the care services is not a direct family member of the person depending on care and that informal care has been provided for at least six months before respite care is requested. If respite care is provided by professional carers additional benefits amount to a maximum value of €1,470 per year in 2008 (€1,510 in 2010 and €1,550 in 2012). If the respite caregiver is a family member or lives in the same household as the care dependent person only the lump-sum transfers are paid but additional expenses (for example for traveling or loss of earnings) can be remunerated up to maximum values applying for professional respite care.

Day and Night Care

Day and night care provides another example for the priority given to home care arrangements compared to institutional care in SLTCI. When home care or home help service is not sufficient (for example due to special needs during the night), a part-time institutional arrangement can be offered. Day/night care comprises transportation to and from the institution. It can be combined with benefits in kind and/or cash allowance, but the total value must not exceed 150% of the underlying type of benefits, i.e. if day/night care is requested only up to 50% of the values in Table 6, the person in need of care is still entitled to 100% of benefits in kind or cash allowance respectively.

Table 6: Day/Night Care Benefits According to Care Levels (Monthly Values in €)

Care Level	Before 07/2008	From 07/2008	2010	2012
Care Level I	384	420	440	450
Care Level II	921	980	1,040	1,100
Care Level III	1,432	1,470	1,510	1,550

Short-Term Care

Short-term care implies institutional care for a maximum duration of four weeks per year. It is granted if day/night care or home care is not sufficient, for example after a stay in hospital

when the person is still too frail for home care or day/night care. Benefits amount to the same values as for respite care (see Table 6).

Institutional Care

A person is entitled to institutional care if home care and similar forms of benefits are not adequate. Benefits are displayed in Table 7 and must not exceed 75% of total expenditures of the institution. The highest amount of benefits in case of hardship cannot be granted to more than 5% of insured persons at care level III. If someone chooses this kind of care regardless of necessity, the person is only entitled to the maximum value of benefits in kind and has to pay for additional costs. If persons in institutions for disabled people are in need of care, SLTCI funds account for up to 10% of monthly charges but not more than €256 per month.

Table 7: Benefits for Institutional Care According to Care Levels (Monthly Values in €)

Care Level	Before 07/2008	From 07/2008	2010	2012
Care Level I	1,023	1,023	1,023	1,023
Care Level II	1,279	1,279	1,279	1,279
Care Level III	1,432	1,470	1,510	1,550
Cases of Hardship	1,432	1,750	1,825	1,918

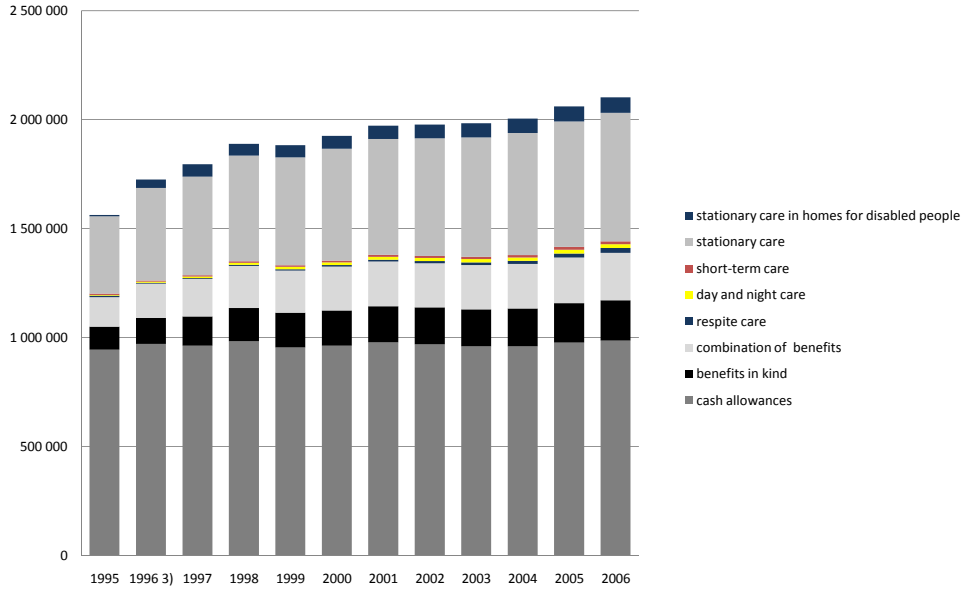
Further Benefits

In addition to cash allowances which can be given to carers there is some additional assistance. SLTCI funds pay contributions to pension funds if informal carers do not work more than 30 hours per week and spend at least 14 hours per week for care.[12] Coverage for accident insurance is comprised automatically. If informal carers are on a leave scheme for providing care for a person they receive grants for contributions to unemployment insurance, social health insurance and SLTCI.[13] Furthermore, SLTCI funds pay courses that teach family members and informal carers how to provide home care.

Until the reform in 2008 the notion of being in need of care did not include persons impaired by dementia, mental handicap or psychic diseases as the definition was constrained to physical restrictions. Since July 2008 persons with psychic impairment (*eingeschränkte Alltagskompetenz*) are also entitled to benefits.[14] The benefits are not assigned for basic care or housekeeping

but for supervision and amount to € 100 per month for basic cases and € 200 for more severe cases. The money can be used to purchase any kind of benefit desired.

Figure 4: Expenses for Different Kinds of Benefits 1995-2006 in €



[3]) Payment for stationary benefits started only in July 1996.Source: Federal Ministery of Health (2009a)

Figure 4 shows the distribution of the shares of benefits over the years 1995 to 2006. It is apparent that the share of cash allowances has remained almost unchanged while the share of institutional care has increased steadily.

3.3 Service Providers

As mentioned above, benefit claimants opting for cash allowances can purchase services from any provider. For benefits in kind or institutional care providers have to be contracted with the SLTCI funds. Eligible for contracts are independent businesses when a person qualified in care is in charge and liable. The skilled person needs to have at least two years of experience in care acquired during the last five years. Furthermore, providers have to pay their employees common regional wages. In addition, all providers have to fulfill quality requirements that are examined regularly. If providers fulfill these criteria a so-called provision contract (*Versorgungsvertrag*) is signed between the service provider and the association of SLTCI funds of the state.

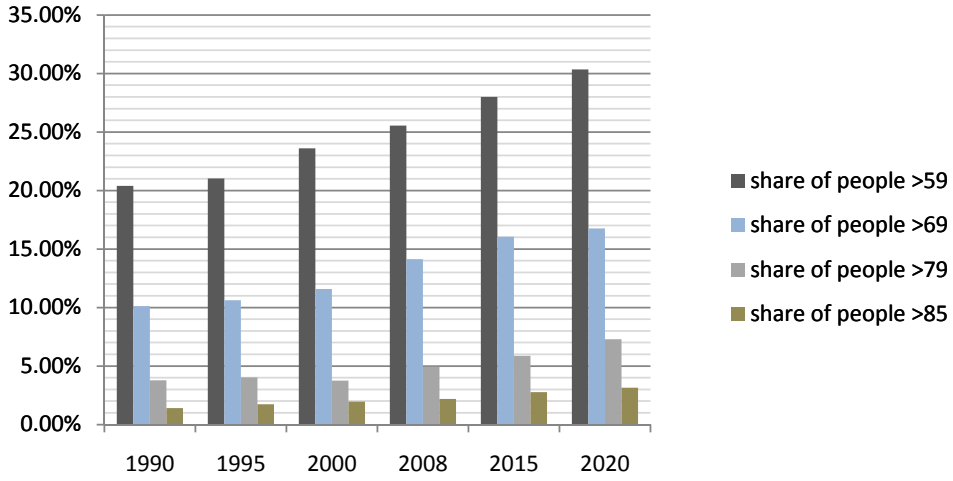
The catalogue of services and the scale of charges for services are defined by governmental departments in cooperation with all affected parties. Thus, prices of services are not market-determined but administered. There are regional differences between charges to account for general wage level and income differences across states.

All providers are monitored and advised by the Medical Review Board of social health insurance funds. Principles and criterions for qualitative care are composed by all stakeholders of SLTCI and are examined regularly in intervals of not more than one year.[15] In case of a special occasion the examination will be conducted more diligently than for a regular evaluation. Results have to be made available to all stakeholders.

4 Threats and Perspectives for Sustainable LTCI in Germany

In face of an ageing society the demand for long-term care is expected to further increase which challenges SLTCI. Figure 5 shows the (expected) development of the share of older people between 1990 and 2020. According to this projection the share of people older than 59 will be almost one third of the population in 2020 (see Figure 5). Together with a constant or even decreasing birth rate and a constant or increasing participation rate of women, the need for professional or institutional care will surely increase.

Figure 5: Share of older people from 1990 to 2020



Data source: Federal Bureau of Statistics (2009b)

4.1 The Role of Informal Care

One reason to prioritize home over institutional care in the German SLTCI is the idea of solidarity and the family ideal. Home care should enable a person in need of care to maintain a self-determined living in the home environment. Besides, family members, relatives or other persons usually provide more than just "technical help" but beyond that give emotional care. Of course, there are also threats from informal care. Although the situation of the person in

need of care is assessed regularly, quality of informal care can be inferior to professional care. Furthermore, the relationship between carer and patient is close and the fact of dependency could give opportunity for exercise of power or even negligence in case of overload on the side of the carer. Görgen, Herbst, and Rabold (2006) find in a survey that about 15% of people in need of care report acts of disregard of autonomy, disregard of dignity, and negligence in caring.[16]

Strengthening of home care should be achieved by provision of cash allowances which allow to reward informal care. As almost 80% of all spending to benefit recipients are cash allowances, informal home care is currently the predominant way of providing care in Germany. Wasem (1997) points out why the existing system of benefits in kind and cash allowances strengthens home care. Benefits in kind enable persons to stay longer at home or to reduce hospital stays instead of having to rely on stationary care. However, Wasem (1997) further argues that the prevalence of cash allowances may lead to a situation where the share of professional home care is low. Of course, benefits in cash can also be used to purchase professional care services. According to Klie (1998), access to supporting networks is identified as the main determinant of the choice between benefits in kind and cash allowances.

Infratest Sozialforschung (2003) present an overview on the structure of informal care in Germany. In a representative survey from 2002 of more than 25,000 households of benefit recipients of SLTCI and other people in need of care they find that about 92% of all benefit recipients receive informal care.[17] The majority of carers are family members, and 73% are female. The fact that one third of all informal carers are 65 years and older reveals the large part of informal care that is provided by the same generation. 69% of all carers are married and 60% are not working. However, about 33% are working more than 15 hours a week. Therefore, a non-negligible part of carers has to shoulder two tasks. It should be noted, that around two third of informal carers live in the same house or household and are therefore disposable around the clock. The average weekly time spent on care amounts to more than 36 hours. According to Klie (1998), about 50% of all informal carers receive monetary remunerations.

Given the demographic figures, i.e. increasing life expectancy and female participation rates combined with lower birthrates, there are doubts that the level of care could be maintained by provision of informal care in the long-run due to the rising number of people in need of care and the shrinking number of possible carers. Klie (1998) points out that people with a "pre-modern" lifestyle, i.e. with more children, living with family, living in rural areas, have more often a solid network available for informal help. In contrast, these solid networks are less likely for people with modern lifestyle, i.e. individualization, urbanization, and less children. According to the description in Klie (1998), trends like individualization and urbanization have more effects on

the lifestyle of the next generation and this will accelerate the loss of solid networks for future benefit recipients. This development will reduce the number of (potential) informal carers in addition to the demographic shift.

4.2 Personnel & Care

Care is very labor intensive and the increase in the number of persons in need of care will also increase the demand for labor in the future. Felder and Fetzer (2008) point out that the combination of inelastic demand and limited technical progress will lead to an over-proportional increase of costs (a so-called Baumol effect). The theoretically derived argument is in line with the cost increases reported in Kronberger Kreis (2005) of 3.4% yearly for out-patient and of 5.9% for in-patient care.

However, given the growth in expenses and number of benefit recipients SLTC insurers attempt to maintain costs at level or at least to prevent them from increasing further. In part, saving labor costs is achieved by remuneration of providers for certain bundles of services. By doing so, the time for single tasks is not accounted separately. The drawback of this approach is that service providers have the incentive to accomplish the tasks in the shortest time possible. This leads to a very "technical" way of accomplishing services which has been criticized.[18] In line with that, the Council of Health Advisors (2005) reports that professional carers feel inferior to voluntary carers since the introduction of SLTCI because their engagement is limited to provide this technical care whereas informal carers seem to be responsible for quality time spent with the patients. Another aspect of the bundling procedure is that service providers limit their supply of services to bundles that could be remunerated according to the SLTCI catalogue of in kind services. As a result, persons who want to use cash allowances to purchase services that are not covered by benefits in kind may have trouble to find a matching provider (see also Council of Health Advisors, 2005).

Another way to reduce labor costs and to meet the increasing demand for personnel is to change the qualification mix of employees. Council of Health Advisors (2001) reports that for institutional care there has been a reduction in qualification during the time from 1996 to 1999; employees without qualification have increased by factor six from around 1% to about 6%. In addition, skilled employees have been substituted partly by assistants who receive lower wages. Cost pressure is very high: already in 1997, there were only 31% skilled employees in institutional care facilities, although a quota of 50% is requested by law.

From 2003 to 2008, the share of skilled nurses in general (for the whole health sector) has

slightly decreased from 57 to 55%. However, the share of nurses without qualification has increased from 9 to 15%. For geriatric nurses the same pattern applies: The share of nurses with a qualification has decreased from 64 to 59%, while the share of those without qualification has increased from 17 to 23%.[19]

4.3 Revenues and Expenses

Status Quo

The aim of SLTCI to provide stable real benefits with stable contribution rates is put at risk for two reasons. First, there will be less revenues as the number of contribution payers will decrease in future years due to the demographic shift. Second, expenses will increase as high-birthrate cohorts are the benefit recipients to come in future years and life expectancy is increasing and with it morbidity of older people.[20] Thus, there is a double pressure on the existing financing mechanism of SLTCI. Furthermore, benefits have not been adapted to price increases in the time between 1995 and 2008. Hence, according to Council of Economic Advisors (2004) the continuously shrinking real benefits can be seen as a privilege for the first benefit recipients shortly after introduction of SLTCI and as a disadvantage for recipients in the period before 2008. Fetzer, Moog, and Raffelhüschen (2003) even show that social LTCI is not an intergenerational contract because no generation balances future receipts with payments.

Projections

A number of authors provide projections on the sustainability of SLTCI in Germany in face of increased spending, decreased earnings, and, therefore, sinking real benefits. However, all available analyses are based on the status quo until 2008 and thus do not take account of the adjustment of benefits introduced thereafter. Nevertheless, the development under a continued status quo in benefits and contributions is revealed quite consistently from the different projections. Council of Economic Advisors (2004) and Kronberger Kreis (2005) point out that in 2050 real benefits will account for only about 50% of their value in 1995. For the time between 1995 and 2004, Kronberger Kreis (2005) reports yearly cost increases of 3.4% for out-patient care and 5.9% for in-patient care. For the projection of real benefits they assume an annual inflation of 1.5%. Then, if cost increases in the health sector stay on a high level, real benefits will shrink even faster.

Concerning the number of future benefit recipients, assumptions with respect to the development of the population and the risk of being in need of care have to be placed. Differences

between the available projections therefore refer mainly to differing assumptions concerning the population development and immigration. Assuming a constant age-specific risk of care dependency, Rothgang (2001) calculates about 2.9 to 3.3 million benefit recipients in 2040. This would be an increase of 55 - 76% compared to 2000. Similarly, Council of Economic Advisors (2004) estimates a number of 2.4 to 3.5 million benefit recipients in 2040 when assuming constant age-specific risks of care dependency. Nevertheless, Rothgang (2001) supposes that the risk of being in need of care will decrease because with increasing life expectancy prevalence also occurs later in life. Including this change, the estimated number of benefit recipients in 2040 changes to 2.5 to 2.7 million. Blinkert and Gräf (2009) likewise analyze scenarios of decreasing prevalence that result in 3.25 to 3.5 million people in need of care; however, their projection refers to the year 2050.

Even when maintaining the status quo of benefit payments of the time until 2008, the contribution rates will have to be raised tremendously. According to Herzog Kommission (2003), contribution rates will amount to (at least) 2.6% of gross earnings subject to social insurance contributions in 2030. Council of Economic Advisors (2004) expects a further rise up to 2.7 to 4.0% conditional on the underlying assumptions about the growth of benefits and the growth of revenues. However, despite this significant increase contribution rates will peak in 2055 between 4.5 to 6.5% (Fetzer, Moog, and Raffelhüschen, 2003). Afterwards, the lower-birthrate cohorts will enter the pool of persons in need of care. Similar results are obtained by projections by Blinkert and Gräf (2009). They estimate a lower boundary for 2050 at 3% when a decreasing prevalence, a low adjustment of benefit levels and a slowly sinking reserve of informal carers are assumed. The upper boundary when a constant prevalence and a high adjustment of benefit levels are assumed amounts to even 7% of gross earnings subject to social insurance contributions.

Total expenses will increase following Rothgang (2001) by between 84 and 109% depending on the assumed share of home and institutional care and the expected increase in the number of benefit recipients. In particular, he assumes the share of professional care to increase mainly due to the higher number of single households which corresponds to an over-proportional increase in total spending compared to the increase in the number of benefit recipients.

With regard to a projection of the revenues of SLTCI, Rothgang (2001) points out that a forecast of future contribution payers and immigrants as well as pensioners is required. On the one hand, there will be less people working in jobs subject to social insurance contributions due to the demographic shift, but, on the other hand, there will be more pensioners as well which will at least partly compensate for the expected loss. In addition, Rothgang (2001) further assumes

that participation rates will increase due to higher employment chances in the labor force when the high-birthrate cohorts leave the labor market. Consideration of these effects results in an expected decrease in revenues between 0 to 17%; the decline will be lowest if adaptations on the labor market are considered. In addition, Blinkert and Gräf (2009) present figures for the relation of contribution payers and benefit recipients. The ratio in 2007 is 26 persons contributing for one recipient, but it will deteriorate to only 10 to 16 persons contributing for one recipient in 2050.

5 Reforming SLTCI: Options and Recent Changes

5.1 Reform Options

The different projections clarify the need to reform the SLTCI. In the following, we will outline a number of different reform options that have been suggested recently. The range of suggestions covers concepts which almost resemble the existing pay-as-you-go system as well as concepts proposing systems with funding principle which should be implemented instantly. The main aspects of the different reform options are summarized in Table 8 below.

Universal Flat Rate Contribution (*Bürgerversicherung*)

The universal flat rate contribution system augments the idea of the existing pay-as-you-go system that only considers employees in jobs subject to social insurance contributions. In the universal flat rate contribution system, all employed citizens including civil servants and self-employed persons will be required to contribute to the insurance. Since the so-far not included professional groups have even higher incomes on average, the revenues of SLTCI will rise. Nevertheless, the social insurance contributions assessment ceiling should maintain in effect but in addition tax allowances of capital revenues will be considered.[21]

Calculations of the corresponding figures of contribution rates for Germany are provided by Lauterbach, Luengen, Stollenwerk, Gerber, and Klever-Deichert (2005). Compared to the status quo scenario (contributions before 2008), they calculate 0.36%points lower contribution rates in the universal flat rate contribution system. When regarding the enlarged population of contribution payers, the expected increase in contribution rates will be smaller as well with corresponding estimates of 1.85% in 2025 compared to 2.33% in the status quo scenario. In addition, Lauterbach, Luengen, Stollenwerk, Gerber, and Klever-Deichert (2005) suggest further to include people suffering from dementia and to raise benefits for home care (level I to €704

and level II to €1,100). In this case, contribution rates of the universal flat rate contribution system would have amounted to 1.88% in 2006 and will rise to 2% in 2025.

Intergenerational Burden Sharing (*Intergenerativer Lastenausgleich*)

Within the scope of a reform proposal for the whole social insurance system in Germany on behalf of the that-time government Rürup Kommission (2003) provided a suggestion for reforming SLTCI. To enable a sustainable level of care provision, they postulated an increase in benefits for the year 2005 up to €400 for care level I, €1,000 for care level II and €1,500 for care level III. Moreover, identical benefit levels for home and institutional care are recommended. Rürup Kommission further proposed an annual adjustment of benefits at a rate of 2.25% assuming an annual increase of nominal wages by 3% and an inflation rate of 1.5%. To finance this increase in benefits, higher contribution rates of pensioners should be implemented. In their scenario, there should be a basic contribution rate at 1.2% of gross earnings for the working population and pensioners to be introduced in 2010. In addition, pensioners will be required to pay further 2% of their income to compensate the increase in benefits. The working population should contribute additional 0.5% to the basic contribution rate that should build a stock of capital paid as a pension, this should enable payment of increased contribution rates during retirement. Over time, this additional rate should fade out until 2030 while holding the overall contribution rate fixed at 1.7%. The increase in the basic contribution rate for the working population should guarantee the stability of the pay-as-you-go system in face of the ageing population. Only the basic contribution rate should be equally shared between employees and employers and between pensioners and the pension insurance institutes respectively, the additional parts of the contribution rate should be deducted from individual's earnings. Rürup Kommission (2003) calculated that contribution rates of pensioners will rise to 4.5% in 2040 (the last year considered in their analysis) and the capital stock accumulated will amount to about €125 billion. This set-up allows a sustainable funding of SLTCI until 2040 when the demographic shift is expected to reach its turning point.

Fixed Premia (*Umlagefinanziertes Pauschalbeitragssystem*)

An alternative approach is recommended by Council of Economic Advisors (2004), where premia are favored that are independent of individual earnings and can be combined with building a capital stock. In that sense, the Fixed Premium model is similar to a universal flat rate benefit system but with lump-sum contributions. Children will be mandatorily insured with

Table 8: Overview of Proposed Reform Options

	Universal Flat Rate Contribution System	**Intergenerational Burden Sharing**	**Fixed Premia**	**Premia with Funding Principle**	**Phase-Out Model**	**Cohort Model**	**Funding Principle Insurance**
Model by	Lauterbach, Luengen, Stollenwerk, Gerber, and Klever-Deichert (2005)	Rürup Kommission (2003)	Council of Economic Advisors (2004)	Herzog Kommission (2003)	Council of Economic Advisors (2004)	Häcker and Raffelhüschen (2004) and Felder and Fetzer (2008)	Kronberger Kreis (2005)
Objective	Risk structure compensation, reactivation of solidarity principle	Relief of younger generations	Disconnect SLTC from labor costs	Smoothing transition to capital covered scheme	Smoothing transition to capital covered scheme	Reducing sustainability gap, establishing intergenerational justice	Prevention of further costly payment commitments
Funding System	Pay-as-you-go scheme	Pay-as-you-go scheme	Pay-as-you go with fixed premia	Capital covered premia	Age-specific premia	Risk-adjusted premia	Risk-adjusted premia
Time horizon	From 2006 on	Spending increase from 2005 on, increased contributions from 2010 on, calculations until 2040	2004-2050	Transition period until 2030	Transition period 2005-2045	Phasing-out 2005-2046 (Häcker and Raffelhüschen, 2004)/ Phasing-out 2007-2047 (Felder and Fetzer, 2008)	Instantly
Benefits	Raise home care benefits for levels I and II (€ 704/€ 1100) and enhance benefits for persons suffering from dementia	Equal benefits for home and stationary care for all levels and adjust them in 2005 to € 400/€ 1000/€ 1500	No change of benefits	No change of benefits	No change of benefits	No change of benefits	Mandatory minimum and voluntary additional benefits; additional state transfers for older people that decrease with time after reform
Adjustment of benefits	No	Yes, at a rate of 2.25%	Recommended	Recommended	Recommended	Yes, at a rate of 1.5%	*
Adjustment of ambulant and stationary benefits	Yes	Yes	No	Yes	No	No	No
Contributions/Premia	1.88% contribution rate for increased benefits; all citizens contribute; all incomes except rental incomes are considered up to the social contribution earnings ceiling	Basic contribution rate of 1.2%; additional 0.5% for employees (for provisions used to smooth contributions at higher age), additional (increasing) 2% for pensioners (as compensation for increased benefits)	Premia independent of age and gender; € 25 in 2004, rising to € 50-162 depending on income and price development	transition period: contribution rate of 3.2% to built collective capital stock; maturity stage: cohort-specific premia	cohorts 1952 and younger pay cohort specific premia and additional lump sums for older cohorts (only in transition period until 2045) and for children; cohorts until 1951: fixed premia of € 50 adding one €for each year after 2005	In 2005 persons < 60 years pay 1.2% income-dependent contribution rate and private insurance premium; persons 60 years and older: fixed premia of € 50 (Häcker and Raffelhüschen, 2004) or increasing income-related premia (Felder and Fetzer, 2008)	Risk-adjusted premia not exceeding € 50 at the beginning
Social balance with tax-transfer	No	No	Yes	Yes	Yes	Yes (Felder and Fetzer, 2008)	Yes

* Category does not apply.

the contribution payer (as in the current system), however, in contrast to the current system spouses will also be required to pay contributions on their own. The fixed premium should be adjusted over time to account for increased overall spending on long-term care. Council of Economic Advisors (2004) suggested an introductory rate at €25 independently of gender and age. Depending on increases in earnings, overall inflation and inflation in care services the fixed rate is expected to rise up to €50-162 in 2050. It should be noted, that no adjustment of benefits is considered in this concept, although Council of Economic Advisors (2004) mentions the necessity to do so. If adjustment of benefits is regarded, premia would be clearly higher. Moreover, if a funding principle would be considered, contributions will differ by gender and age.

Premia with Funding Principle (*Kapitalgedecktes Prämienmodell*)

The so-far presented reform options propose to maintain the pay-as-you-go character of the current SLTCI system or to adopt flexible combinations or hybrid systems with funding principle. In contrast to that, Herzog Kommission (2003) suggests the transition into a capital funded system in the long-run by fading out the pay-as-you-go components completely. In their proposal, the transition period will last until 2030, and afterwards cohort-dependent fixed premia will be imposed. During the transition period, there should be a constant contribution rate of 3.2% of gross earnings subject to social insurance contributions. These higher contribution rates compared to the existing status quo should be used to build up a collective capital stock which will subsidize contributions of older people from 2030 onwards. The expected level of premia for a 20 year old person in 2030 will amount to €52 per month and will be higher for older persons. Children and spouses will be mandatorily covered. People who are not able to account for premia will receive subsidies paid from tax transfers. Herzog Kommission (2003) suggests to compensate employers by abolition of another paid holiday and further recommends the adjustments of benefits.

Cohort Model (*Kohortenmodell*)

Besides the fixed premium model, the Council of Economic Advisors (2004) suggests the transition to a system with funding principle. In the original proposal, starting in 2005 persons born after 1951 should drop out of the SLTCI and pay cohort-specific premia in a private long-term care insurance. Cohorts born before 1951 should remain in the old SLTCI system but will have to pay fixed premia of €50 per month that will be adjusted by €1 annually from 2005 onwards.

The transition period will last until 2045, then almost every living person will be insured in the cohort-specific premium system with capital covered insurance. Benefits will remain the same, but with an increasing number of older people in need of care younger cohorts will be forced to pay additional contributions for the older cohorts and also for children. With regard to the expected demographic change, these additional contributions for older cohorts will reduce to zero in 2045. Again, Council of Economic Advisors (2004) generally recommends the adjustment of benefits, but no scenarios for adjusted benefits are considered in their calculations.

Phase-Out Model (*Auslaufmodell*)

Using a method of generation accounting, Häcker and Raffelhüschen (2004) calculate that all living generations are net receivers of SLTCI whereas all future generations will be net contributors. Therefore, the current status quo of the SLTCI includes a sustainability gap (*Nachhaltigkeitslücke*) that stems from the difference between the budget restriction and future net payment flows of all cohorts. Overall, the sustainability gap for all future years amounts to about 50 to 89% of German GDP for the year 2000, where differences occur due to the underlying assumptions concerning cost pressure for prices of care.

In order to reduce this burden, Häcker and Raffelhüschen (2004) suggest a phase-out-model. In this model, the current pay-as-you-go scheme is slowly converted into a capital covered scheme with the following characteristics: In 2005, persons younger than 60 will drop out of SLTCI and instead will contract with a (compulsory) private insurance. Persons 60 years and older will start to pay a fixed premium of €50. Benefits will be adjusted at an annual rate of 1.5% and as older persons' fixed premia are not sufficient to compensate for benefit payments the younger cohorts have to pay a solidary contribution of 1.2% of their income. This additional contribution will rise to 1.7% in 2027 when the high-birthrate cohorts become the risk group of people in need of care; afterwards, the additional contribution will slightly phase out until 2047. In this set-up, the sustainability gap reduces to 0 to 4.3% (in terms of German GDP for the year 2000) and the financial situation will be almost balanced. Felder and Fetzer (2008) suggest a similar model. It only differs with respect to the start of the phasing-out period already in 2007 and that older cohorts will be required to pay increasing income-related contributions instead of fixed premia.

Immediate Fully Capital Funded Model (*Sofortige Kapitaldeckung*)

The most radical reform option is suggested by Kronberger Kreis (2005). They criticize the other reform options for keeping too many aspects of the existing system or for waiting too long to introduce a system with funding principle respectively. Particularly, the linkage to wage and the combination of insurance and redistribution are assessed to be the main fallacies of the current system. Therefore, they recommend to switch to a fully capital covered system with risk-adjusted premia. A transition period as proposed by Council of Economic Advisors (2004) and Häcker and Raffelhüschen (2004) is assessed to be too costly and for the same reason contributions paid so far should not be refunded. Furthermore, Kronberger Kreis (2005) recommends to combine health insurance and LTC insurance.

This compulsory private health and long-term insurance should be based on the cost-of-service principle, so that every insured person approximately pays for possible future benefits according to the inherent risk. Only basic coverage should be guaranteed by the compulsory part of the insurance, but further protection will be voluntarily available. Premia should not exceed €50 per month in the beginning and the accumulated stock of savings should be completely transferable in case the insured person changes the insurer. Every person in need of care will have to pay an excess for benefits received. Kronberger Kreis (2005) suggests to offset benefits with state transfers when older persons' benefits surpass their contributions with premia. This compensation will be up to the full level of benefits in the old pay-as-you-go scheme in the first year and will decrease with every additional year after the reform. It will end in the 11th year after introduction of the capital covered private insurance. For persons not able to afford the private insurance, subsidies from tax transfers should be provided.

5.2 The reform of SLTCI in 2008

Despite the variety of proposals for reforming long-term care insurance, a reform law of long-term care (*Pflegeweiterentwicklungsgesetz*) was adopted in 2008 changing a number of important aspects.[22] First of all, according to the recommendations and postulation of several advisors, e.g. Herzog Kommission (2003), Rothgang (2008), Rürup Kommission (2003), Council of Economic Advisors (2004), Häcker and Raffelhüschen (2004), Council of Health Advisors (2005), an adjustment of benefits was introduced. In addition, the required contribution period for eligibility of benefit receipt was reduced from five to two years. With regard to respite care, the minimum duration until entitlement was reduced from 12 to six months.

Since benefits were not adjusted to inflation during 1995 to 2008, real benefits were shrinking.

In the course of the reform benefits will be raised in three steps in 2008, 2010 and 2012. To prevent real benefits from decreasing again, payments will be adjusted from 2015 onwards. Every three years, the required amount of adjustment will be assessed.[23] According to the respective law, raises will be oriented towards the cumulative inflation of the last three years but must not exceed the increase of gross incomes. Rothgang (2008) criticizes that no rule-based procedure for the adjustment of benefits was implemented. Linking the adjustment of benefits to regular examination of whether this is required carries with it the danger not to guarantee constant real values of benefits over time. The sole change adopted to increase revenues of SLTCI to finance the adjustment of benefits is the increase of contribution rates by 0.25%points. Rothgang (2008) notes that the obtained additional revenues will be only sufficient to finance the raise of benefits until 2012, and, therefore, do not provide a means for the targeted adjustment of benefits starting afterwards. He calculates that if increases in benefits will be spread proportionally over the years 1996-2015, there has to be an additional annual increase of 0.4%. Hence, the adopted benefit increases will mitigate the loss of real value of benefits, but are still not able to compensate for it. Furthermore, Klie (2008) criticizes that funding has not been detached from being solely based on labor earnings. All reform proposals described above recommend an enlargement of the basis of contributors or even to introduce (partly) capital coverage. The recent reform therefore provides only a continued status quo. Given the unchanged risks SLTCI faces, another increase in contributions has to be expected soon or, put differently, another fundamental debate about reforming the funding system in general.

Second, the group of people eligible for benefits was augmented by people suffering from dementia or other psychic impairments, even if no care level is assessed. This inclusion has also been postulated by a number of advisors, e.g. Lauterbach, Luengen, Stollenwerk, Gerber, and Klever-Deichert (2005), Rürup Kommission (2003), or Council of Health Advisors (2005). However, despite this inclusion a reformed definition of who is in need of care is missing in the reform. Therefore, asymmetries in the eligibility criteria are imposed. According to Klie (2008) the major reason for the delay in providing a general definition of "being in need of care" is that especially restraints from psychic diseases are difficult to integrate into a notion that is by now largely orientated towards somatic concepts.

Third, in order to improve the quality and sustainability of home care, so-called care stations (*Pflegestützpunkte*) are established that provide an intensified counseling for the benefit claimants and their carers. In addition, regular quality controls will be conducted at least annually starting in 2011. However, Igl and Naegele (2008) criticize these innovations as being too much concentrated on infrastructure. In addition, in their opinion federal institutions take

over a too large part of organization of care, a responsibility essentially originated at the federal states and municipalities.

Fourth, relatives of persons in need of care are entitled to a leave scheme that guarantees continued social insurance, and incentives for voluntary commitment should be raised. The implemented leave scheme and contributions to social insurances can provide appropriate measures, but it remains an open question whether it will prove effective to reach the intended goal.

Moreover, it is now possible for groups of people in need of care to pool benefits and to use saved expenses for supplementary services. Further measures adopted in the new law comprise a reduction of the processing time for applications, an improvement in the cooperation between institutional care providers and medical assistance, and an increase in the number of certified professional carers. Finally, incentives to apply for prevention measures are expanded.

6 Summary

This paper has provided an overview of the German SLTCI system. In the current state, Germany provides a universal, non means-tested contribution-financed social insurance for long-term care. This insurance should partially cover the care needs of the benefit claimants. Similar to the other social insurances in Germany, it is organized as a pay-as-you-go system. The benefit scheme allows for some flexibility in the provision of services due to recognition of different levels of care dependency and different types of benefits available including cash allowances on the one hand and support for institutional care on the other hand. In the current situation, most claimants apply for cash allowances that should enable to maintain home care arrangements with the help of informal carers.

The ageing of society will increase the number of persons in care dependency and will reduce the number of potential informal carers. Both developments challenge the sustainability of German SLTCI. Therefore, a number of reform options have been suggested by several authors. Some of these reform options suggest to only slightly adjusting the status quo system to take account of the changed demands, whereas other proposals postulate a radical reform of abolishing the pay-as-you-go system in favor of a system with funding principle. Despite the availability of options and the concerns about the status quo, the German legislator introduced a first reform of the SLTCI system in 2008. Although remarkable innovations were adopted, like the nominal adjustment of benefits to maintain constant real values, the reform has to be

criticized as being non-sustainable already in the medium-run. Therefore, further reforms will be necessary in the near future.

Notes

[1]See §1, subparagraph 1.

[2]Countries that have opted for direct service provision on a tax basis often also have their health care system financed by taxes (thus, institutional resources play a crucial role for the choice). According to OECD (2005) countries with contribution financed long-term care provision are Germany, Japan, Luxembourg, the Netherlands, (partly) Switzerland (differs across cantons), and partly in the United Stated of America. Tax based systems are implemented in Scandinavia, but also in Australia, Austria, Canada, New Zealand, UK, and also partly in the USA.

[3]See Götting, Haug, and Hinrichs (1994) and Meyer (1996) for an extended discussion with regard to the arguments and timeline of the debate of the different parties and interest groups involved.

[4]Some minor exceptions should be noted. Unemployment insurance contributions consist of employer's and employee's contributions and a third item, contributions for the promotion of job creation. Those are not shared on a basis of parity in all cases.

[5]SLTCI funds are public cooperations. Some of the larger insurers like the public community insurances (AOK, *Allgemeine Ortskrankenkassen*) or the company health insurances (BKK, *Betriebskrankenkassen*) are organized on the level of federal states.

[6] See Social Security Code XI § 9 (SGB XI, *Sozialgesetzbuch XI*).

[7]This adjustment became necessary due to a judgement of the Federal Constitutional Court in April 2001 and was enclosed in the so-called "children consideration law" (*Kinderberücksichtigungsgesetz*).

[8]Herzog Kommission (2003) notes that renouncement of a paid public holiday is equal to 0.5 contribution rate points.

[9]Employees from Saxony put forward an institutional complaint that their additional contribution overcompensates an extra holiday. However, The Federal Constitutional Court decided that a calculated "compensation gap" of €40 (for average salary) was bearable and was not an obstacle to the principle of non-discrimination.

[10]The surplus in 2006 was due to the shift of contribution payments to the end of a month. SLTCI funds took 13 payments in 2006 instead of 12.

[11]See SGB XI §14a.

[12]The maximum grants are €133.73 (113.30) for care level I, €267.46 (226.59) for care level II and €401.18 (339.89) for care level III. Values in brackets apply to East Germany.

[13]Maximum grants for unemployment insurance are €7.06 (5.98) (term in brackets applies to East Germany), €130.20 for health insurance and €16.38 for SLTCI.

[14]Before the reform there was also the possibility to obtain some benefits (maximum €460 per year) but there was no clear-cut definition of eligible persons.

[15]Quality assessment was introduced with the reform in 2008. Until 2010 one examination has to take place for every service provider and from 2011 on regular examination starts.

[16]The sample is not representative as only those who were able to answer the questions are subject to the survey. However, the study provides at least a qualitative hint that this hazard might exist.

[17]Similar results are obtained by other studies for Germany. For example, with regard to the *Freiburger Pflegestudie* Klie (1998) mentions that 87 % of all help is provided through informal care.

[18]The Ministry of Health has commissioned research for a new definition of being in need of care and suggestions for new ways how to implement a more holistic care.

[19]Figures are taken from the Federal Bureau of Statistics (2008). Unqualified employees comprise those who have not started an apprenticeship training or do not possess a university degree.

[20]Medical progress has restricted mortality more than morbidity. People get older but often are of poor health in their last years, see Kronberger Kreis (2005).

[21]For the reform of health insurance rental incomes should also be considered for deductions.

[22]Further details on the major changes are provided by Federal Ministery of Health (2008).

[23]The federal government will examine the need for adjustment of care benefits for the first time in 2014.

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