The Social Long-term Care Insurance: A Frail Pillar of the German Social Insurance System

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Introduction

Until 1995, financial support for long-term care in Germany was granted as means-tested welfare for people in need of long-term care (Hilfe zur Pflege, Bundessozialhilfegesetz). At that time, being in need of care was not explicitly defined, meaning that every "helpless" person was eligible for means-tested allowances that in most federal states were provided by local municipalities. As a result of increasing numbers of individuals in need of care and shrinking informal networks to provide unpaid support, increasing numbers of frail elderly thus became welfare dependent. While in 1963 only 165,000 had been eligible for long term care allowances, these numbers rose to 675,000 in 1992.[1] For people who had been working their whole lives and only became welfare-dependent due to their long-term care needs, this was considered a stigma. The related discontent, together with increasing financial pressures on the municipalities, thus started a political debate[2] that, in 1994, resulted in the introduction of the so called fifth pillar of the German social insurance system[3]: a social long-term care insurance (SLTCI).

Designed as a universal, non means-tested and contribution-financed insurance, SLTCI grants long-term care allowances for individuals in need of care. Its introduction thus improved the situation of many frail elderly, and it also boosted the market for long-term care services. On the negative side, the SLTCI inherited the typical diseases of a pay-as-you go funded insurance in an ageing society: shrinking revenues and increasing expenditures.

This article gives an overview about the institutional background and the set up of the SLTCI including a description of the available long term care programs. Following this introduction, we discuss the current and projected development on the revenue and the expenditure side of the SLCTI and summarize the existing estimations regarding the likely fiscal development of SLTCI in a mid to long term perspective. This part forms the basis for a concluding discussion of potential reform options that may improve the fiscal sustainability of SLTCI.

Set-up and funding

SLTCI in Germany is a mandatory and non means-tested insurance for the almost 90 percent of the population who are also covered by a social health insurance such as most employees and their children, retirees and recipients of social welfare or unemployment benefits. Persons whose job is not subject to social security need to have coverage by a private long-term care insurance (PLTCI). This concerns the approximately 10 percent of the German population who are civil servants, self-employed or employed with a wage income above the social security threshold. Only about 0.5 percent of the German population is not covered by any long-term care insurance (e.g., homeless persons). In contrast to health insurance, SLTCI is not intended to fully cover the risk of being in need of long-term care, but only covers basic needs. Thus, individuals in need of care are expected to contribute additional private funds for long-term care, with social welfare still being the last resort for those lacking sufficient financial resources. Long-term care allowances as welfare payment were thus not abolished, but decreased by around 70 per-

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[1] This number also includes eastern Germany. For a more detailed description on the history of social long-term care insurance in Germany, see Heinicke and Thomsen (2010).

[2] As emphasized by Götting, Haug and Hinrichs (1994), the shrinking supply of informal caregivers and concerns about the supply and quality of professional care in light of an increasing demand also fueled this debate.

[3] Before the introduction of the social long-term care insurance, the German social insurance system was comprised of four pillars: unemployment insurance, health insurance, pension insurance, and accident insurance. They all follow the principles of solidarity, self-administration and funding by social insurance contributions.

Table 1

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)
Assistance for personal care, nutrition or mobility	at least once a day for at least two ADL	at least three times a day at different times of the day	permanent assistance
Assistance for housekeeping	several times per week	several times per week	several times per week
Time needed*	at least 90min/day on average including a maximum of 45min/day for housekeeping	at least 3h/day on average including a maximum of 1h/day for housekeeping	at least 5h/day on average including a maximum of 1h/day for housekeeping
* Time exposure is calculated for non-professional caregivers.			

Source: German Federal Minstry of Health (http://www.bmg.bund.de/cln_160/nn_1168258/SharedDocs/Standard-artikel/ DE/AZ/P/ Glossarbegriff-Pflegestufen.html?__nnn=true)

cent in the five years after the introduction of SLTCI (German Federal Ministry of Health 2004, 67).

Unlike the other social insurances, the SLTCI does not have an independent administrative organization, but is administered by the approximately 250 health insurers in Germany,[4] who are also responsible for monitoring the adequacy and quality of the long-term care that is provided by informal and professional caregivers. In addition, federal states are responsible for providing an adequate infrastructure (e.g., sufficient nursing homes) for long-term care. Financing is based on a pay-as-you go scheme[5] and started with social security contributions of 1 percent of an employee's gross earnings in January 1995.[6] Since benefit payments did not start before April 1995 for out-patient care and before July 1996 for in-patient care, an initial stock of savings was collected. In July 1996, the contribution rate was increased to 1.7 percent. Moreover, an additional premium of 0.25 percentage points has been required of childless people since 2005 in order to account for the fact that they are likely to receive higher SLTCI grants on average.[7] After an amendment of the SLTCI law in 2008 (Pflegeweiterentwicklungsgesetz), contribution rates were further raised by 0.25 percentage points in order to finance additional benefit schemes.

Eligibility, benefits and provision of services

Individuals who are covered by the SLTCI are eligible for benefits if they are impaired in two or more activities of daily life (ADL) and require help several times per week. ADL consist of abilities such as bathing, dressing and undressing, eating, using the toilet or walking.[8] The Medical Review Board of the health insurers (Medizinischer Dienst der Krankenkassen) is responsible for assessing the required level of care.[9] Physicians and nurses, mandated by the Medical Review Board, evaluate the demand for support in four basic domains: personal care, nutrition, mobility and housekeeping. Based on this assessment, three care levels are granted according to the severity of care needs as summarized in Table 1. The Medical Review Board is also required to assess whether care dependency can be avoided or mitigated by measures of rehabilitation since, by law, rehabilitative measures take precedence over long-term care. Moreover, preventive measures can be recommended in order to stabilize the current need for care. In 2008, eligibility criteria were reformed to include persons with mental impairment such as dementia (eingeschränkte Alltagskompetenz) are also entitled to benefits. The corresponding benefits are

[4] Some of the larger insurers like the public community insurances (AOK, Allgemeine Ortskrankenkassen) or the company health insurances (BKK, Betriebskrankenkassen) are organized at the level of federal states.

[5] In contrast, private long-term insurance is fully capital funded. Thus, only around 20 percent of the current PLTCI revenues are spent on benefits whereas most of the money is used to build up the capital stock and capital reserves for its members. In 2006, the capital stock of the PLTCI already comprised around 17 billion EUR (German Federal Ministry of Health 2007, 30).

[6] The contribution rate applies only to the gross earnings below the so-called social security threshold. In 2003, this threshold was EUR 45,900, but was raised afterwards to EUR 48,600 in 2008.

[7] This adjustment was demanded by the Federal Constitutional Court based on the "children consideration law" (Kinderberücksichtigungsgesetz). Exempted are childless persons born before 1940, persons younger than 23, and recipients of unemployment assistance or persons in military or alternative service.

[8] In addition, the instrumental activities of daily life (IADL) comprise "telephoning, shopping, food preparation, housekeeping, laundering, use of transportation, use of medicine, and financial behavior" (Lawton and Browdy 1969).

[9] According to the Federal Ministry of Health (Bundesministerium für Gesundheit) the probability of being in need of care is 0.7 percent for persons younger than 60, 4.4 percent for persons between 60 and 80 years, and increases to 28.6 percent for persons older than 80 years.

Table 2

Benefit levels for benefits in kind, cash allowances and institutional care (monthly values in EUR)

Care Level	Since2007/08	2010	2012
	Benefits in-kind		
I	420	440	450
II	980	1,040	1,100
III*	1,470	1,510	1,550
	Cash Allowances		
I	215	225	235
II	420	430	440
III	675	685	700
	Institutional Care		
I	1,023	1,023	1,023
II	1,279	1,279	1,279
III	1,470	1,510	1,550
Cases of Hardship	1,750	1,825	1,918

* Additional benefits can be allocated for persons at care level III in cases of hardship, but only up to a maximum value of EUR 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.

Source: German Federal Ministry of Health (http://www.bmg.bund.de/cln_160/nn_1168258/SharedDocs/Standardartikel/DE/AZ/P/Glossarbegriff-Pflegestufen.html?__nnn=true)

not assigned for basic care or housekeeping but for supervision and amount to EUR 100 per month for basic cases and EUR 200 for more severe cases. The money can be used to purchase any kind of benefit desired.

Individuals who have been granted one of the three levels of disability can choose between nursing home care and two home care programs: cash benefits (Pflegegeld) or agency services in kind (Sachleistung). In addition, if the monthly claim for agency services is not exhausted the remaining percentage can be granted as a cash benefit; claimants then receive a combination of both types of home care programs. Table 2 provides an overview of the three levels of disabilities and corresponding benefit levels depending on the type of program. Cash benefits only amount to about half the monetary value of agency services which corresponds to only 37–72 percent of the benefit level for nursing home care for the first two disability levels. Table 2 also displays the adjusted benefit levels that will come into effect in 2010 and 2012 as a result of the reform in 2008.

Home care benefits

Individuals in need of care who lack sufficient informal support but prefer to stay at home tend to opt for agency services in kind. Agency services encompass a pre-defined catalogue of services that are related to the ADL that are assessed by the Medical Review Board. Therefore, agency services that are reimbursed by the SLTCI[10] are limited and do not include support for those with mental impairments such as dementia. Moreover, agency services have to be provided by care agencies that have been authorized and contracted by the SLTCI (Versorgungsvertrag). For this authorization, agencies have to fulfill certain criteria concerning the organization and quality of care. Prices are negotiated between SLTC insurers and authorized agencies, thus undermining a truly competitive market for long-term care services. Due to its limited coverage and flexibility, agency services have been criticized for not fully meeting the care recipient's needs (Klie 1999).

In contrast, a recipient of the cash allowance receives a cash payment that can be used at the full discretion of the person in need of care. This cash payment thus enables care recipients to act as employers of care assistants and to spend the money on care services that best suit their needs. However, the German cash option is mainly designed for care households with an informal caregiver as the main caregiver so that the cash payment in many cases is used to remunerate informal care. In fact, the cash option can only be granted conditional on such informal support. Compliance with this eligibility rule is monitored by regular visits from SLTCI-licensed agents, which take place at least once in six (three) months for persons with care levels I or II (III). To relieve the main caregiver of some of the burden, recipients of the cash payment may be entitled to additional respite care[11] for a maximum duration of four weeks per year if the main caregiver is not a direct family member and informal care has been provided for at least six months before claiming respite care. In addition,

[10] The care recipient receives the care services, but does not pay the providers himself.

[11] If respite care is provided by a professional caregiver, additional benefits amount to a maximum value of EUR 1,470 per year in 2008. 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 the maximum values of professional respite care.

the SLTCI pays contributions to pension funds if informal caregivers do not work more than 30 hours per week and spend at least 14 hours per week on care. If informal caregivers are on leave for providing care, SLTCI also pays for the unemployment insurance, social health insurance and SLTCI.

Institutional care

A person is entitled to institutional care if the Medical Review Board considers home care inadequate. If someone is assessed to need the highest care level, institutional care is in fact the default recommendation of the Medical Review Board (German Federal Ministry of Health 2008). The benefits for institutional care are displayed in Table 2 and must not exceed 75 percent of the institution's expenditures. If someone chooses institutional care regardless of necessity, the person is only entitled to the maximum value of agency services in kind and has to pay for additional costs.

There are also possibilities to combine home and institutional care. In case of special needs during the night, for example, a part-time institutional arrangement can be offered. Day/night care (Tag- und Nachtpflege) comprises transportation to and from the institution. It can be combined with agency services in kind and/or a cash allowance, but the total value must not exceed 150 percent of the monetary value of the benefit scheme the person in need of care is entitled to. Moreover, short-term care (Kurzzeitpflege) 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 hospital stay. Benefit levels are the same as for respite care.

The current state of the SLTCI: questionable fiscal sustainability

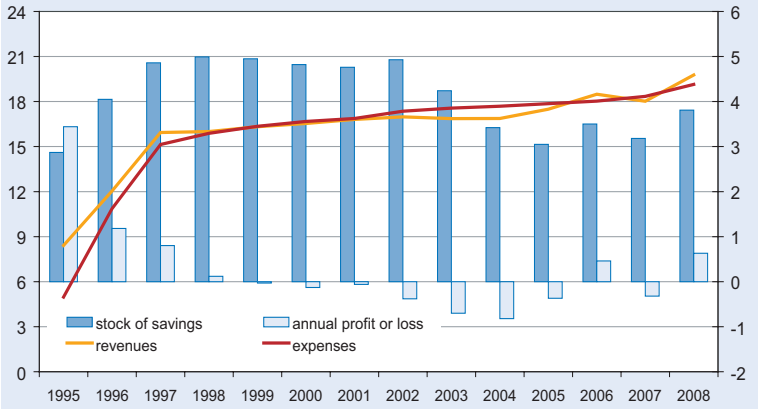
Since contribution payments started some months before benefits could be claimed, a stock of savings was built up after the implementation of the SLTCI. However, expenses started to exceed revenues after 1999 with the exception of the year 2006 (see Figure 1).[12] The fiscal sustainability of the SLTCI was thus questioned only a few years after its introduction. In particular, one can identify three main factors that affect projected SLTCI revenues and expenditures: (i) the number of benefit recipients, (ii) the increasing dependency on professional long-term care, and (iii) the decrease in revenues due to demographic ageing and a shrinking of the working age population.

Since the introduction of SLTCI in 1995 the number of benefit claimants increased steadily as shown in Figure 2. This development is likely to continue and

[12] 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.

Figure 1

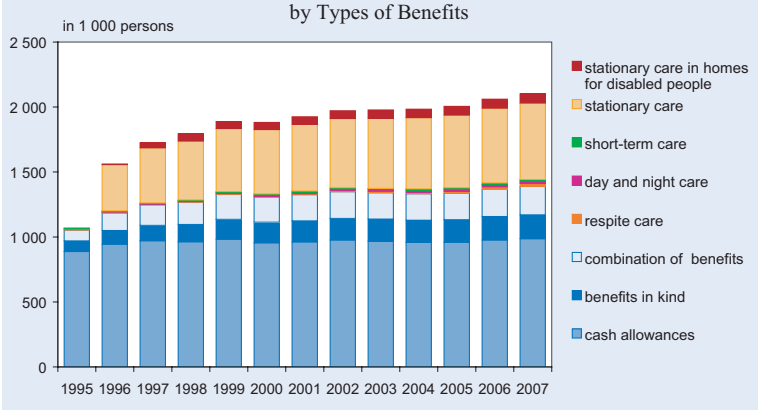
REVENUES AND SPENDING OF SLTCI BETWEEN 1995 AND 2008



Source: German Federal Ministry of Health (2009b).

Figure 2

BENEFIT RECIPIENTS OF SLTCI BETWEEN 1995 AND 2007
by Types of Benefits



1996: Second half year.
Source: German Federal Ministry of Health (2009a).

even accelerate in the future because the ageing of high-birthrate cohorts tends to increase the number of care recipients. Assuming a constant age-specific risk of care dependency, Rothgang (2001) calculates about 2.9 to 3.3 million benefit recipients in 2040, an increase of 55–76 percent compared to 2000. Similarly, the Council of Economic Advisors (2004) estimates a number of 2.4 to 3.5 million benefit recipients in 2040, assuming constant age-specific risks of care dependency. Taking into account that the risk of being in need of care will be shifted to later ages as life expectancy increases, Rothgang (2001) estimates around 2.5 to 2.7 million benefit recipients in 2040. Blinkert and Gräf (2009) analyze similar scenarios resulting in 3.25 to 3.5 million projected benefit recipients in 2050.

The second factor that raises expenditures concerns the increasing dependency on professional long term care that is reflected in growing shares of care recipients in institutional care and an increasing share of agency services recipients (see Figure 2). While in 1996 only around 20 percent of all home care recipients received agency services, this share increased to 29 percent in 2007. Moreover, the share of recipients in nursing homes increased from 24.1 percent in 1996 to 33 percent in 2007 (German Federal Ministry of Health 2007, 108). This trend is likely to continue in the future because a growing share of frail elderly in the population and a simultaneous reduction in the number of informal caregivers forces increasing numbers of claimants into institutionalized care (for a corresponding projection see Schulz, Leidl and König 2004). As a consequence, Rothgang (2001) estimates total expenses to increase by 84 to 109 percent depending on the assumed shares of home and institutional care, and the expected increase in the number of benefit recipients.

At the same time, LTCI revenues are projected to decrease due to demographic ageing and a resulting reduction in the average contribution paid by the assured. Based on forecasts concerning the future contribution payers (including immigrants and pensioners), Rothgang (2001) suggests that revenues will decrease up to 17 percent depending on future labor force participation rates. In addition, Blinkert and Gräf (2009) estimate that only 10 to 16 contribution payers have to finance one care recipient in 2050, while 26 contribution payers finance one care recipient in 2007.

The fiscal challenges facing every pay-as-you-go system in an ageing society are thus particularly pronounced for the SLTCI because both its revenues as well as its expenditures are strongly affected. Therefore, the contribution rates will have to be raised tremendously to maintain, ceteris paribus, the current level of support.[13] According to Herzog Commission (2003), contribution rates will amount to (at least) 2.6 percent of gross earnings subject to social insurance contributions in 2030. The Council of Economic Advisors (2004) expects a further rise up to between 2.7 and 4.0 percent conditional on the underlying assumptions about the growth of benefits and the growth of revenues. According to Fetzer, Moog and Raffelhüschen (2003), contribution rates will peak in 2055 between 4.5 to 6.5 percent before lower-birthrate cohorts will relieve some of the financial pressures.

Discussion

The introduction of the SLTCI improved the situation of many frail elderly in need of care in Germany; they are now less welfare dependent, they have access to SLTCI funded professional long-term care and the long-term care infrastructure in Germany for both institutional and home care has improved notably since the early 1990s. At the same time, however, the SLTCI has been criticized from early on for being unsustainable in light of increasing expenditures and shrinking revenues. The reform in 2008 can only mitigate this development temporarily since additional revenues due to higher contribution rates are mainly used to finance higher benefit levels as well as certain other extensions that raise expenditures such as an allowance for individuals with mental impairment.

A reform that ensures the fiscal sustainability of the SLTCI is thus still to come. Most reform options that have been discussed in recent years aim at reforming the funding principles of SLCTI. The least extreme reform suggestion simply aims at raising contribution rates, especially among the high-risk group of pensioners (Rürup Kommision 2003). Lauterbach et al. (2005), on the other hand, propose a universal coverage, thus extending the SLTCI to those who are currently covered by the already capital funded

[13] In 2008, benefits were adapted to price increases for the first time since 1995. The Council of Economic Advisors (2004) and Kronberger Kreis (2005) point out that if benefit levels are not continuously adjusted, real benefits in 2050 will account for only about 50 percent of their value in 1995. As a consequence, SLTCI cannot be considered an inter-generational contract because no generation will be able to balance future receipts with payments (Fetzer, Moog and Raffelhüschen 2003).

PLTCI (e.g. civil servants). Since these additional contribution payers would generate high revenues due to relatively high wage levels, this would relieve the insurance of some of its financial pressures. While these reform options adhere to the pay-as-you-go scheme of the SLTCI, a number of long-term care experts in Germany favor a capital funded insurance scheme to achieve fiscal sustainability in the long run. The corresponding suggestions differ, however, in the length of the transition period and the distribution of the corresponding costs across different cohorts. While Kronberger Kreis (2005) propose an immediate transition to a fully-funded system, others prefer a relatively long transition period (Herzog Kommission 2003; Council of Economic Advisors 2004; Häcker and Raffelhüschen 2004). Some reform suggestions also support hybrid insurance schemes that combine elements of a capital funded with a pay-as-you-go scheme (Council of Economic Advisors 2004).

Since a transition to a capital funded LTCI scheme is considered to be extremely costly, some recent reform suggestions also focus on improving the cost efficiency of long-term provision, thus aiming at the expenditure side of the SLTCI. In particular, an amendment of the LTCI law in 2002 forms the legal basis for testing alternative or supplementary home care programs that (i) aim at improving the provision of long-term care at constant benefit levels and (ii) thereby aim at strengthening home care relative to the more expensive institutional care. As an example, so-called personal budgets (Pflegebudget) were tested as a supplementary home care program in a field experiment in seven German counties between 2004 and 2008.[14] Personal budgets mainly aim at individuals who lack sufficient informal support to opt for the cash payment and for whom agency services may not be flexible enough to stay at home. Personal budgets thus relax many of the restrictions imposed by agency services in-kind and have, in fact, been evaluated to extend professional care hours for former recipients of agency services at constant benefit levels (Arntz and Thomsen 2008a). However, as a side effect, many cash recipients were found to switch to the twice as generous personal budget, thus resulting in a strong increase in SLTCI spending (Arntz and Thomsen 2008b). The personal budget example thus highlights that a higher efficiency of long-term care provision is a reasonable goal, but that SLTCI is likely to remain a frail pillar of the German social insurance system as long as its funding scheme is not adjusted to the realities of an ageing society.

[14] In six of the selected counties, personal budgets were tested in a social experiment with a randomized treatment and control group.

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