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Non-technical summary

Regarding social needs in Germany long-term care is an important issue due to an ageing population. Shrinking social networks are leading to a greater need for a public long-term care system. In 1995 the social long-term care insurance was introduced in Germany which is similar in nature to the other social insurances, such as the health care or pension insurance. Long-term care insurance funds are generally linked to health insurance funds. The benefits are financed by virtue of an income-based system where all employees covered by the social security system and their employers have to pay equal contributions on a pay-as-you-go basis.

In case of long-term care needs a frail person is assigned to one of three care levels according to his/her severity of need. Benefit recipients living in private households can choose between three kinds of transfers: in-kind transfers, lump-sum transfers and combined transfers whereas the amount of in-kind transfers is higher than the lump-sum transfers in all care levels. Benefit recipients living in nursing homes receive the highest amount of transfers.

In recent years some drawbacks of the social long-term care insurance structure turned out to be in need of reform: While health insurance is a fully comprehensive system, long-term care insurance only provides limited cover. Therefore, insurance funds have an incentive to shift some services from health care to long-term care insurance. For instance, there is a low incentive to provide rehabilitation measures in order to lower the care level. Additionally, there is no free competition on the long-term care market because care packages included in the in-kind transfers are negotiated (with respect to services and prices) between insurance funds and professional care providers. Finally, the financial situation of the German social long-term care insurance is tight. While in the first years after introduction the net results of revenues and expenditures were positive they have been negative since 1999 which is due to an increasing number of benefit recipients.

Therefore, we discuss several reform options which have been proposed in order to overcome the financial and structural problems. Suggestions for the income side include the introduction of fixed premiums, a fully funded system, a private insurance, or a citizens' insurance. The main problem here is to finance the transition from one system to another system. Some proposals are discussed here. The introduction of individual budgets is the most popular option for the outcome side. A social experiment is under way in order to evaluate the impact of so-called matching transfers.

The German Social Long-Term Care Insurance – Structure and Reform Options

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Content

1 Introduction

In recent years there has been a growing output of literature on long-term care - not only in the economic sciences, but also in the fields of sociology, psychology and medicine. Although all developed countries face similar issues relating to long-term care, most of the literature in Germany has been restricted to a single-country discussion. However, in order to reflect on a long-term care system and to implement reforms in the existing system it is very helpful to examine experiences in other countries. The need for information about country-specific systems and current developments became apparent at an international conference on long-term care held at ZEW in October 2005. Although several international comparisons of the way in which long-term care is financed and organized in European or OECD countries (Holdenrieder 2003, OECD 1996, OECD 2005) are available, we are not aware of any papers written in English which deal in detail with current developments and reform options for the long-term care system in Germany. It is our intention that this paper should fill this gap.

Why is there so much interest in long-term care (LTC) in developed countries? The answer to this question is that low birth rates, restrictive immigration quotas and increased life expectancy are all causing the population to age. With a current fertility rate (Fertilitätsrate) of about 1.4 (which is predicted to be constant) and a decreasing immigration quota (Immigrationsquote) the German population will shrink consistently in the decades ahead. The population statistics of the Federal Statistical Office (Statistisches Bundesamt) also predict that the life expectancy of 60-year-old men (women) will increase from 19.2 (23.5) in 2000 to at least 22.0 (27.7) in 2050.[1] In 2040 the so-called baby boomer generation (cohorts born in the early 1960s, when birth rates were extremely high in Germany) will be about 80 years. As a result the fraction of the population composed of people aged 60 plus (24.1 per cent in 2001) will increase to 36.7 per cent in 2050. The share of people aged 80 and older (3.9 per cent in 2001) will increase to 12.1 per cent (Statistisches Bundesamt 2003). Furthermore, the risk of needing care increases dramatically for the over-80s - rising from 3.9 per cent in the 60 to 80 age group to 31.8 per cent in the 80 plus group (Bundesministerium für Gesundheit 2006a). The number of frail elderly is therefore expected to rise enormously.

There will also be greater need for professional long-term care in the future as lower birth rates mean there will be fewer people available to care for their frail elderly parents, social networks will be eroded and more women will be in gainful employment. At present around 80 per cent of all frail elderly people are looked after by at least one family member (so-called

[1] We show the life expectancy calculated by variant 1 which is the most conservative estimate of three different variants.

informal care providers (informell Pflegende)). Moreover, in 55 per cent of all households with a frail elderly person informal care is the only form of care available (Schneekloth and Leven 2003). Obviously, a decreasing supply of informal care (Pflege durch Angehörige) will have to be substituted by care providers (Pflegedienste) which will entail a substantial increase in costs. Depending on the type of long-term care system this will have to be paid for by higher contributions to an LTC insurance scheme, higher taxes, or higher out-of-pocket payments (Zuzahlungen der Versicherten). How to finance rising costs and how to guarantee LTC services of acceptable quality are the main issues being addressed in the German discussion on long-term care.

Chapter 2 describes the German social long-term care insurance system (soziale Pflegeversicherung). Chapter 3 gives an overview of public assistance. Apart from health insurance this was the only benefit available to frail elderly people who were unable to afford long-term care services on their own prior to the introduction of long term care social insurance. Chapter 4 discusses several reform options and Chapter 5 concludes.

2 German social long-term care insurance

A long-term care insurance scheme, similar in nature to other social insurance systems in Germany (pension, employment and health insurance), was introduced by the German Parliament in 1994.[2] All employees earning less than the social security earnings ceiling (Pflichtversicherungsgrenze) for the German social insurance system (3,937.50 euros per month in 2006) are members of this system. Contributions are paid equally by employers and employees and are calculated from gross income up to a social security contribution ceiling (Beitragsbemessungsgrenze) which is fixed every year. Employees who are not covered by the social insurance system (i.e. civil-servants, self-employed etc.) are usually members of a private health and pension insurance.

All members of the social health insurance scheme are automatically covered by social long-term care insurance. The responsible long-term care insurance funds (Pflegekassen) are affiliated to the corresponding health insurance funds (Krankenkassen). Employees who are not covered by social LTC insurance are permitted to contract with a private long-term care insurance institution as long as they are members of a private health insurance scheme. Around 90 per cent of the German population is consequently covered by the social LTC insurance scheme and around 9 per cent have private LTC insurance cover.

[2] There is also an industrial accident insurance for which contributions have to be paid by the employer for all employees regardless of their gross income.

2.1 Institutions

The *federal states* are responsible for ensuring that an efficient and cost-effective long-term care infrastructure is provided, for guaranteeing that the scale of services on offer is adequate, and for the quality and efficiency of LTC institutions. It is the task of the authorities (the Federal Government, governments of the states, local authorities) to avoid disparities in support and to ensure a regular supply of long-term care in every region in Germany. This includes assuming the investment costs of all local, state-owned, and non-profit-making care institutions and private maintenance.

The remit of the *long-term care insurance funds* is to ensure the supply of permanent care for their insured and to eliminate shortcomings in quality. They consequently control the quality of the care supplied. Nevertheless, their ability to ensure the supply of care is limited by the fact that they have no appropriate influence on the creation, promotion or maintenance of an LTC infrastructure. This task is assigned to the states. Furthermore, the LTC transfers are paid by the insurance funds. Together with the Medical Review Board of the Statutory Health Insurance Funds (Medizinische Dienste der Krankenkassen MDK) they assign the appropriate level of care assistance to the person in need, and bargain for the price of the care assistance with care providers. They also offer LTC courses to voluntary care-giving staff to make home care easier and more efficient. LTC insurance funds are thus responsible for guaranteeing nursing quality on the one hand, and paying and bargaining for the costs on the other. The combination of these functions (increasing the quality of nursing vs. decreasing costs) may be a source of conflicts.

Long-term care providers are supported either locally, by the federal states, or by non-profit or private organisations. A supply contract (Versorgungsvertrag) is concluded between these institutions and the insurance funds. This contract is essential for ongoing home care or nursing home care in that it qualifies this form of support for the recognised LTC market. The supply contract regulates the type, contents, and extent of the general nursing benefits which a care institution must provide. It also defines the so-called care package (Leistungskomplexe). Nursing institutions must guarantee humane, dignified, and stimulating care, and must respect human rights. Frail elderly people must be nursed, looked after, and comforted; terminal care (Sterbebegleitung) must also be provided where applicable. Qualifying nursing institutions must contribute to quality assurance procedures.

2.2 Financing

LTC insurance is similar to other German social insurance schemes in that it is financed by contributions based on gross income which are shared equally by employers and employees in

a pay-as-you-go system.[3] Children and non-employed married partners can be co-insured without paying extra contributions. The contributions are calculated as a share of gross income up to a contribution ceiling of 3,562,50 euros (in 2006). This means of course that people on higher incomes contribute more to the social insurance scheme in accordance with the solidarity principle. Between January 1, 1994, and April 1, 1995 the contribution rate was 1 per cent. During this time no transfers were paid through the LTC insurance. The contribution rate since April 1, 1995 has been 1.7 per cent.[4] Benefits for home care were granted from April 1, 1995 onwards, whereas those for nursing home care entered into effect on July 1, 1996. In line with a verdict of the Federal Constitutional Court (Bundesverfassungsgericht) from 2001, which stated that it was unconstitutional for long-term care insurance members with children to pay the same level of contributions as childless members, the federal government drafted a "children-consideration law" (Kinderberücksichtigungsgesetz) which increased the contribution rate for childless people aged 22 and older by 0.25 percentage points on January 1, 2005.

Table 1: Financial situation of the social long-term care insurance (in Billion euros)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Revenues	8.41	12.04	15.94	16.00	16.32	16.55	16.81	16.98	16.86	16.87	17.49
Expenditures	4.97	10.86	15.14	15.88	16.35	16.67	16.87	17.36	17.56	17.69	17.86
Net result	3.44	1.18	0.80	0.13	-0.03	-0.13	-0.06	-0.38	-0.69	-0.82	-0.36

Source: Bundesministerium für Gesundheit und Soziale Sicherung (2006b)

In the first few years following its introduction revenues exceeded expenditures and a considerable balance could consequently be built up. However, since 1999 the scheme has ceased to be fully funded and its reserves have been reduced from year to year (see Table 1). In the long run sustainable financial insurance cannot therefore be guaranteed. The costs of maintaining present standards of care would require an increase in the premium rate up to at least 3.2 per cent by 2040 (Häcker et al. 2004). Alternatively, the level of care will have to be lowered in order to adjust the imbalance between revenues and expenses.

There are about 250 long-term care insurance funds in Germany. While these funds are affiliated to the health insurance funds they differ as regards their financial structure in three main ways. Firstly, while health insurance is a fully comprehensive insurance system which

[3] Since April 1, 2004 pensioners have been required to pay the contributions entirely from their own pockets and no longer receive a contribution subsidy from the pension funds.

[4] The employer's contribution was financed by abolishing Germany's Penance Day public holiday, except in Saxony where the scheme is funded by employers and employees paying 1.35 per cent (0.675 per cent) instead of 0.85 per cent.

covers all necessary health services, LTC insurance only provides limited insurance cover. This means that services which could potentially fall within the remit of both insurance schemes tend to be shifted to the LTC insurance because this is much cheaper. Secondly, although the revenues and costs of all the German health funds are equalized to take account of their respective member structures (age, gender) (Strukturausgleich), this is not the case for the revenues and costs of the LTC funds. This leads to a high disincentive for the LTC funds to minimize their costs. Thirdly, the health insurance funds are in competition with each other as far as their contribution rates are concerned, i.e. they have an incentive to lower their expenditures for services and administration. With respect to a fixed contribution rate this is not the case for the LTC funds and thus there is no incentive to produce long-term care efficiently. All this leads to a shift from services which should be paid by the health insurance to the LTC insurance (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2006, 559ff).

2.3 Benefit Recipients

In order to claim benefits from the compulsory long-term care insurance scheme an insured person must be defined as "frail". The Social Security Code (SGB, Sozialgesetzbuch) XI defines a frail person as “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, grundlegende Aktivitäten des täglichen Lebens) and ‘Instrumental Activities of Daily Life’ (IADL, instrumentelle Aktivitäten des täglichen Lebens)[5] due to physical, mental or psychological illness or disability” (Holdenrieder 2003). Such a person is dependent on assistance with personal care, nutrition, mobility and housekeeping.

The verification of care needs is the responsibility of the long-term care insurance funds. The funds entrust the task of identifying, verifying and assessing the severity of care needs to the Medical Review Board of the Statutory Health Insurance Funds, which is primarily made up of doctors and nurses. The assessment takes place in the home of the insured person provided they give their consent. If such an assessment is not performed the insurance funds are entitled to refuse to pay benefits.

The Medical Review Boards examine the care needs on the basis of the following categories:
Body care (Körperpflege): washing, showering, bathing, dental care, combing (Kämmen), shaving, micturition (Blasenentleerung) and defecation (Darmentleerung)

[5] ADL refers to activities such as combing and dressing, whereas IADL comprises more complex procedures like preparing meals or banking transactions.

Nutrition (Ernährung): assistance with ingestion (Nahrungsaufnahme) and preparation of bite-sized meals

Mobility (Mobilität): getting up and going to bed, dressing and undressing, walking, standing and climbing stairs at home, assistance with leaving and entering the accommodation for the purpose of maintaining the person's lifestyle (e.g. for consultation)

Household help (hauswirtschaftliche Versorgung)): shopping, cooking, washing up, cleaning and changing of clothing as well as tidying up and heating the accommodation.

These guidelines, which only relate to physical impairment, take no account of the special needs of people with learning disabilities or people suffering from dementia (Demenz). After their care needs have been evaluated, the persons requiring care are assigned to one of the three care levels shown in Table 2. Table 3 shows the number of benefit recipients and their assignment to the different care levels. The figures clearly show that the share of frail elderly in nursing homes has increased continuously since 1996.

Table 2: Care levels and care needs

	Care level I - need for considerable care	Care level II - need for intensive care	Care level III - need for highly intensive care
Help with 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
Additional assistance	several times a week in taking care of the household	several times a week in taking care of the household	several times per week in taking care of the household
Nursing staff needs	at least 1.5 hours/day on the average	at least 3 hours/day on the average	at least 5 hours/day on the average

Table 3: Social long-term care insurance benefit recipients at the end of 1996, 2000 and 2005

		Care level I	Care level II	Care level III	Sum
1996	Home care	508,462	507,329	146,393	1,162,184
		(43.8)	(43.7)	(12.6)	(75.1)
	Nursing home care	111,856	162,818	109,888	384,562
		(29.1)	(42.3)	(28.6)	(28.9)
2000	Home care	681,658	448,406	130,696	1,260,760
		(54.1)	(35.6)	(10.4)	(69.2)
	Nursing home care	210,883	234,836	115,625	561,344
		(37.6)	(41.8)	(20.6)	(30.8)
2005	Home care	759,114	425,843	124,549	1,309,506
		(58.0)	(32.5)	(9.5)	(67.0)
	Nursing home care	251,730	262,528	128,189	642,477
		(39.2)	(40.9)	(19.9)	(33.0)

Note: Per cent in parentheses.

Source: Bundesministerium für Gesundheit und soziale Sicherung (2004), Bundesministerium für Gesundheit und soziale Sicherung (2006a).

Once a frail person is assigned to a care level, only the affected person, their relatives, the institution in which the person lives or the LTC insurance fund can ask for a new examination by the Medical Review Board. Benefit recipients are not examined on a regular basis but the Medical Review Board can recommend the next date for an examination to the insurance fund in the former report (Medizinischer Dienst, 2006). The Medical Review Board must also check the options for rehabilitation measures (Rehabilitationsmaßnahmen) available. Rehabilitation advice is not given to the person in need of care or their physician but to the insurance fund. Rehabilitation measures must be paid by the health insurance funds which are interested in shifting costs to the LTC insurance scheme (see above). This leads to a disincentive to finance rehabilitation measures and the fund therefore prefers to pay higher LTC transfers (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2003, 644; 2006, 573ff). This implies that persons could stay in a higher care level even if their condition improved. On the other hand, the frail person him/herself or his/her family will only apply for a new examination if they see a chance of being assigned to a higher care level. Summing up, there are high disincentives to assigning a frail person to a lower care level. There were only 530,000 repeated examinations in 2004 accounting for 27.5 per cent of all benefit recipients at the end of the year (Medizinischer Dienst 2006). The percentage of cases which are assigned to a higher, the same, or a lower level following repeated examination is shown in Table 4.

Table 4: Benefit recipients according to care level (in per cent) for 2004

	Home care			Nursing home care		
	Same level	Lower level	Higher level	Same level	Lower level	Higher level
Level I	46.0	8.2	45.8	29.2	2.2	68.6
Level II	54.8	11.1	34.1	43.5	4.3	52.3
Level III	82.2	17.8	-	75.0	25.0	-

Source: Medizinischer Dienst (2006).

2.4 Transfers

The kind of transfers granted depends on the severity of the frailty (care level) and the type of care arrangements chosen (by family members, care providers or in a nursing home). Persons requiring home care can thus either draw lump-sum transfers (Geldleistung), in-kind transfers (Sachleistung), or a combination of both. Only lump-sum transfers can be claimed for nursing home care. German legislation assigns priority to home care over nursing home care and the LTC insurance is expected to continue supporting patients being cared for at home for as long as possible. This means that the Medical Review Board must assess the need for a frail elderly person to live in a nursing home. If the Board believes such care is not necessary, the insured person only receives the benefits due for home care.

2.4.1 Transfers for home care

In-kind transfers

Home care is provided by professional staff (care providers) with whom the LTC insurance funds conclude a supply contract. It consists of assistance in the areas of basic care (personal hygiene, food, mobility) and household help. The scale of transfers depends on the level of need. People who need considerable care (care level I) receive 384 euros per month, those in need of intensive care (care level II) 921 euros, and people in need of highly intensive care (care level III) 1,432 euros per month (see also Table 5). In cases of hardship, i.e. if someone requires extraordinary intensive care which exceeds the assistance reserved for care level III, such as at the end-stage of cancer when regular assistance is required several times during the night, the insurance funds may allow further benefits of up to 1,918 euros per month. The person in need of care can request assistance according to his needs. For this reason, contracts are concluded with a care service. These differ from federal state to federal state and form a clear framework for the in-kind benefits. These packages contain a detailed list of the costs of

each service and are a means for discounting. As the contents of the package of services are mandatory, the assistance granted by the in-kind benefits is not very flexible.

Lump-sum transfers

Instead of in-kind transfers the frail elderly person can apply for lump-sum transfers, which in turn depend on the care level. People in care level I receive 205 euros, those in care level II 410 euros, and people in care level III 665 euros per month (see Table 4). The lump-sum transfers include gratuities for relatives and are not dedicated, i.e. they can be used for any type of purchase. For this reason, in order to ensure the quality of home care and professional backup for domestic assistants, everyone receiving lump-sum transfers must request care advice from a professional care service. If this service is not requested, the payment of the transfers can either be interrupted or cancelled. As for care levels I and II, this service has to be called on at least once every six months, and at least quarterly for care level III.

Combined transfers

If the monthly claim for in-kind transfers is not used entirely, a certain percentage of the remaining amount is paid as a lump-sum transfer. The rate is calculated as the ratio of the maximum sum for the in-kind benefits and the actually drawn sum. The lump-sum transfer is granted according to this ratio under the condition that another person (e.g. relative or neighbour) takes over the remaining nursing needs not covered by the care provider. The frail elderly person is bound to the decision on the proportion of in-kind benefits and lump-sum benefits for six months.

Additional benefits

If the informal care provider is unable to provide the care (e.g. in case of illness or vacation), the long-term care insurance fund pays the costs of a respite caregiver. The frail elderly person thus does not have to move out of his home for that period of time. To be entitled to this form of benefit, the previous caregiver must have been caring for the frail elderly person in his home for at least twelve months. The insurance funds pay up to 1,432 euros of additional transfers for a maximum period of four weeks per calendar year. If the respite carer (Pflegevertretung) is provided by a non-professional person, only the lump-sum transfer based on the assessed care level will be paid. In addition, necessary and substantiated costs which have been incurred by the caregiver during the period of respite care will be remunerated (e.g. travelling expenses, earning losses) up to a maximum sum of 1,432 euros of the whole care costs. Instead of respite care in the domestic environment the frail elderly can make use of a

suitable institution. For the refund of these care expenses (excluding accommodation and catering) the above mentioned maximum sum and time limitations apply analogously.

In some cases while frail elderly people may be able to live in their own homes, it may not be possible to provide professional care due, for example, to the need for permanent night care. The person is then entitled to day/night care in a nursing home (teilstationäre Tages-/Nachtpflege) respectively, including medical treatment, social care, and transportation costs. The maximum sum of 1,432 euros a month is charged against the other benefits.

The insurance funds may accept the costs of short-term care (Kurzzeitpflege) if only partial or no home care at all is provided and day/night care is not sufficient, e.g. during a transition period after nursing home care or in the event of a severe intensification in the need for care. Short-term care is provided for in licensed nursing homes for up to four weeks per calendar year. The transfers for this care level do not exceed 1,432 euros. Entitlement to these benefits covers the costs of assistance-related expenditures, charges for medical treatment and social care. Accommodation, catering, and possible additional demands must be paid by the insured person.

Home care is supplemented by providing auxiliary care products (e.g. disinfectants (Desinfektionsmittel), drawsheets (Unterlagen), etc.) and technical aid (e.g. sick-beds (Pflegebetten), wheelchairs (Rollstühle), etc.), making home care easier or allowing frail elderly people a more independent lifestyle. Up to 31 euros per month are provided for these supplementaries by the insurance funds. Technical aid is made available at no additional costs. Where this is not possible, the insured person (aged 18 or above) must contribute 10 per cent of the costs (not exceeding 25 euros).

2.4.2 Transfers for nursing home care

The frail elderly are entitled to care in fulltime nursing homes if domestic or day/night care is not possible or is out of question in special individual cases. The home-care transfers provided under the LTC insurance scheme again depend on the care level of the insured: 1,023 euros for those in care level I, 1,279 euros, for care level II, 1,432 euros for care level III, and 1,668 euros for cases of hardship. There is thus a wide gap between the maximum amount of in-kind transfers and those for nursing home care, especially for care level I. The annual expenditure of the long-term care insurance funds may not exceed an average amount of 15,339 euros per frail elderly person This means that the benefit receipts for care level III and hardship cases may be capped at the end of a year.

Table 5: Benefit receipts for different care levels (in euros)

Kind of assistance	Level I	Level II	Level III	Hardship case
In-kind transfers /month	384	921	1,432	1,918
Lump-sum transfers/month	205	410	665	-
Respite care/year	1,432	1,432	1,432	-
Day/Night care/month	384	921	1,432	-
Short-term care/year	1,432	1,432	1,432	-
Nursing home care/month	1,023	1,279	1,432	1,688

Source: Bundesministerium für Gesundheit und soziale Sicherung (2004).

Table 6: Benefit recipients of different kinds of benefits on average in 2003

In-kind transfers	Lump-sum transfers	Combined transfers	Respite care	Day/night care
169,580	968,289	202,710	10,362	13,864
(8.6)	(49.0)	(10.3)	(0.5)	(0.7)

Short-term care	Nursing home care	Care in institutions for disabled persons	Sum
9,317	540,070	63,104	1,977,296
(0.5)	(27.3)	(3.2)	(100)

Note: Per cent in parentheses.
Source: Bundesministerium für Gesundheit und soziale Sicherung (2004).

2.5 Quality

2.5.1 Legal regulations

The long-term care insurance law (Pflegeversicherungsgesetz) requires all participating institutions and authorities to maintain basic levels of quality. They should develop common "principles and standards for the quality and quality assurance of nursing home and home care as well as for the development of quality management for nursing homes" (Grundsätze und Maßstäbe für die Qualität und Qualitätssicherung der ambulanten und stationären Pflege sowie für die Entwicklung einrichtungsinternen Qualitätsmanagements). These common principles should provide an evaluation scale for the quality of professional care providers. However, the quality assurance of informal care is not regulated by the common principles. While drawing lump-sum transfers only the designated professional services are subject to those principles.

Furthermore, home care providers and nursing homes are subject to the control of the Medical Review Board on the order of the LTC insurance funds. In case of serious shortcomings the

contract between the care providers and the insurance funds can be cancelled. Nevertheless, the Medical Review Board is only able to expose serious shortcomings and cannot therefore guarantee comprehensive quality assurance (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2006, 538). In 2001, the long-term care insurance law was amended to include the requirement to fulfil performance and quality agreements reached between insurance funds and nursing homes. The federal government is now also empowered to order comparative surveys of all nursing homes in Germany.

2.5.2 Quality assurance and competition

One way of ensuring that specific standards of quality are achieved in long-term care is to establish a fully competitive market for LTC providers. This means that competition should create economic incentives for care providers to perform efficiently and provide good quality services. Open competition is restricted in Germany, however, by quasi-governmental control of the LTC insurance funds. The relationship between insurance funds, care providers and customers leads to asymmetric information which impedes open competition on the LTC market. Whether a product is traded on the market depends on whether it belongs to the care package and thus on the definition powers wielded by the insurance funds. Additionally, fixed prices for care packages mean that price-competition is out of question. The sovereignty of the care market's consumers is also limited, as the availability and offer of the services is standardized in the care packages, providing the receivers with no influence in the negotiation process between insurance funds and care providers.

2.5.3 Recent developments

Quality assurance is one of the main objectives of the social long-term care insurance. However, the number of institutions, providers, consumers etc. involved in the LTC market makes quality-control of the care processes or even the introduction of quality management difficult. Although all of the participants in the market are likely to guarantee high-quality care, no general definition of this term is yet available. Nevertheless, the following three kinds of quality are generally discussed (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2002, 128ff):

> Q*uality of structure* refers to the general framework of care, especially personal, regional and factual configuration of the entire care institution.
>
> *Process quality* refers to nursing and supply activities as well as accommodation. Process quality consists of the design, supervision, implementation and documentation of care benefits.

Quality of results refers to comparisons of intended and actually achieved care results, taking account of the satisfaction and condition of the affected frail elderly people.

The evaluation and improvement of the structural and process quality of long-term care is well established in German institutions, although mainly in connection with the efficient use of economic resources and the introduction of quality management (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2002, 389 ff.). Some institutions use quality marks or certificates, others have adopted benchmark-oriented approaches or concepts of dynamic quality improvement (Igl et al. 2002). Nevertheless, a comprehensive comparison of institutions is not possible. Furthermore, the quality of results and thus the perspective of the consumers are more or less ruled out of the quality management of LTC institutions in Germany (Schönberg und Schnabel 2002).[6]

3 Public Assistance

Apart from the German social insurance system there is also the option of receiving means-tested public assistance. "Current public assistance" (Hilfe zum Lebensunterhalt) benefits are available to cover general daily living expenses and "special public assistance" (Hilfe in besonderen Lebenslagen) can be claimed to cover special expenses which include, among other things, "special public LTC assistance" (Hilfe zur Pflege). Prior to the introduction of social long-term care insurance "special public LTC assistance" was the main financial resource for frail persons who could not afford comprehensive care services from their own means. Additionally, since 1988 the health insurance scheme has paid in-kind transfers of up to 750 DM (383 euros) (or 25 visits) per month for professional home care for people with serious handicaps, or up to 400 DM (205 euros) per month of lump-sum transfers for private caregivers. Home care of up to four weeks a year was subsidised with 1,800 DM (920 euros) to enable informal care providers to take a vacation and to pay for temporary professional respite provision (OECD 1996). Although costs for home care were partly covered by the health insurance scheme, nursing home care was not covered at all. However, costs in LTC institutions are high and often exceed the incomes of the frail elderly. Therefore, prior to the implementation of the German LTC insurance scheme, 69 (88) per cent of frail elderly persons living in nursing homes in western (eastern) Germany claimed public assistance transfers (Schneekloth and Müller 1999). This imposed a heavy burden on local authorities paying for public assistance. Additionally, many frail elderly persons felt stigmatised by their dependence on selective benefits intended for the poorest of society. Solutions to this problem

[6] Several projects have attempted to evaluate the quality of nursing homes using the satisfaction of residents as one indicator (see Klie et al. 2002).

were the focus of discussion for several years prior to the introduction of the long-term care insurance scheme by the federal government. Indeed, the number of people receiving public assistance decreased after its introduction. The share of people on public assistance benefits in nursing homes, for example, decreased to 44 (29) per cent of all residents in western (eastern) Germany in 1998. However, there are still an enormous number of public assistance recipients especially among nursing home residents (see Table 7). Spending on "special public LTC assistance" (which is the highest for nursing home care) decreased from 9 billion euros in 1994 to 2.9 billion euros in 2000 (see Table 8).

Table 7: Recipients "special public LTC assistance"

	Home care	Nursing home care	Total*
1994	189,254	268,382	453,613
1995	85,092	288,199	372,828
1996	66,387	219,136	285,340
1997	64,396	186,672	250,911
1998	62,202	160,238	222,231
1999	56,616	190,868	247,333
2000	58,797	202,734	261,405
2001	60,514	195,531	255,883
2002	59,801	186,591	246,212
2003	55,405	186,867	242,066

Note: * Excluding multiple counting if identifiable; The numbers were counted at the end of every year.
Source: Bundesministerium für Gesundheit und soziale Sicherung (2004), Bundesregierung (2005).

Table 8: Spending on "special public LTC assistance" in thousand DM (euros)

	Home care	Nursing home care	Sum
1994	1,633,579	16,089,662	17,723,241
	(835,236)	(8,226,514)	(9,061,749)
1995	1,068,302	16,404,842	17,473,144
	(546,214)	(8,387,663)	(8,933,877)
2000	826,980	4,798,824	5,625,804
	(422,828)	(2,453,600)	(2,876,428)
2004	(540,012)	(2,601,883)	(3,141,896)

Source: Statistisches Bundesamt (1994, 1995, 2000, 2004).

4 Reform options

4.1 Main issues

Several reasons for the financial problems encountered by social insurance schemes in Germany can be identified. Population ageing and the rising costs associated with an increase in the number of claimants clearly play a role. Additionally, the difficult labour market has eroded the system's income basis in recent years and there is no prospect of this situation improving in the near future. What is more, people on incomes above the contribution ceiling generally are not members of the social LTC insurance and do not therefore contribute to the redistribution system despite having a higher mean income than that of members of the social insurance schemes. Finally, the price of long-term care services have risen much faster than general consumer prices and average wages in recent years. This trend is expected to continue. Between 1995 and 2004 prices for health services at home increased 3.4 per cent per year on average. In the same period prices for institutional health services increased 5.9 per cent per year (Kronberger Kreis 2005).

If the German long-term care insurance system is not reformed contribution rates will increase dramatically over the next 45 years. Kronberger Kreis (2005) and Häcker and Raffelhüschen (2004), for instance, anticipate a contribution rate of 5.9 per cent in 2050. The Herzog-Commission (2003) predicts a rate of 5.8 per cent. Only the Rürup Commission (2003) expects a lower contribution rate of 3.0 per cent in 2040. Nevertheless, increasing the contribution rate is a very unpopular means of solving financial problems. Non-labour wage costs (Lohnnebenkosten) are already high in Germany and are one of the reasons for the country's high rate of unemployment. Therefore, other reform options are widely discussed in academia and politics. However, a distinction must be made between the income and output sides of the system. The former is discussed first. Several proposals for reform have been mapped with the objective of counteracting the increasing financial problems of the social insurance system. Four different instruments are proposed which can be partially mixed. They all contrast the status quo:

- Fixed premiums vs. income-related contributions (status quo)
- Fully-funded vs. pay-as-you-go system (status quo)
- Private insurance vs. social and private insurance (status quo)
- Citizens insurance vs. social and private insurance (status quo)

In addition to the problems on the income side, spending is also expected to rise sharply. The benefit package on the output side must therefore be adjusted. On the one hand, nursing home

care will play a greater role owing to changing family structures and because nursing home care transfers cost a great deal more than home care transfers. This leads to cost pressure. Incentives must therefore be changed to make home care more attractive. On the other hand, while LTC receipts have not changed since the introduction of the LTC insurance scheme, the prices for care services have increased substantially. Furthermore, there is a huge need for care for dementia patients which is seldom covered by LTC insurance. Therefore, an extension and adjustment of benefit receipts should be part of a reform of the whole system. Reform options on the outcome side - which are demanded by almost all authors dealing with the social long-term care insurance system - relate to changes in the composition of transfers (matching transfer) to provide an incentive for long-term home care. Furthermore, an extension of the benefit package and a regular adjustment of the benefit receipts are demanded.

4.2 Income side options

Fixed Premiums

In Germany there is a huge debate about whether to keep social insurance contributions linked to incomes or to introduce fixed premiums, at least for social health and social long-term care insurance. Supporters of the fixed premium model argue that premiums should be completely independent of wages and that the tax system should be responsible for redistribution. Premiums should therefore be calculated dependent on entrance age but independent of sex and health status and would be fixed for a lifetime. Premiums might range from 52 euros for 20-year-old new entrants, for example, to 66 euros for those aged 45 and older. If the rate exceeds a certain percentage (own contribution rate) of household income, the state will assist with subsidies paid from taxes. The employer’s current contribution would be paid as gross taxable earnings. Bearing in mind that the transition phase from the current to the new system would impose a burden on paying members, taxpayers would have to pay an equalizing amount in compensation (Herzog-Kommission 2003). Opponents of the fixed premium model argue that this would violate the solidarity principle in which better off contributors pay more to finance social insurance benefits than less well off contributors. There are other models for calculating premiums and some are presented in the next section.

Fully funded system

This reform option would entail transforming the pay-as-you-go system into a fully-funded model. The advantage of a fully-funded system is that it breaks the relationship between claimants and contributors because every generation would build its own capital stock from

their own lifetime paid contributions. This capital would then be used to pay for the transfers which would be paid if care is needed. However, the main problem is that during the transition phase older claimants would need to be entitled to transfers from the insurance scheme despite not having built up a capital stock (protection of confidence). On the other hand, the younger generation must build up a capital stock to finance their future needs and will not therefore be able to contribute to the pay-as-you-go system in the same way as before. The question then is how to finance these transitional costs. Several proposals for overcoming this problem are presented in the following, although it is important to emphasise that all the models propose a switch to fixed premiums.

During the transition period capital stock could be built up by increasing the contribution rate to 3.2 per cent which would still be paid equally by employers and employees. Additionally, the income basis for calculating the contributions could be extended to include other sources of income, e.g. rental and capital revenues. Increased wage costs could be compensated for by abolishing a public holiday or a paid leave day (Herzog Commission 2003). Another proposal is to pay the additional costs through taxes. The older generation (70 years and older) who did not build up a capital stock would still pay contributions. All others would build up a capital stock to finance their future needs. Additionally, the contribution rate for the older generation would be increased to about 3.2 per cent. All further costs to finance the LTC transfers of this generation could be paid by taxes (Ottnad 2003). A third suggestion proposes protecting the confidence of insured people aged 60 and older (in 2005). This group would pay a fixed income independent premium of 50 euros per month. Additionally, the younger generation would pay an income-related average contribution rate of 0.7 per cent (as a solidarity contribution) to finance the additional costs. These contributions would decrease to zero until the end of the transition period. Furthermore, the younger generation would pay a monthly premium of about 40 euros to build up their own capital stock (Häcker and Raffelhüschen, 2004). In its 2004/2005 report, the Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung (2004) argues for a switch to a fully-funded model referred to as the cohort model (Kohortenmodell). During the transition period cohorts born before 1950 would remain in a system on a pay-as-you-go basis. They would continue paying their contributions (fixed premiums) and would receive the required benefits when in need of care. Contributions would amount to 50 euros at the beginning and would increase by one euro every year. Birth cohorts after 1951 would take out fully-funded cohort-specific care insurance cover. The premiums would be calculated from the respective benefit provider, taking into account the expected expenditures for each cohort. The premium for older cohorts would be higher than for younger cohorts. Premiums would be differentiated according to the entry age, i.e. depending on the time remaining for capital accumulation. In addition to their

cohort-specific premium, younger cohorts would pay an additional allocation amount, called an “elderly lump-sum”, to finance the additional costs during the transition period. Additionally, if coinsurance cover is provided for children, a so called “children lump-sum” would be added to the fixed premiums (Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung 2004). Another suggestion which goes further in this direction limits contributions to 50 euros per month. This would be high enough for younger generations to build up a capital stock to finance future expenditures for long-term care. For older generations this amount would not be sufficient to finance their future needs which would mean that their insurance contracts would cover just part of their risks with an residual needs being paid by a mix of tax-financed transfers and out-of-pocket payments (Kronberger Kreis 2005).

Pay-as-you-go system linked to a fully funded system

Another proposal involves combining aspects of the pay-as-you-go and fully-funded systems to overcome the ageing population problem - especially that associated with the baby boomer generation. From 2010 onwards all citizens would build up a funded care account (kapitalgedecktes Pflegekonto). The general wage-related contribution rate would be lowered from 1.7 to 1.2 percentage points with the difference of 0.5 percentage points being deposited in a personal financial security account (privates Vorsorgekonto). The correlating additional savings would be disbursed by the time the insured person reaches retirement age. In return, pensioners would pay 2.6 instead of 0.85 per cent of their pensions to the LTC insurance scheme. Implementing the propositions might ensure financing for about 35 years based on both the compensation payments of the older and the provisional contributions of the younger generations, at the same time maintaining the premium rate at 1.7 per cent (Rürup Commission 2003).

Private insurance

The change from social long-term care insurance to private long-term care insurance (private Pflegeversicherung) is often demanded in context with a fully-funded system (Ottnad 2003, Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung 2004, Häcker and Raffelhüschen 2004, Kronberger Kreis 2005). Private LTC insurance would be compulsory for everyone. An obligation to contract would be imposed on the private insurance funds. To maintain the standards of the actual long-term care insurance the benefit package and the limited-cover character could be maintained and would be the same for all insurance funds (Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung 2004). Another suggestion is to provide a compulsory contract with basic

securities. This would mean that everyone would be able to opt to conclude additional contracts on a voluntary basis. Furthermore, contributions in this reform option would be risk equivalent, i.e. higher contributions would be calculated for people whose potential need of care is higher (Kronberger Kreis 2005).[7]

A private insurance contribution system might be designed as follows. Everyone would be insured in the private LTC insurance scheme from birth. During the first 54 years of life fixed premiums to finance the LTC risk for this life period within a pay-as-you-go system would be paid. The premiums would therefore be relatively low during this period. At the age of 55 contributions would be re-calculated to enable a share premium account to be built which would guarantee sufficient transfers when the person is in need of care. Additionally, the share premium account could be built up prior to the age of 55 on a voluntary basis. Families and low-income earners would receive tax paid transfers to finance the premiums (Ottnad 2003).[8]

Citizens Insurance

Introducing the citizens insurance (Bürgerversicherung) means expanding the circle of insured persons to comprise all citizens, including civil servants, and self-employed persons. Additionally, adjusting the contribution ceiling, e.g. from 3,526 euros (contribution ceiling in 2004) to the earnings ceiling of the pension insurance (5,100 euros in 2004) would be an option to expand the income basis (Lauterbach 2004). Furthermore, an extended income basis with additional sources such as rental and capital revenues should be introduced in this context (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2006, Lauterbach 2005). However, it would only be possible to stabilise the premium rate if expanding the group of insured persons, widening the income basis and increasing the assessment threshold led to significant additional receipts. What is more, the people who would be added to the community of insured people should be significantly younger (Verjüngung) as including another person subgroup into the social insurance would of course lead to an increase in the number of people entitled to receive benefits.

[7] If parents insure their unborn children, contributions will be the same for all children because the possibility to assess future needs of care is low. When a person changes the insurance fund during her life, premiums will be calculated again and this could lead to differences between insured according to the health status.

Integration of long-term care into health insurance

Separating the compulsory health insurance, which is partially competitive-oriented, from the social LTC insurance, which is non-competitive, might lead to disadvantages for the insured and create immense problems in cooperation between the different schemes. Problems occur with the shift of costs from one class of insurance to another and the ambiguous competencies which result. Therefore, an integration of the long-term care insurance into the health care insurance is demanded (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2006).

4.3 Outcome side options

Individual Budget

Individual budgets are fairly modern and popular development. The Netherlands and the USA, for example, have already tried out and implemented individual budgets in the care sector (Foster et al., 2003, Tilly and Wiener 2001, Evers et al. 1992). In Germany, an individual budget scheme is offered in the care for disabled persons. Individual budgets are introduced in order to reduce long-term care costs by encouraging more people to choose cheaper home care. Furthermore, the quality of life and satisfaction of the frail elderly as well as their families is improved as the budget system stimulates competition between care providers. Additionally, self-determination and the sovereignty of the frail elderly is promoted. In 2004, the implementation of a social experiment for matching transfers (the German form of individual budgets) and new housing schemes in order to exploit the rationalisation potential by making care benefits more flexible was introduced by the German Parliament.

German matching transfers (personengebundenes Pflegebudget) provide a specific cash benefit equal in value to that of in-kind transfers which can be used for the purchase of appropriate care services. As it even allows for the purchase of services from providers who not concluded a supply contract with insurance funds, it can be seen as an addition to existing forms of lump-sum transfers, in-kind transfers, and combined transfers. Providers must be lawful and may not be a family member or illicit workers. This means that the person receiving a matching transfer is not bound to predefined services but may individually make up his or her own service arrangements. Advice and support is given by a case manager who assists in the allocation of services and the conclusion of contracts. Anyone who has been

[8] Premiums would be fixed for the rest of the person's life with the exception of possible adjustments to secure real money.

examined and allocated to one of the three care levels may apply for a matching transfer (Arntz and Spermann 2004). A social experiment is currently being undertaken by the social long-term care insurance funds to evaluate the impact of matching transfers (Arntz and Spermann 2005).

Extension of transfers

As referred to above, no services are included in the current benefit package for the special needs of people suffering from dementia. Because the household structure of frail elderly people is changing from multi-generation households to single households there is an increasing need for these special services. Many long-term care professionals are consequently demanding the introduction of special benefits for dementia patients. Their objective, for example, is to extend care assistance for dementia patients by about 30 minutes per day which would result in many of them being allocated to the next higher care level (Lauterbach 2005, Rürup Commission 2003).

In order to provide more incentives for home care, the transfers for home care and for nursing home care should be adjusted. This would be achieved by increasing the rates for home care and cutting the rates for nursing home care in care levels I and II. As for care level III, which already shows a financial equalisation in both services, the rates should be increased accordingly (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2006, Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung 2004, Rürup Commission 2003, Lauterbach 2005). Additionally, the benefits provided by the LTC insurance scheme should be adjusted regularly (Rürup Commission 2003).

5 Conclusions

This paper outlines the German long-term care insurance system and the reform options which have been proposed to solve financial problems and to guarantee a sufficient benefit package. The social LTC insurance scheme was introduced in 1995 on a pay-as-you-go basis with income-related contributions. In the first few years revenues exceeded expenditures. Since 1999 the surplus has decreased and will shrink to zero within a few years. An ageing population as well as an increase in the prices for long-term care services will exacerbate the financial situation of the social LTC insurance. Additionally, the loss of social networks will lead to increasing need for professional long-term care services.

Several reform options have been proposed to overcome this problem, ranging from expanding the income basis to abolishing social insurance altogether and introducing private insurance with fully-funded financing. Almost all authors suggest a fully-funded system with

fixed premiums. The main problem, however, will be the transition from the current to the new system: on the one hand the older generation should enjoy protection of confidence and thus receive transfers from the current system. The younger generation, on the other hand, will have to contribute to the new system in order to build up a sufficient capital stock to finance their future expenditures for long-term care. The financing of the costs for the older generation is an open issue. Various proposals have been made which mainly differentiate in terms of the size of the burden placed on the older and younger generations. However, since the social LTC insurance scheme is a relatively young insurance system, the transition period is foreseeable and thus the cost gap could be financed.

Based on the benefit package and the benefit receipts granted by the LTC insurance the main proposal is to implement matching transfers which would guarantee more flexibility in purchasing care services. A social experiment designed to evaluate the impact of these transfers is currently underway. Additionally, demands are also being raised for an annual adjustment of benefit receipts in line with current retail price trends and an extension of the benefit package to include more services for patients with dementia. Obviously, there are many suggestions about how to reform the social long-term care insurance in order to prepare it for future needs and challenges. It is the task of current policies to put some of these suggestions into action.

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