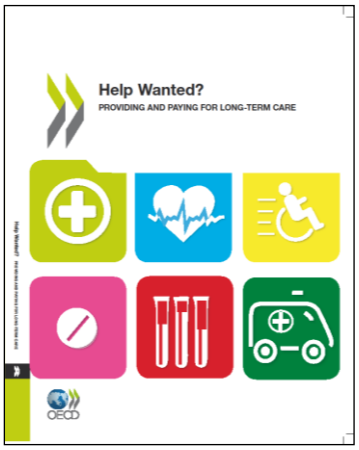
Germany

Long-term Care

18 May 2011

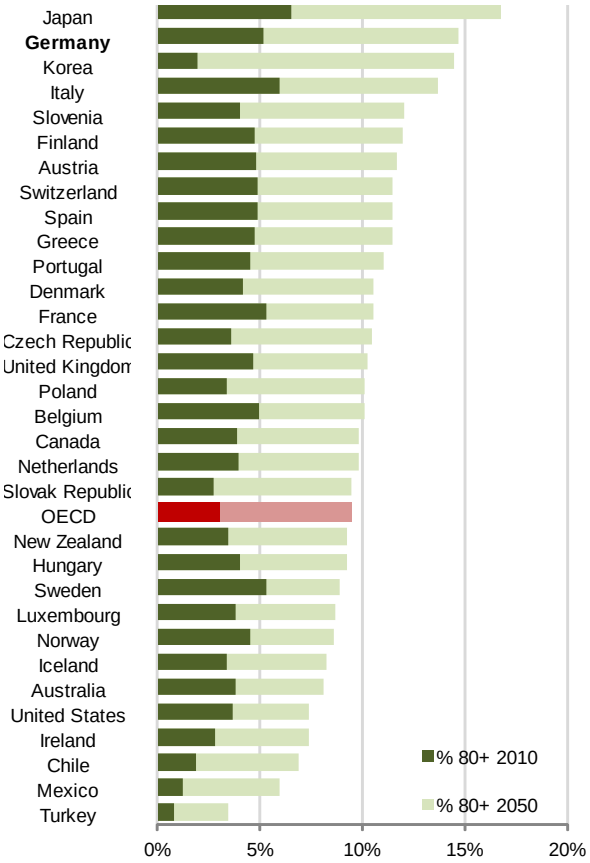
Highlights from *Help Wanted? Providing and Paying for Long-Term Care*, OECD Publishing, 2011.



- Germany spent 1.3% of its GDP on Long-Term Nursing Care in 2008. This share is expected to at least double by 2050.

- Similarly, the demand for long-term care (LTC) workers is set to significantly increase. For Germany, meeting the expected demand for LTC services by increasing the supply of workers may be more challenging than for some other OECD countries, because it will take place in the context of population ageing and a shrinking labour force.

By 2050, Germany will have the second highest share of over 80 years old in the OECD



- Germany provides examples of good practices to attract and retain workers in the long-term care sector. Those include: i) initiatives to recruit from specific target groups (young people, male, those re-entering the labour market); and ii) measures to improve job status in long-term care by developing national curricula for the training of carers and creating new job categories.

- Germany, like Japan, Korea, the Netherlands and Luxembourg, provides universal coverage for long-term care through a dedicated social-insurance system financed through a separate funding channel; participation is mandatory for all persons covered by the public health insurance scheme. But as it is possible to opt out of public health insurance when income exceeds the contribution threshold, the capacity of the public health and LTC insurance system to pool funds and risks is limited.

- The adjustment since 2008 in the level of LTC benefits in the German social LTC insurance will help users afford the cost of care but expenditure will increase more rapidly in the future.

- The cash-benefit option for recipients living at home will continue to help control future cost pressures and support family carers, potentially reducing demand for more expensive forms of care. As in the Netherlands, the value of the cash benefits is lower than equivalent services in-kind.

- Introducing pre-funding in LTC insurance is a way to better ensure sustainable financing in social LTC care insurance systems and take into account intergenerational equity. This would represent a noteworthy, forward-looking innovation within the OECD. If Germany moves in this direction, considerations should however be given to introducing partial pre-funding instead of moving to a fully-funded LTC insurance system, given the uncertainty surrounding the future LTC liabilities in the long term.

OECD (2011), *Help Wanted? Providing and Paying for Long-Term Care*, Paris,
www.oecd.org/health/longtermcare and www.oecd.org/health/longtermcare/helpwanted

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Key Facts

- Approximately 20% of the German population is aged over 65 years (OECD average 15%) with 5% of the population over 80 (OECD average 4%).
- Germany spent 1.3% GDP on long-term nursing care in 2008, of which 0.9% was publicly funded.
- In 2006, approximately 7% of Germany's population over the age of 65 years received LTC at home and 3.7% received care in an institution.
- There were 3.6 long-term care workers per 1000 population over the age 65 in Germany in 2007.
- In 2007, there were 48 long-term care beds per 1000 population over the age of 65 in Germany (OECD Health Data, 2010)

Background

Prior to the Long-Term Care act (1994), the public long-term care (LTC) system in Germany was characterised by substantial co-payments for services, which were mainly part of the welfare system or the health insurance coverage. With the introduction of an independent, statutory LTC insurance scheme in the same year, Germany expanded universal coverage for the risk of needing LTC and further developed benefit provisions.

Benefits and Eligibility Criteria

Since 2008, eligibility for public LTC benefits has been based on a qualifying period of at least 2 years of LTCI contribution within the decade prior to application (before 2008 it was 5 years). In addition, medical and long-term care assessments[1] undertaken by the Medical Review Board (Medizinischer Dienst der Krankenversicherung - MDK), chiefly skilled care staff and doctors, are necessary for the carrier of the LTCI (the long-term care funds) to provide evidence of a long-term care requirement and the degree of severity/dependency. They are an important prerequisite for the approval of the applicant's needs.

There is a binding choice for the beneficiary between cash, in-kind, or a combination of cash and in-kind benefits every six months, if there is no change in the individual situation to be met. Furthermore these benefits are differentiated according to three dependency levels legally fixed in amount and the setting in which care is received. About 67% of LTC beneficiaries are aged 65 and over (OECD Health Data 2010). 8% of LTC recipients use cash benefits and benefits in-kind, 17% use only benefits in-kind, and 30% institutional care. While previously, adjustments to benefits were at the discretion of the federal government, the 2008 Act ensures that benefits will be adjusted periodically to compensate for fluctuations in purchasing power.

Statutory long-term care scheme covers the social and private long-term care insurances, and both are designed as compulsory insurances. This means that almost the entire population is insured against the risk of needing long-term care in accordance with the principle "Long-term care insurance follows health insurance". Social long-term care protection is therefore provided to everybody who is insured in the statutory health insurance scheme. Members of private compulsory long-term care insurance schemes are people who have their health insurance with a private health insurance company or via special systems. The benefits are fixed by statute and are identical in both systems. Long-term care insurance benefits are not a "core protection", i.e. they represent basic provision, which may however not always cover requirements in individual cases. When LTC insurance benefits do not suffice, social assistance will supplement in a means-tested fashion and there is also family obligation to help pay for home or institutional care.

Against this background, all citizens are free to purchase supplementary private LTC coverage. As of 2009, over 1.58 million people own additional private insurance(s) such as Pflegerentenversicherung (a kind of life insurance), Pflegekostenversicherung (insurance that pays remaining LTC costs) and Pflegetagegeldversicherung (insurance that pays a set additional amount for LTC regardless of real costs).

[1] The range described within the act from 1.5 hours (level 1) to 5 hours (level 3) of help of a non-professional caregiver per day in the area of given ADL and IADLs is only a "benchmark" for the assessment procedure of the MDK, but not for the delivery of services itself.

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Social LTC insurance provides in-kind benefits such as home and institutional care services: nursing home and outpatient services, so-called low-threshold support offers by volunteers supervised by professionals or care at home, and cash benefits.
Home based care benefits are set at a national level by law and the value of in-kind benefits are about double that of cash benefits.

Cash benefits also correspond to 3 care levels and amount to EUR 225 (level 1,), EUR 430 (level 2) and EUR 685 (level 3) per month as of 2010. In 2010, benefits in-kind were a maximum of EUR 440 (level 1), EUR 1 040 (level2) and EUR 1 510 (level 3) per month. For auxiliary care products that assist the elderly in independent living, a supplement with a maximum of 2 557 Euros annually is available, subject to copayments.

In 2010, monthly social LTCI benefits for institutional care have the monetary value of EUR 1 023 (level 1) to EUR 1 510 (level 3). For individuals who need the highest level of care (level 3) in home or institutional care EUR 1 918 Euros per month are available up to 3% to 5% of all people in that level of care. The residual costs (e.g. co-payments, fees for board & lodging, investment costs) differ across the 16 Länder.and even between the service providers themselves. The average expected co-payment for formal care, regardless of care setting, is EUR 350 per month (Augurzky et al., 2008; Rothgang, 2010).

Additional day and night care which covers transportation costs between a care institution is available according to the dependency level of the care recipient. In 2010, allowances were a maximum of EUR 440 (level 1), EUR 1 041 (level 2) and EUR 1 510 (level 3) per month.

There are supplementary monetary grants for people in special circumstances; particularly individuals who suffer from mental diseases or dementia are given an additional EUR 1 200 or EUR 2 400 per year, depending on severity.

Benefits for Caregivers

Informal family carers are eligible for a maximum of four weeks vacation during which the LTCI will cover expenses and arrange for the provision of care to the recipient to a maximum of EUR 1 510. Subject to certain business requirements, employees may take a 10 days leave or a maximum of half a year unpaid leave from work to organise or provide LTC for a family member under the Nursing Care Time Act (generally social security payments will be covered by LTCI).

Informal caregivers are also given options for free educational and training courses. Informal carers who work for less than 30 hours a week and provide care for at least 14 hours a week are paid pensions by the LTC insurance programme and they are covered by accident insurance.

Furthermore some measures in favour of caregiving relatives have been introduced, including an increased care allowance for people with dementia, which was introduced in 2008, and can be used to provide a short-term release of carers by recognized providers or low-threshold offers, the introduction of an official *Pflegestufe Null* a payment, and measures to reduce the tax-(and social insurance) burden of hiring legally allowed providers.

Funding and Coverage

LTC insurance is a social insurance representing a pay-as-you-go system and is almost entirely financed by contributions and premiums. Contributions are income-dependent and shared equally between the employee (50%) and the employer (50%)[2]; since 1st January 2005 childless members pay an additional contribution of 0.25%. Pensioners must contribute the amounts themselves while the contributions from the unemployed are covered by the Unemployment Insurance. After the 2008 Act, standard contribution rates for the first 44 550 Euros of annual income are 1.95 % and 2.2 percent for childless contributors.

Because SHI holders are automatically enrolled into the LTCI programme and it is mandatory for private insurance holders to purchase LTC insurance, coverage is consequently universal. Public spending

[2] With the exception of pensioners.

makes up more than 50% of total LTC expenditure but out-of-pocket payments remain a significant 31% of expenditure and is especially prevalent in nursing home care (Rothgang et al., 2008).

Delivery

Institutions

LTC is managed by a number of LTCI funds in an environment where inter alia charges/remunerations for services are negotiated in advance between the "costbearers" and the service providers and not by governmental departments. Formal care services are almost entirely (97%) provided by private for profit and not-for-profit providers who have been contracted by LTCI funds. Similarly, semi-residential home providers are overwhelmingly private, with non-profit originations representing over half of all such homes.

Long-term care in kind is only provided by those who are licensed and contracted by LTC insurers and as such provides a guarantee of certain contents of overarching quality standards in care. Currently, with the introduction of the Arbitration board (Schiedsstelle) for issues with quality, home care providers as well as residential nursing homes will be inspected annually according to the agreed quality and transparency requirements. Results will be published starting from 2011.

Workforce

Since 2003 the *Altenpflegegesetz* has centralized the requirements for education of specialized staff on federal level, replacing pre-existing requirements at Länder level and adjusted the framework on vocational training with the one of other health professions, mainly nurses. Furthermore, as of July 2010 a minimum wage floor has been implemented for caregiving workers in LTC facilities.

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