

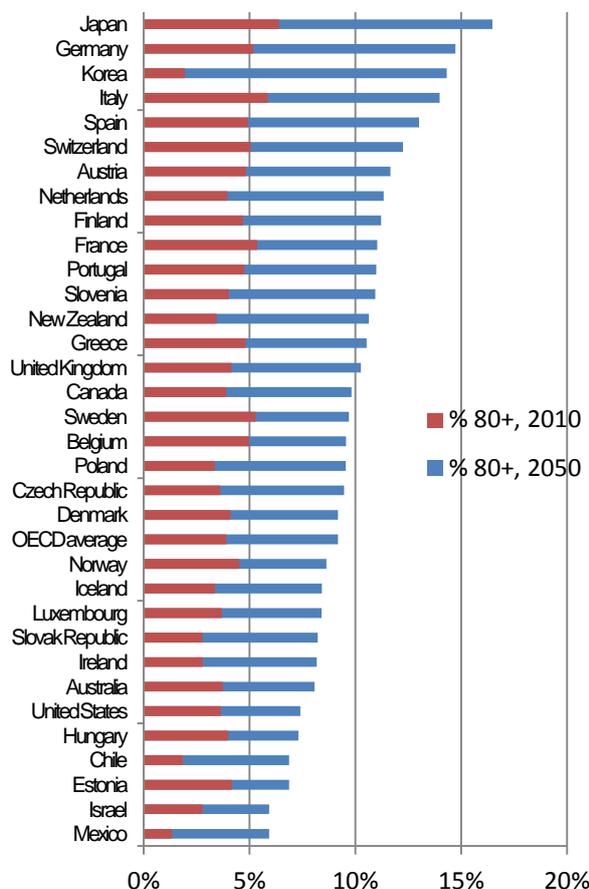
## Germany

### Highlights from

### *A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care, OECD Publishing, 2013.*

- In 2010, 21% of the German population was over the age of 65 and 5% of the population was over the age of 80. By 2050, 33% of the German population will be over the age of 65 and 15% of the population will be over the age of 80.
- Germany spent 1% of its GDP on long-term care in 2010. This share is expected to at least double by 2050.

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



Source: OECD Health Data 2012

- Germany collects indicators related to clinical effectiveness, satisfaction and experience of long-term care services. There is also a national data collection on waiting times for LTC. However, clinical indicators focus mostly on process of care rather than quality outcomes.
- Authorisation to practise for nursing homes is based on structural standards (e.g., personnel and finances), but also standards on whether quality management systems are used. Audits have to be carried out each year without prior notice; yet, stringent enforcement against poor quality providers is rarely taken.
- Quality management system for nursing homes – which set management standards for organisations – are compulsory in Germany, similar to what happens in Austria, Italy, Luxembourg and Slovenia. There is evidence that their use is leading to improvements such as communications and transparency.
- Germany publishes reports on performance of LTC providers to stimulate competition among providers and improve transparency. Similar quality grading systems in the United States and Korea. This system offers LTC recipients the possibility of making choices, but it is unclear whether the quality indicators cover the issues that are most important to LTC recipients.
- Germany is one of the few OECD countries that has accreditation for both nursing home and home care providers. However, standards for home care are not as strict.

---

## Germany

### Key facts

- In 2010, 21% of the German population was over the age of 65 (OECD average 15% in 2010) and 5% of the population was over the age of 80 (OECD average 4% in 2010). In 2050, 33% of the German population will be over the age of 65 and 15% of the population will be over the age of 80 (OECD Historical Population Data and Projections Database, 2013).
- Germany spends 1% of public expenditure as share of GDP on LTC in 2010 (OECD average 1.6%) (OECD Health Data 2012).
- In 2010, 3.8% of the population over the age of 65 received long-term care in institutions (4% OECD average) while a 7.6% of this population received care at home (OECD average 7.9%) (OECD Health Data 2012).
- Germany has 26 LTC workers in institutions per 1000 people aged 65 years old and over, and 12 LTC workers working in home care settings in 2009. In 2011, 26% of the LTC workers are nurses and 74% of LTC workers are personal care workers (OECD Health Data 2012). This places Germany in the bottom third of OECD countries with availability of LTC workers.

### Background

With the *Long-Term Care Act* of 1994, Germany established a statutory LTC insurance scheme specifying benefits and coverage for all those in need of LTC; national rules for quality assurance in institutional care and home-care services were also set up. Eligibility for public LTC benefits requires a qualifying period of at least 2 years of contribution to the Long Term Care Insurance within the decade prior to application (before 2008, this was set at 5 years).

The statutory LTC scheme covers social and private long-term care insurances (the latter for higher-income people), both of which are compulsory insurances. Social long-term care protection is provided to everybody who is insured in the statutory health insurance scheme. Members of private compulsory long-term care insurance scheme are people who have their health insurance with a private health insurance company or via special systems for particular group of workers. 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 not always cover all requirements in individual cases.

### Quality assurance

Responsibilities for quality assurance have been traditionally assigned to provider bodies, such as the medical advisory service of the Federal Association of Health Insurance Funds (Medizinische Dienste der Krankenversicherung) and its operative units on the regional level. The medical advisory board is a central body responsible for needs assessment and quality assurance in LTC, with its role extending to reporting and publishing audit results. Provisional contracts’ between the Federation of providers and regional branches of the LTC insurance give authorisation to the provider on the basis of a number of structural prerequisites, such as content of services, financial stipulations and personnel levels. These contracts spell out accreditation criteria. Although audits by the medical advisory boards of sickness funds are co-ordinated at federal level, each German Lander is responsible for nursing homes’ surveillance and for monitoring compliance. Self-regulation plays an important role due to its obligation to each contact.

### *Accreditation and certification of workforce*

---

## Germany

Germany is one of the few OECD countries that has accreditation for both nursing home and home care providers. The accreditation requires that the provider of institutional or home-based care services commits to quality management system (such as ISO or E-Qulin), use minimum quality standards and ensure that the nursing personnel has the required qualifications. Minimum standards have to be continually updated and are expected to define what is generally recognised as the current state of the art in terms of medical and nursing care. Nurse can complete an additional course to qualify him/her for a managerial position. LTCI funds have to offer training courses on care for family carers and voluntary carers.

The associations of the LTC insurance funds tasks the Medical Advisory Boards with *auditing* residential and non-residential long-term care facilities under contract. The Medical Advisory Boards check compliance with federal provisions. In addition, the supervisory authorities of the Land monitor compliance with the Land regulations governing residential accommodation and perform *inspections*.

The audit is carried out by a team usually comprised of a qualified community worker, a registered nurse and an administration employee. These teams are sometimes accompanied by physicians. The audits involve observation of the facilities and interviews with residents, relatives and staff. In residential and semi-residential care, standard audits look at the quality of general care services, social care and services related to accommodation and meals. In non-residential care, standard audits look at the quality of basic nursing, home-making services, and home nursing services. In addition, a review of the care documentation also feeds into the evaluation. The Medical Advisory Boards' audit team holds a meeting to discuss shortcomings and advise the long-term care facilities on how to improve quality.

The facilities are overseen and inspected by the Local Residential Homes Authorities (Heimaufsicht), a government agency. The inspections are carried out without prior notice. The inspections must be carried out each year, unless the Medical Advisory Boards have inspected the institutions. Close collaboration between the Residential Homes Authorities, the Medical Advisory Boards and local authorities is required to prevent nursing homes from being inspected twice. They include inspections of the rooms, living areas, documentation on relevant activities, and personal visits among the residents to verify their care status. If nursing home providers fail inspections, the Medical Advisory Board can cut payments or exclude care-homes providers entirely. Closure of nursing homes is rarely imposed as in the case of other OECD countries.

Assessors follow quality assurance guidelines (QPR) issued by the Central Federal Association of health insurance funds. Quality dimensions range from structural issues and satisfaction of recipients, to safeguarding resident rights, and accountability. The list of items covered in inspections varies across care settings and countries. The underlying guidelines are regularly adapted to the latest innovations in medical and nursing care to reflect the most recent scientific findings related to appropriate patient care.

According to a 2010 survey of care providers in Germany, only one in four nursing homes and one in three home care service providers were satisfied with the paper work, lack of focus on outcomes and arbitrariness of the audit carried out by the Medical Advisory Boards. This led to plans to change the audit process and the underlying guidelines (Schulz, 2012).

### Measuring Quality in LTC

#### *Quality indicators*

The quality related indicators used in audits are related to the following dimensions of care: personalised procedural and quality outcomes (nursing care, mobility, nutrition and fluid intake, incontinence, dementia, body hygiene), patient satisfaction, and structural and procedural quality (design of patients' rooms and

---

## Germany

community rooms', movement within institutions, operational structure, quality management, hygiene, food, social care).

Results from user satisfaction surveys showed improvement in aspects such as communications and responsiveness (the last report was published in 2007). For example, the proportion of institutions with a development plan increased from 84.1% in 2007 to 93.6% in 2010, while 96.8% of outpatient services could ensure continuity of staff. However, the 2012 report also showed that only 59.3% of residents in nursing home at risk of pressure ulcers received the necessary measures (such as rolling), with no improvement since 2007. Also, 36.5% of beneficiaries receiving home care services was at risk of pressure ulcers but only 40.5% of them received advice from care services and only 18.2% providers agreed to provide measure to prevent pressure ulcers. Pain management also shows no improvement since 2007 (MDS, 2012). Germany's transparency report has led to some criticism that the results were too positively portrayed and over-rated. Providers often complain that quality assessment and ranking pay more attention to documentation than evaluation of the care provided and the outcomes of care (Schulz, 2012).

### **Regulation and Control over inputs**

#### *Needs assessment and care planning*

The staff members of the care funds analyse the need of care on the basis of a the Medical Advisory Boards guidelines and then set up a plan. The assessment of the need of long-term care has to be repeated regularly. The assessor has to needs to evaluate whether reasonable curative, care or rehabilitation measures have been provided, as well as the usage of aids and care-aids. Assessment results are taken into consideration to determine the level of care needed (that ranges from level I to level IV).

### **Monitoring and standardisation of processes**

#### *Public reporting of outcomes and performance*

An obligation to disclose audit results [section 115 (1a) SGB XI] was introduced in 2008 (European Peer Review, 2009). The results of the audits have to be published in a manner that is easily understandable and consumer friendly. Nursing homes are required to post the latest audit results in a highly visible location. These public reports use an easily understandable assessment system according to school grades, e.g. from "very good" to "poor", so that the public can recognise "at a glance" whether a facility provides good quality care. Reports are available at individual provider level.

In addition, providers are obliged to meet transparency agreements and report information for publication in transparency reports. The first transparency report was published in 2009. The preparation of the audit reports and the publication of the transparency reports are two separate procedures. Transparency reports include not only inspections of the rooms, living areas and documentation on relevant activities, but also personal visits among the residents. Recommendations for improving quality are provided (European Review, 2009; Schulz, 2012).

Germany has completed three LTC user satisfaction surveys, covering both home care and institutional settings. The third report, published in 2012 shows an increase in the level of satisfaction from 67% in 2007 to 76%; though, some indicators shown constant results.

### **System improvement through incentives**

#### *Choice*

---

## Germany

Germany offers LTC recipients the possibility to choose between cash benefits and personal budgets and in-kind services. Together with the notice of approval the care funds provide a list with a comparison of services and prices of the facilities in the area. Care advisers are staff members of the care funds, who analyse the need for care on the basis of a MDK-report, set up a plan for the provision of social benefits and rehabilitation, preventive, curative or other medical, and care based social assistance.

There is a binding choice for the beneficiary between cash, in-kind, or a combination of cash and in-kind benefits every six months. Furthermore these benefits are differentiated according to the disability levels and the setting in which care is received.

### *Integration and co-ordination policies*

Counselling for persons in need of care and their relatives is provided by case managers, the majority of whom are qualified nurses.

### *Preventing and Identifying Elder Abuse*

Germany has a specific legislation to safeguard the rights of LTC users, as charters or bills of rights in Alberta and Ontario, Canada, Norway, US states and federal government), which elucidates role and responsibilities of individuals and organisations for addressing cases of abuses.

## References

OECD Questionnaire on Long-term Care Quality, 2012.

OECD Health Data 2012.

OECD Historical Population Data and Projections Database, 2013.

MDS and GKV-Spitzenverband (2012) *Pressekonferenz am 24. April 2012. Ausgewählte Ergebnisse des 3. Pflege-. Qualitätsberichts.*

Leichsenring, K. (2010), “Achieving Quality Long-term Care in Residential Facilities, Synthesis Report”, Peer review in Social Protection and Social Inclusion 2010, *European Centre for Social Welfare Policy and Research*, 18-19 October, Murnau/Bavaria

Schulz, E. (2012), “Quality Assurance Policies and Indicators for Long-Term Care in the European Union Country Report: Germany”, *ENEPRI Research Report No. 104, Work Package 5*, February.

## Contacts

Francesca Colombo: + 33 1 45 24 93 60, [francesca.colombo@oecd.org](mailto:francesca.colombo@oecd.org)

Yuki Murakami: + 33 1 45 24 98 23, [yuki.murakami@oecd.org](mailto:yuki.murakami@oecd.org)

<http://www.oecd.org/health/health-systems/good-life-in-old-age.htm>