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The Long-Term Care System in Germany

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Abstract:

This document provides an overview of the long-term care system, the number and development of beneficiaries and the long-term care policy in Germany. The report is part of the first stage of the European project ANCIEN (Assessing Needs of Care in European Nations), commissioned by the European Commission under the Seventh Framework Programme (FP7). The first part of the project aims to facilitate structured comparison of the long-term care systems and policies in European Nations. Thus, this report is one of comparable reports provided for most European countries.

JEL classification: H51**,** I18, I19

Keywords: Long-term care system, long-term care policy, beneficiaries

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1 The long-term care system

1.1 Overview

Philosophy

In general social care systems in European Member States can be grouped into three categories:

- the state responsibility model,
- the family care model, and
- the subsidiary model.

The subsidiary model is common in Germany, but until 1994 long-term care giving was predominately the tasks of the family and only persons who could not cover the costs could apply for means tested benefits from the social assistance scheme. After a long discussion driven by the increasing social assistance expenditure a mandatory, universal social long-term care insurance system as a 5th pillar of the social security system was introduced in Germany in 1995 (Social Code Book, Part XI, Long-term care insurance).[1] Long-term care insurance (LTCI) covers almost the entire population, according the principle: long-term care insurance follows health insurance. Members of the public health insurance system become members of the public long-term care insurance scheme, and those who have private health insurance are obliged to buy private mandatory LTCI providing the same benefit packages.

Objectives

The main objectives of the LTCI are:

- Socially securing the risk of the need for care in a similar way to insurance against illness, accidents and unemployment and to protect income in old age,
- Helping to mitigate the physical, mental and financial stresses resulting from the need for care and ensuring that the majority of people affected no longer depend on social assistance because of their need of care,
- Enabling people in need of care to stay in their familiar home and family environment for as long as possible. Long-term care insurance services are based on the principles of "Prevention and rehabilitation before care, out-patient care before inpatient care and short-stay care before full-time in-patient care",
- Improving social security for carers who are not employed in order to promote willingness to provide care at home and to recognise the great commitment of carers who often give up their job fully or partially because of caring,
- Helping the care infrastructure to be expanded and consolidated, and to promote competition between service providers.

[1] The Long-term care insurance system is the same over all parts of the country.

The LTCI covers not all expenses caused by long-term care giving. All insurance benefits are capped. The aim was to provide an insurance covering the basic long-term care needs, but not all.

Eligibility criteria

Benefits are available for all insured persons depending on the extent of the need of care, but irrespective of age, income or wealth. Since July 2008 it takes two years to qualify for benefits (before 2008 five years). In legal terms, the "need of long-term care" refers to those people who, owing to a physical, psychological or mental disease or handicap, require a significant or major amount of help to carry out the daily and recurring activities of everyday life over a prolonged period of time, most likely for a minimum period of six months. The entitlement to claim benefits is based on whether the individual needs help with carrying out at least two basic activities of daily living (ADL) and one additional instrumental activity of daily living (IADL). Three levels of dependency are distinguished depending on how often assistance is needed and how long it takes a non-professional care-giver to help the dependent person.

- Care level I: People who need assistance with personal hygiene, feeding or mobility for at least two activities from one or more areas at least once a day and additional need help in the household several times during the week for at least 90 minutes a day with 45 minutes accounted for basic care.
- Care level II: People who need assistance in at least two basic ADL at least three times a day at various times and additional help in IADL several times a week for at least three hours a day with two hours accounted for basic care.
- Care level III: People who need assistance in at least two ADL around the clock and additional help in IADL several times during the week for at least five hours per day with four hours accounted for basic care.
- Hardship cases: People in care level III in particular individual cases who need assistance in ADL for at least seven hours a day with at least two hours during the night or who need basic care that can only be provided by several people together (at the same time).

Available services

The Long-term care insurance predominantly provides assistance benefits for domiciliary care, in an effort to enable beneficiaries to remain at their home and their family context for as long as possible. People in need of care are entitled to receive benefits from the insurance funds since April 1995 for care giving at home and since July 1996 also for care giving in institutions if they need help in personal care and by housekeeping to a substantial degree. The various forms of long-term care services offered under German legislation include benefits for care giving at home in cash and in kind, in day or night care institutions and in nursing homes (Table 1). Additional counselling for people in need for care and their relatives will be provided as well as training courses for family care givers. The benefits are set by law. Beneficiaries may choose between different benefits and services.

People in home care can choose between in-kind benefits for community care and cash benefits. Cash benefits are given directly to the dependent person, who can choose to pass the cash on to a family (or other informal) carer, but the use of cash benefits is at the beneficiary's discretion – given that care giving is guaranteed. To improve the quality of care giving recipients

of cash benefits have to call for a professional care giver twice a year for review. The result will be reported to the LTCI funds. In case of community care the bills are covered by LTCI funds up to a fixed amount. Cash and in-kind benefits may be combined. If a family care giver is on vacation, the LTCI will cover the expense of a professional carer for a period up to four weeks – up to a ceiling of 1470 Euro(as of 1.7.2008, and 1510 in 2010). Additionally, LTCI funds pay pension contributions of informal carers who provide care 14 hours a week or more and are not employed or work less than 30 hours a week.

In general, all benefits are capped or given as lump sums. In nursing homes expenses are only co-financed. The LTCI funds reimburse care giving costs up to a fixed amount; the so called hotel costs (board and lodging) are not covered. Uncovered costs have to be paid by the people in need of long-term care themselves. Co-payments may be quite substantial, particularly if an average monthly amount of about 376 Euro for investment costs has to be added. This is the case if they are not covered by the provinces, the Federal Länder.

Funding

Social long-term care insurance is funded by means of salary deductions of income-based insurance contributions. The contribution rate is set by law. Since July 2008 the contribution rate is a uniform 1.95% of income subject to contributions. Additionally, members aged 23 years and older without children have to pay a surcharge of 0.25% (since January 2005). Before July 2008 the contribution rate was 1.7%. Dependent children and spouses, whose monthly income does not exceed the contribution threshold, are insured without contributions as part of family insurance. There is comprehensive financial balancing between the long-term care insurance providers.

Private mandatory long-term care insurance is financed within the context of the capital covering method. Fixed by law (Social Code Book XI, § 110), the services of private mandatory long-term care insurance correspond to those of social long-term care insurance, in particular there are no health checks and children must be insured without contributions. The premiums in private mandatory long-term care insurance are not based on the income of the insured person, but on the age of the person when the contract was taken out. Insurance companies have agreed financial balance among each other.

Costs for long-term care giving not covered by the LTCI funds have to be paid by the recipients themselves. Sometimes co-payments can be substantial and people in need of care who are not able to cover these costs can apply for means-tested social assistance.

The Länder have the responsibility for financing investments in premises for long-term care services. Regulations vary greatly among the 16 provinces. Some Länder directly finance investments in nursing homes, while others only provide subsidies for dependent older people living in nursing homes who rely or would otherwise rely on social assistance.

Beneficiaries

In 2007 around 2.25 million people received benefits form the private and social long-term care insurance funds. This was 2.73% of the total population in Germany. Around 1.86 million recipients were 65 years old and older. Thus, 11.3% of the elderly population received benefits for long-term care.

The need of care is strong related to age. While only 2.6% of people aged 65 to 70 received benefits, the share increases sharply in higher ages: 4.9% of the 70-75 old, 10% of the 75-80 old, 20% of the 80-85 old, 37% of the 85-90 old, and 62% of the people age 90 and older. The share of people in need for highly intensive care (care level III) is highest in the younger age-groups, but the share rises again in the very old ages. Two out of three beneficiaries are women. Caused by the higher life expectancy of women the share of female beneficiaries is with some 80% highest in the oldest age-group.

Additionally, some 3 million people are estimated to be in need of help mostly with household chores, but not fulfilling the eligibility criteria to receive benefits from the LTCI funds.

1.2 Assessment of needs

The Medical Advisory Service of the Statutory Health Insurance Funds performs the assessment to determine whether an individual is entitled to benefits. For private LTCI, Mediproof, a private company, carries out this task.

Fifteen Medical Boards nationwide conduct in-home assessments for the Statutory LTCI funds (at home or in nursing homes). These assessments are done primarily by geriatric-trained nurses and physicians, who observe both the home and social environment of the person in need of care and assess their health and functional status on the basis of national standards. The detailed guidelines for assessment procedures and assessment standards are specified and drawn up by the Medical Board and these rules are agreed by all involved parties, nationwide the same and binding (MDS 2006).

Individuals are assessed for limitations in activities of daily living, such as bathing and dressing, and instrumental activities of daily living, such as shopping and cooking, as well as hours of care needed per day. These assessments have focused largely on physical needs for personal care, nutrition, and mobility rather than on needs for supervision or cueing, which persons with dementia or learning disabilities often need.[2] The new LTCI reform changed this situation. People whose competence in coping with everyday life is considerably impaired will be assessed on the basis of a special criteria catalogue. If applicants fulfil the criteria they can receive additional benefits, and also such people who do not fulfil the criteria for care level I are entitled to receive benefits (MDS 2008a).

[2] The assessment process focuses currently on the level of limitations in personal care: washing, to take a shower, bathing, dental care, combing, shaving, defecation, urination; in nutrition: bite-sized preparation of nutrition, ingestion; in mobility: moving in and out the bed, dressing, moving, standing, climbing up the stairs, leaving and moving back to the home, as well as on the level of limitations in IADL: shopping, cooking, cleaning the dwelling, washing the dishes, washing and cleaning and ironing the closes, heating (MDS 2006).

The assessment does not focus on income or assets, but on the family situation and the home environment. Therefore, the "stresses in caring and the stress-bearing capacity" of informal carer are assessed and, if possible, help is offered to them as well, such as measures to improve the home environment. In accordance with the principle that rehabilitation services should be available before LTC services, the assessment encompasses also options for rehabilitation, including the need for medical equipment and technical aides.

The result of the assessment will be reported to the LTCI fund and the applicant receive a written report from their insurance fund. In the report the needed care services and the intensity of care needed (classification of care level) will be stated as well as the option of care giving at home or the requirement of care giving in institutions. The applicant can reapply to the medical unit for reassessment of the reported disability level. This is also the case if their functional status changes. In general, the assessment will be repeated in a required time interval appointed in the assessment notification.

1.3 Available long-term care services

General

The available benefits from the LTCI funds are fixed by law (Social Code Book XI). They are the same for the private long-term care insurance funds as for the social long-term care insurance funds. They include benefits for home care, institutional care and for informal care givers.

Which services?

Out-patient care benefits have been in place since 1st April 1995, those provided in full-time in-patient care settings entered into effect on 1st July 1996. Currently the following services are available (all mentioned in the Social Code Book XI):

- Benefits in-kind for community care (§ 36)
- Benefits in cash for informal care (§ 37)
- Combination of benefits in cash and in kind (§ 38)
- Respite care at home during a vacation or illness of informal carers (§ 39)
- Medical equipment and technical aides (§ 40)
- Day care and night care (§ 41)
- Short time institutional care (§ 42)
- Full-time inpatient care (§ 43)
- Long-term care giving in institutions for the disabled (§ 43a)
- Benefits for social security of informal carers (§ 44)
- Benefits for carers who take long-term care leave (§ 44a)
- Training courses for family carers and voluntary carers (§ 45)

- Additional benefits for people whose competence in coping with everyday life is considerable impaired (§ 45b)
- Benefits for a personal budget (§ 17)

Additionally insured persons will be entitled to claim individual care counselling provided by the LTCI funds (§ 7a). Disabled persons can apply for benefits from the LTCI funds additionally to the benefits for the disabled (Social Code Book IX).

The provided amount of benefits depends on the care level needed. As of 1.7.2008, benefits in cash for informal care giving accounts up to 215 Euro per month for care level I, up to 420 Euro for care level II and up to 675 Euro for care level III. Benefits for professional home care services are in general higher than for informal care giving. The LTCI funds reimburse costs of home care services up to 420 Euro per month for care level I, up to 980 Euro for care level II, up to 1470 Euro for care level III, and up to 1918 Euro for hardship cases. The same amounts are available for part-time institutional care. For full-time institutional care a lump sum will be provided: for care level I 1023 Euro per month, for care level II 1279 Euro, for care level III 1470 Euro and for hardship cases 1750 Euro. The amount of benefits will increase in 2010 and 2012 (see in detail Table 1).

Who is eligible?

Eligible for benefits are all insured persons, irrespective of age, income or wealth. The period to qualify for benefits is two years (before July 2008 it was five years). Insured persons living in Germany are entitled to all services, persons who are insured in Germany, but livings in another EU country are entitled for cash benefits only. Beneficiaries receive their benefits during vacation outside Germany up to four weeks.

In 2007 around 70 million persons were insured in the statutory health and long-term care insurance system and some 9.4 million people had a long-term care insurance contract with a private LTCI fund. Therefore a small part of the population was not insured and was therefore not eligible to receive benefits form the LTCI system. The reform of the social health insurance from 2008 (Social Code Book V) will lead to a higher coverage of the total population in Germany. As of 1 January 2009 all citizens must have a health insurance and therefore long-term care insurance, because persons with health insurance must have long-term care insurance.[3] Persons not covered by the social health insurance funds have to place a contract with a private insurer at a basic tariff.

The insured persons can apply for benefits from the social or private LTCI funds, if they meet the criteria for “need of care”.

1.4 Management and organisation

In Germany the organisation of health care and therefore long-term care is based on the self-administration. Each health insurance funds has an affiliated care insurance fund. In 2009

[3] With the exception of special groups of beneficiaries of social assistance, in particular disabled, persons receiving “help to care”, “help to subsistence” or basic social care for the elderly.

seven types of statutory health insurance funds and therefore long-term care insurance funds with around 200 single funds exist.[4] They are self-administrating corporations under public law. That means they carry out the legally mandated tasks under government supervision but are organisationally and financially independent. Additionally around 40 private long-term care insurance funds exist. The seven statutory health insurance types are organized into the Central Association of Health Insurance Funds (GKV-Spitzenverband). This central organization also administers the tasks of the Federal Association of Long Term Care Insurance Funds (Spitzenverband Bund der Pflegekassen). Together with the Federal Working Group of Supraregional Social Welfare Agencies (Bundesarbeitsgemeinschaft der überörtlichen Träger der Sozialhilfe), the Confederation of Municipal Authorities' Associations (Bundesvereinigung der kommunalen Spitzenverbände) and the Federal Association of Long-term Care Providers and the participation of the Association of Private Insurance Funds they manage the organisation of long-term care tasks based on self-government. The LTCI funds are mainly responsible for capacity planning, monitoring, the organisation of care provision and the assessment of long-term care, but also for quality control. The contract parties within the framework of providing long-term care (Pflegeselbstverwaltung) must ensure that national quality standards (expert standards) are developed and continually updated.

The LTCI funds have to negotiate the services to be provided and the prices with the care provider. Each care facility is supposed to negotiate its per diem rates for care individually with the LTCI funds, and each facility has its own individual benefit and price structure. The LTCI funds operate collectively, raising potentially buying power.

For home care, provider associations have developed about 20 bundles of care services (e.g. brief morning and evening visits to help with dressing and personal hygiene) that are assigned weights and form the basis for payments for most providers.

The Medical Advisory Board of the Health Insurance Funds will set up guidelines for quality control in institutions and for home care services together with the above mentioned Associations. The Medical Advisory Service will be responsible for conducting quality audits. They include reviews and assessments, but also recommendations for improving quality. Homes will be required to post the last audit at a highly visible location (for example: entry of the nursing home).

1.5 Integration of Long-term care

Long-term care stand beside health care and is almost separated. In the new reform of the LTCI more integration and better coordination between long-term care, medical and social assistance is intended (see also 3.2). As of 1 January 2009, an individual and comprehensive claim to care counselling (case management) will be established. Long-term care support

[4] The seven types are: 1) general local insurance funds organized into the Federal Association of Local Health Insurance Funds (AOK), 2) alternative health insurance funds organized into the Federation of Alternative Health Insurance Funds (vdek), 3) company insurance funds organized into the Federal Association of Company Health Insurance Funds (BKK), 4) guild insurance funds organized into the Federal Association of Guild Health Insurance Funds (IKK), 5) agricultural insurance funds organized into the Central Agricultural Social Insurance Fund (LSV), and 6+7) the Sickness Fund for Miners and Seamen (Knappschaft, since 1.1.2008 including the See-Krankenkasse).

bases are to be established in order to provide people requiring long-term care, and their relatives, with central, local portals through which they can access services (§92c SCBXI). The support base will be a place where referrals can be made and for measures to provide long-term care along with medical and social assistance and support will be coordinated. LTCI funds can conclude contracts with long-term care providers and other partners for integrated care (§92b SCBXI). The new reform supports a better discharge management from hospitals to nursing homes or rehabilitation or home care.

2 Funding

Germany has a mixed public-private system of financing. The public LTCI system is financed through a nationally uniform payroll tax of currently 1.95% of wages shared equally by employer and employees (0.975%), subject to a wage ceiling of 3,600 Euro per month in 2008. Dependents (spouse and children) with incomes below a certain threshold are covered without any additional worker contributions. Retirees have to pay the full contribution rate themselves (from the beginning of 2006). As of January 2005, childless employees aged 23 or older began paying an additional 0.25% of their income, raising their contribution rate to 1.225%. The rationale was that child rearing is "one of the pillars of the viability of social insurance systems, which is being financed as a pay-as-you-go-system"(Schwanenflügel 2006).

Employees which have earned more than on average 4,012.50 Euro per month in the last three years can opt for a private health and long-term care insurance. The mandatory private LTCI funds must offer at least the same level of benefits as the public mandatory LTCI. Premiums are established primarily on the basis of the age at which the individual becomes insured and are the same for men and women (which are different from the calculation of the health insurance premiums and fixed by law). Premiums may not exceed the contribution levels for the public LTCI. Children have to be covered without additional contributions.

As the benefits of the LTCI are capped, co-payments in particular for institutional care are high. Beneficiaries in nursing homes have to pay the so called "hotel costs", room and board, themselves. The charges vary substantially, they averaged about 580 Euro in 2007 (Federal Ministry of Health 2008). Additionally, in some Länder beneficiaries in nursing homes have to pay for investment costs of building and modernizing care facilities. While these capital investments are considered to be the responsibility of the Länder, regulations about the amount of subsidies for such costs vary greatly among the Länder. In practice, these costs have often been passed on to residents, at an estimated average monthly amount of 347 Euro in 2007 (Federal Ministry of Health 2008).

According to the System of Health Accounts (SHA) from Eurostat (2008) in total 1.28% of GPD were spent on long-term care in 2005, the public expenditure accounts for 0.93% of GDP and the private expenditure 0.35%. The statistic of the social LTCI funds provides information about the expenditure on long-term care subdivided by kind of benefits. The expenditure of the social LTCI funds accounts for 18.34 billion Euro in total in 2007. The highest amount was spent on full time institutional care (8.83 billion) together with full-time institutional care for the disabled (0.24 billion). Benefits in cash for people in need of care receiving informal care accounts to 4 billion Euro and the benefits for professional home care services to 2.47 billion (Table 2).

While the benefits for home care services covers the costs for personal care and help with practical duties according to the level of need of care assessed by the Medical Board Services, the benefits for institutional care covers only a part of the total costs of nursing homes. The average costs for nursing homes per month accounts for care level I 1,889 Euros, for care level II 2,322 Euros, and for care level III 2,756 Euros in 2007. The provided lump sums for care giving in nursing homes are lower than the average costs. The LTCI funds covers on average around half of the costs (investment costs not included): 54% by care level I, 55% by care level II, and 52% by care level III.

Beneficiaries who are not able to cover the additional costs are entitled for means tested social assistance. During the year 2007 218 thousand people received social benefits for long-term care additional to the benefits from the LTCI funds, most of them - 209 thousand - were residents in nursing homes. In total some 3.2 billion Euro were spent on social assistance for "help for care" in 2007.

3 Demand and supply of LTC

3.1 Need for Long-term care

In 2007 around 82.2 million people lived in Germany, thereof 16.5 million aged 65 years and older. Thus, every fifth person was in retirement age. In particular in the older age-groups lead the reduction in mortality in the past to a growing number of very old persons. In 2007 around 3.9 million people were 80 years old and older, 1.2 million men and 2.7 million women. According the Eurostat population forecast the population in Germany will decrease to 74.5 million in 2050, while the share of the elderly (65) will increase from 19.8% to 31.7% and the share of the oldest old from (80+) 4.6% to 14%.

The number of people in need of care is hard to quantify. Well known is the number of people receiving benefits from the long-term care insurance funds. But the benefits from the LTCI funds are restricted to persons with substantial impairments in the activities of daily living (ADL and IADL). Therefore, the demand for long-term care giving is greater than the number of recipients of the private and social LTCI funds. Official statistics rely only on the data on the beneficiaries of the LTCI funds (social and private). The need of care of people not fulfilling the eligibility criteria can only be estimated.

The Federal Ministry of Family Affairs, Senior Citizens, Women, and Youth initiated a research programme named "Prospects and constraints of self-contained living of people in need of help and care", in which surveys (in private households and in institutions) were carried out to estimate the total number of people in need of care including those people who do not receive benefits from the LTCI funds. In 2002 the number of people in need of care not receiving benefits from the LTCI funds living in private households was estimated to amount for about 3 million (Schneekloth 2005), in institution for about 45,000 in 2005 (Schneekloth and von Törne 2007).

In 2007 some 2.2 million people received benefits in cash or in kind from the social and private LTCI funds (Table 3).[5] The number of people in need for care can be calculated to amount to 5,1 million people taken the estimation of Schneekloth et al. and the official number of beneficiaries of the LTCI funds into account.

More than two thirds of the beneficiaries (68%) received benefits for care at home by informal care givers or/and professional home care services, 32% lived in nursing homes (Figure 1).

Most of the people in need of care were 65 years and older. In total, around 4 million people aged 65 and older - that are 24 % of the elderly - were in need of help by household chores or of personal care in 2007, thereof 1.9 million beneficiaries and 2.1 million "non-beneficiaries" (Table 4).

The Ageing Working Group carried out a new estimation of the future development of long-term care expenditure (EC/EPC 2009). As basic information they estimated also the number of dependent persons using the SHARE data and/or the EU-SILC data. According to this estimation the number of dependent people amounts to 3.2 million in 2007 and will rise to 5.954 million by 2050. The number of dependent people receiving formal care is estimated to amount 1.589 million in 2007 and to rise to 3.483 million in 2050. The number of dependent people receiving only informal care or no care is estimated to amount to 1.612 million and to rise to 2.471 million by 2050. Thus, the estimation of the AWG is lower than the number of people in need for care estimated by Schneekloth et al.. The difference can be traced back to the number of people who rate themselves as in need of help with practical duties, but are not classified as dependent according the definition used by the AWG.

There is little information about the characteristics of the people in need of care. Detailed information is only available for the beneficiaries of the statutory and private LTCI funds. For this group some additional characteristics like the age-profile and the intensity of care giving can be shown.

Beneficiaries by sex, age-groups and care level

The need for care is strongly related to age. The share of long-term care recipients in population accounts for less than 1% in the younger and middle age-groups (until the age of 55 years), amounts to 1% for people aged 55 to 60 years, 1.6% for people aged 60 to 65 years, and 2.6% for people aged 65 to 70 years. Thereafter the share of people in need of care in-

[5] In Germany two kinds of statistics concerning the number of people in need of care exist. The Federal Statistical Office provides the long-term care statistics based on data provided by the long-term care institutions (nursing homes) and the provider of home care services, as well as on data for the LTCI funds concerning people receiving benefits in cash. This statistic do not include person in special homes for the disabled, receiving additional benefits in kind from the LTCI funds. But people receiving benefits in cash and simultaneously benefits in kind may be counted twice. The second kind of statistics is the statistics of beneficiaries of the social LTCI funds and the statistic of beneficiaries of the private LTCI funds. These two statistics together provide the number of beneficiaries of the private and social LTCI funds. This statistic includes people living in a special home for the disabled if they receive additional benefits from the LTCI funds. The statistics form the Federal Statistical Office and from the LTCI funds differ a little bit in the total number of people in need of care, but in the single age-groups the differences are much higher. This depends on the double counting and the people living in special homes for the disabled. We used for our report the statistics of the Federal Statistical Office.

creases sharply. The proportion accounts for around 5% among people aged 70 to 75, 10% among the 75 to 80 years old, 20% among the 80 to 85 years old, 37% among the 85 to 90 years old, and 62% among the people aged 90 and older (Table 4). The number of beneficiaries has increased by 230,000 people between 1999 and 2007. As this can be lead back almost to the ageing of the population, the share of beneficiaries in population was nearly the same in the age-groups during this period (Figure 2).

The proportion of beneficiaries is higher for women than for men, in particular in the oldest age-groups. Women have a higher life-expectancy, but often the additional years are years in bad health. For example the share of male beneficiaries amounts to 28% in the age-group 85 to 90 and to 39% in the age-group 90 and older, while the share of female beneficiaries was 41% (85-90) respectively 69% (90+) in 2007.

More than half (52%) of the elderly in need of care had substantial impairments in ADL and IADL (care level I), around one third (35%) severe impairments and 12% very severe impairments in 2007 (Table 6). While in 2007 the share of very severe impaired persons was a little bit lower among the elderly than among the beneficiaries in total, the development in the past show a higher dynamic among the elderly. The number of elderly beneficiaries increased in total by 16%, the number of elderly with substantial impairments increased by 29%, with severe impairments by 4% and with very severe impairments by 5% between 1999 and 2007. The increase in total beneficiaries was with 11% (all care levels), 25% (care level I), 0.3% (care level II) and 3% (care level III) lower.

People in need of care wanted to live for as long as possible in their own home, therefore, a great part of the beneficiaries received benefits for care giving at home. In 2007 some 46% received cash benefits and another 22% benefits in kind for home care services. With around 65% (40% cash and 25% in kind) was the share of beneficiaries at home among the elderly a little bit lower compared to the beneficiaries in total, and therefore the share of elderly beneficiaries in institutions a little bit higher (Table 7). In the past (between 1999 and 2007) a shift from home care to institutional care takes place among the elderly.

The causes of need of care are manifold. The main diagnoses constituting the need of care are mental behavioural disorders, mostly dementia, diseases of circulatory system, mostly stroke as well as cancer and diseases of musculoskeletal system. In 2006 some 23% of assessed applicants had mental disorders; another 10% are in need of care caused by stroke (Wagner and Fleer 2007).

Since July 2008 people whose competence in coping with everyday life is considerable impaired (mostly demented people) can apply for benefits from the LTCI funds, even if they do not fulfil the eligibility criteria of care level I. Therefore, the number of long-term care recipients will be higher in the future. The very first results of the second half of the year 2008 show that additional 20.000 people received such benefits for the demented with care level 0 (Wagner et al. 2009).

3.2 Role of informal and formal care in LTC system

Germany LTCI is based on the principle 'Rehabilitation before care giving, care giving at home before institutional care, and short time institutional care giving before full-time institutional care'. Care giving by informal care givers has the priority. Informal carers will be supported by benefits from the LTCI funds. These benefits include respite care, contributions to social security insurance for informal carer who provide care at least 14 hours a week and are not employed or work less than 30 hours a week, training courses and counselling.

3.3 Demand and supply of informal care

Demand

Recipients of informal care at home

Beneficiaries

People in need of care at home can receive benefits in cash for informal carers at home (solely), or benefits in kind for professional home care services or a combination of both. People receiving solely benefits in cash were accounted as people receiving informal care giving. People receiving benefits in kind or a combination of benefits in cash and in kind are accounted as people receiving ambulant care.

In 2007, around 1 million people receive benefits in cash solely, 0.4 million men and 0.6 million women. Three out of four beneficiaries were 65 years old and older. People receiving informal care without the help of professional care services are to a great degree people with (only) substantial impairments in ADL. Two thirds of the elderly receiving informal care had substantial impairments (care level I), 28% severe impairments (care level II) and 6% very severe impairments (care level III) in 2007 (Table 8). The number of elderly receiving cash benefits solely increase by 32,000 between 1999 and 2007. This increase was accompanied by a shift to an on average lower care level, because only the number of elderly with substantial impairments increased (75,000) while the number of elderly with severe (-36,000) and very severe impairments (-7,000) declined.

While the prevalence rates of need of care in total was nearly constant over the period 1999 to 2007, the prevalence rates for informal care giving (solely) decreased in particular in the oldest ages (Figure 3). That indicates that the share of older people in need of care relying on professional home care or institutional care has increased.

The proportion of people receiving care giving at home depends on the living arrangements of the elderly and the availability of informal care givers. The German micro-census, a representative survey covering 1% of all private households, provides information about the family status of people receiving long-term care benefits form the private or social insurance funds (Federal Statistical Office of Germany 2003). Great differences concerning the marital status exist between males and females receiving long-term care at home. Most of the male beneficiaries were married (55%), one fourth was never married and only 17% were widowed. Among the female beneficiaries (like among female population) widowhood is common, 58% are widowed, but only 23% are married (Table 9). This is the result of the differences in life

expectancy between men and women and the fact that in a partnership mostly females are around three years younger than men.

Widowed people are often living alone. From the 530,000 widowed females around 470,000 are living as singles, and around 10% in other households. In total more than half of women are living in a one-person household, among females aged 85 to 90 the highest share of females living alone can be observed, 68% (Table 10). The proportion of women living in a 3-and-more-person-household is higher in the age-group 90 and over than in the age-group 85 to 90. This can be traced back to a removal of females – not able to live alone anymore – into the household of their children. In total, only 22% of female beneficiaries are living in a three-and-more-person- household in 2006, while male beneficiaries are more often living in a two-person-household (53%) or a 3-and-more-person-household (26%). Thus, changes in living arrangements of people in need of care may also be a driver of the shift to professional care giving at home or to institutional care in the past.

Estimated people in need for care without LTCI benefits

Family care is also required for people in need of care with care level 0. Schneekloth and Leven (2003) provide some information about the characteristics of people with care level 0. People in need of care, but receiving no benefits from the long-term care insurance funds are accounted for some 3 million in 2006[6]. They are on average younger than beneficiaries of the LTCI funds. The share of elderly amount to 68% (75% among the beneficiaries) and the share of the oldest old (80 years and older) amount to 30% (see also Table 4).

A high percentage of people in need of help is married (42%), but also widowhood is common (36%). 41 % are living alone, another 40% in a two-person-household, and 11% in a three-person-household. Two thirds are women.

Average hours of care

The people in need of help and personal care were asked how many hours of care they received per week (Schneekloth and Leven 2003). Beneficiaries, who have at least substantial impairments in ADL received on average 36.7 hours care and help per week (Table 11), people who need help and personal care to a lower degree (Care level 0) received on average 14.7 hours of care and help per week. The average hours of care depends on the level of dependency. People with care level I received on average 29.4 hours, people with care level II 42.2 hours and people with care level III 54.2 hours. In particular the supervision of demented people requires more time than the help and personal care of elderly without mental illnesses. On average demented people with care level III received 61.9 hours of help and care in 2002.

Supply

Estimated number of informal care givers

In Germany informal care giving plays a significant role, but the number of informal care givers can only be estimated. Information about the situation of informal care provision and

[6] Estimation by DIW based on the information of Schneekloth and Leven for 2002.

the characteristics of informal carer provides the survey on care giving at home carried out by Infratest in 2002 (Schneekloth and Leven 2003). The study showed that informal care giving activities are often shared between some members of the family. On average, beneficiaries receive help by two informal care givers, people with care level 0 by 1.7 persons. Only one third of people in need of care receive help by one individual person (36%), but 29% have two and 27% have three or more family carer. In view of the number of people in need of care at home (around 1 million without help of professional care givers and 230,000 people receiving benefits in kind and in cash) and additional considering the people in need of help with practical duties (3 million) the number of family members providing any kind of help or personal care can be estimated to amount to 5 to 7 million people. According the European Community Household Panel (ECHP), on average 5% of the population provided help and care to elderly people in Germany in 2001 (Schulz 2004). That is more consistent with the lower estimation of 5 million carer.

Characteristics of the main informal care givers

In most cases the spouse, daughters or daughters in law are responsible for personal care, but also the sons provide help mostly with financial tasks: 28% receive help from their partner, 32% from the daughter or daughter in law, and 10% from their son (main care givers). As care giving occurs in higher ages, and the partner's ranges first as care givers, also the informal care givers are to a significant degree elderly persons. Around one third of informal carers are in retirement age, another quarter is aged between 55 and 65, and around one quarter between 40 and 55 (Table 18).

Care giving is in the majority of cases a full time job and a heavy burden for informal carers. Reconciliation of care giving and work is often hard. Therefore, informal care givers aged 15 to 64 years are to a high degree not employed (people providing help for beneficiaries 60%, people providing help for persons with care level 0 some 50%), and only to a low degree full time employed (19% respectively 32%). The same pictures provides the question if care givers have changed their employment status at the beginning of care giving. Around half of informal carer were not employed as care giving occurs, some 10% (care giving to beneficiaries) respectively 4% (care giving to people in need of help) give up their job, 11% respectively 5% reduced the working time, but 26% respectively 40% continued to work in 2002 (Table 19).

The reconciliation of care giving and employment is a little bit easier if the people in need of care are living in the same household, in the same house or in a short distance to the carer. Whereas beneficiaries on average live in a short distance to their informal care giver (70% in the same house, another 14% in a distance less than 10 minutes), people in need of care living alone show not such a comfortable situation. Only 57% live in a short distance to their informal carer (Table 20).

Available support for informal care givers

Informal care giving will be supported by the LTCI funds with several measures. (1) If an informal carer is ill or on vacation the LTCI funds will cover the expenses of a professional care giver or of another family carer up to four weeks per year up to a ceiling of 1470 Euro in 2008. (2) LTCI funds pay pension contributions of informal carer who provide care 14 hours a week or more and are not employed or work less than 30 hours a week. (3) As of 1 July

2008, relatives of persons requiring long-term care will be entitled to claim long-term care leaves benefits. People employed in companies with at least 15 employees can take leave for a period of up to six months. During this period they will receive no pay, but they will continue to be covered by social insurance. (4) In the event that a relative suddenly requires long-term care, help must be organized quickly. In this case working relatives can take up to ten days leave from work at short notice. (5) Informal carers can receive counselling using the support base or an individual contact person of the LTCI funds. Additional, they are entitled to receive training courses free of charge.

Informal care giving is a hard burden for family carers in particular if they are employed. Thus, a growing part of recipients of informal care engage additional private financed home helpers to disburden the family carer. The number of private financed home helpers is estimated to amount to 100,000 persons in 2008. In particular persons aged 80 and older with substantial impairments in ADL who are living alone engage additional home helpers. Often home helpers from east-middle European countries were preferred; because their wages are lower (Neuhaus et al. 2009). On average they earn between 800 and 1200 Euro and get free board and lodging. The share of illegal employment can not be estimated.

Additional home helpers are mostly engaged for beneficiaries who need supervision around the clock due to mental illnesses. Such arrangements of assistance are seen as an alternative to institutional care.

3.4 Demand and supply of formal care

Demand

Recipients of formal home care services

Around 0.5 million beneficiaries at home (0.15 million men and 0.35 million women) received benefits in kind or a combination of benefits in cash and in kind in 2007. Nearly all persons (90%) receiving benefits in kind were 65 years old and older and therefore on average older than beneficiaries of cash benefits. 60% of the beneficiaries were 80 years old and older. This may be an indicator, that informal care giving to the oldest old is a hard job and informal carer, who are often also in older ages, need the additional help of professional home care services.

Figure 4 shows the share of dependent elderly by age-groups. While in total the prevalence rates remain nearly constant between 1999 and 2007, the proportion of beneficiaries receiving formal home care increased in particular in the older age-groups.

People receiving formal home care are on average more dependent than people receiving only informal care. The share of elderly with care level I is therefore lower than among elderly receiving informal care solely (54% compared to 66%) and the proportion of elderly with severe impairments (36%) and very severe impairments (11%) analogical higher (Table 12). Unlike the development of elderly receiving benefits in cash, the number of elderly receiving benefits in kind increased in all care levels. The number of elderly receiving formal home care increased by 82,000 in total, with an increase of 68,000 in care level I, of 12,000 in care level II and of 1,000 in care level III between 1999 and 2007.

The number of beneficiaries receiving formal home care can be subdivided into people receiving kind benefits solely and people receiving a combination of benefits in kind and in cash. Latter may be an indicator for need of additional help by professional home care services caused by the burden of informal carers. In 2007 around 234,000 people received a combination of benefits in kind and in cash (Table 13). Thus, nearly half of the beneficiaries of ambulant care received this combination of benefits. This share increased between 1999 and 2007 from 37% to 46%.

Concerning the burden of care giving for informal carers (who are mainly the spouses) the share of recipients of a combination of benefits in kind and in cash in all recipients of cash benefits (including those with a combination of benefits) are of interest. The figures show that 1) the share of beneficiaries who receive additional help from professional home care services increases with age, 2) the share increased between 1999 and 2007 in all age-groups, but 3) in particular in the oldest ages. The share of people receiving a combination of benefits is among the oldest old (80+) higher for male than for female beneficiaries (see Table 13).

People receiving care in institutions

Beneficiaries

In 2007 around 710,000 people received benefits for institutional care, thereof 670,000 for full-time institutional care, 15,000 for short-time institutional care, and 23,000 for day care. The number of people receiving night care was with 33 people negligible (Table 14). Thus, nearly all beneficiaries of institutional care are living in nursing homes in 2007 (95%). Most of the people receiving institutional care were 65 years old and older (93%). 69% were 80 years old and older. In view of the higher life expectancy of women the proportion of female beneficiaries in institutions amounts to 80% among the elderly and 85% among the oldest old (80+).

As people in need of care prefer to live in their family environment and in their own home for as long as possible, moving into a nursing home is the last step. A removal into a nursing home is necessary if the beneficiary need care around the clock, if there is no family carer or the care giving to the required degree is not possible. The availability of informal carer is the key for staying at home. People receiving care at home are in general to a higher percentage married compared to people living in a nursing home. Thus, never married or widowed persons have a higher possibility to be institutionalized than married people. Around two out of three men and 90% of women living in a nursing home are widowed or were never married (Table 14).

The absence of informal carers at home is one point for institutionalization; another point is the dependency and the level of care needed. If people are growing older and severity of impairments increases than the care giving burden will rise. At the end of such a process a removal into a nursing home may be necessary. Around 20% of people living in nursing homes have very severe impairments in activities of daily living, which means they need care around the clock (Table 15). The share of hardship cases amounts to 0.5 %. Only one third of beneficiaries in nursing home have substantial impairments. The number of elderly living in nursing homes increased to a higher degree than the number of elderly receiving care giving at home. In total the number of elderly in nursing homes increased by some 137,000, that is to say 26%, thereof 78,000 with substantial impairments (49% increase), 50,000 with severe im-

pairments (21% increase), 16,000 very severe impairments (14% increase) and around 2,000 hardship cases (110% increase) between 1999 and 2007.

The removal into nursing homes takes place mostly in the higher ages, and as mentioned above it is the last alternative. The average age at the time of moving into a nursing home was 81 years in 2007. Therefore, it is not astonishing that one third of institutionalized people (31%) died within the first year living in a nursing home, one out of five in the first six months. On average, the length of stay amounts to 3.4 years, 3.9 years for women and 2.2 years for men (Table 17).

Between 1999 and 2007 the proportion of beneficiaries living in nursing homes in total population increased, in particular in the older ages (Figure 5). In the past the average age at moving into a nursing home has increased, and also the share of people receiving around the clock care raised, but the length of stay declined. The tendency is that people in nursing homes are to an increasing part demented, with very severe impairments in ADL and in very old age. This was mainly driven by the above mentioned determinants.

Persons in need of care not receiving LTC benefits

Infratest carried out a survey in homes for the elderly in 1994 and 2005 (Schneekloth and von Törne 2007). In 2005 nearly all homes for the elderly (97%) were nursing homes with a contract with LTCI funds according the SCBXI. Thus, a high percentage of people living in such institutions were beneficiaries of the LTCI funds (86%). Some 6% were people in need of care and help, but not fulfilling the eligibility criteria of the LTCI (45,000 people with care level 0). But the survey does not provide the characteristics of people in nursing homes subdivided by care level.

Supply

Home care services

Since the introduction of the LTCI in Germany the number of professional home care services show a high dynamic, in particular the number of private home care services. Between 1999 and 2007 the number of home care services increase in total by 700, whereas the number of private companies increased by 1,400 (Table 21). In 2007 in total 11,530 companies provided home care services for 504,230 persons in need of care. The average number of people cared for was 44 per company. Between 1999 and 2007 the average number of people cared for per company increased, thus a tendency to greater service companies exists.

In total around 236,160 people were employed in home care services in 2007. Most of the employees were nurses, followed by home helpers. More than 80% were women (Table 22). The home care services provide not only personal care and home help, but also nursing care. Beside state-approved nurses for the elderly and state-approved geriatric nurses, they employ also registered nurses and auxiliary nurses, but also orthopedists and occupational therapists.

Between 1999 and 2007 the number of employees increased by some 52,000 people, that is to say nearly 30% (Table 23). The highest increase can be seen for in part-time employed people and thereof for people working more than 50% of the normal working time (58% increase).

The home care services provide the agreed service bundle to the people in need of care at home and they will be reimbursed by the LTCI funds up to a fixed ceiling depending on the dependency of the people in need of care and the required services. For an example of the service bundle see Table 24. Common is that all services provide brief and intensive morning/evening toilet, help by eating, help by going out and in the bed or going out and return to the dwelling, but also cleaning the dwelling, washing and ironing the closes, preparing the meals. The bundles and the prices will be agreed between the LTCI funds and the service providers often with duration of more than one year.

New forms of living arrangements

People in need of care will be supported in their desire to continue to live self-determined lives and also supports new form of living such as residential groups. As of July 2008, persons sharing the same residence will be allowed to pool their claims to benefits in kind and to jointly claim benefits for basic care and housekeeping (NSR 2008). By pooling claims to benefits in new residential forms, it will be possible to make use of efficiency reserves. The time that comes free as a result, is to be used by outpatient care services exclusively in the interest of caring for those people in need of care who participate in the pool. But currently residential groups are not wide spread.

Nursing homes

In 2007 11,029 nursing homes exists in Germany with in total 799,059 places. The average number of places per institution amounts to 72.5 (Table 25). Between 1999 and 2007 the number of nursing homes increased by nearly one quarter. While the number of public nursing homes decreased by 15%, the number of private nursing home increased by 40%. Thus, the structure of nursing home providers changed markedly in this period.

In 2007, 573,545 persons were employed in nursing homes, thereof 202,764 in full-time jobs (Table 26). Traditionally most of the employees were women, in particular among nurses, social workers and home helpers. In total 68% were nurses and some 17% home helpers. Nursing homes do not employ doctors. The medical care will be provided by doctors and specialist of the ambulatory health care system.

Between 1999 and 2007 the number of persons employed in nursing homes increased by some 133,000 people, that is to say 30% (Table 27). While the number of full-time employees decreased by 4%, in particular the number of part-time employees working more than 50% of the normal working time increased markedly (by 83%).

On average the expenditure for full-time institutional care including board and lodging range from 63 Euro (care level I) to 91 Euro (care level III) per day in 2007 (Table 28). In these costs investment costs are not included. As the LTCI funds only reimburse the costs to a lump sum which is lower than the average costs, people in need of care have to pay high co-payments. But people who are not able to pay these co-payments can apply for means-tested social assistance. In general a new trend to high quality accommodations can be seen with high monthly prices. These homes compete on the growing number of elderly with middle and high income.

4 LTC policy

Germany has succeeded in creating a comprehensive social network in the area of tension between public welfare, on the one hand, and personal responsibility on the other. This process has its origins in the 19th century when Reich Chancellor *Bismark* organised the first large scale provision of security against life's major crises with the introduction of his social legislation. The health insurance law of 1883, the accident insurance laws of 1884 and those on invalidity and old age provision of 1889, were the beginnings of state social policy (Schwanenflügel 2006). On the 1 January 1995 the long-term care insurance was introduced as the 5th pillar of the social security system. It ensures that the risk of "need of care" is also covered in its own mandatory insurance system according to the principle "long-term care insurance follows health insurance". The individual branches of the social insurance are not subsidiaries of the State, but self-administrated institutions. They organize self-help in a large, solidarity risk community complementing the solidarity of the families by assuming the tasks which are too much for the individual or the family to cope with.

4.1 Policy goals

The main goal of the long-term care insurance is to provide coverage for the risk of dependency, helping the people to mitigate the physical, mental and financial burdens resulting from frailty and dependency. It is supposed only to secure basic provision that usually suffices to cover the expenses of nursing care and hence ensure that, in the majority of cases, those affected no longer depend on social assistance as a result of their need of care. The goal is to provide predominantly benefits for care giving at home to enable beneficiaries to remain at home and in their family for as long as possible. The aim is "rehabilitation care before long-term care, home care before institutional care, short time care before full-time inpatient care". Informal care giving will be supported by the provision of respite care, contribution rates for the social security for those not employed or working less than 30 hours a week, training courses and counselling.

4.2 Integration policy

In general, the long-term care insurance is separated from other social security laws and benefits, like health insurance benefits or social assistance. Before the introduction of the new LTCI reform on 1 July 2008, the several security systems were not sufficiently networked and coordinated with each other. One aim of the reform is to improve the networking, integration and coordination of the relevant systems. Long-term care and health insurance funds will establish long-term care support bases when the Federal Land in question opts for them. The long-term care support bases will combine care counselling with efforts to network various benefits for care, medical assistance and social welfare under one roof. All of the services related to long-term care are to be included, i.e. also social assistance for the elderly and aid for long-term care according to the laws on social assistance. In order to promote the establishment of long-term care support bases throughout the country as rapidly as possible, the long-term care insurance equalisation fund has provided initial funding of 45,000 Euros per support bases and additional 5,000 Euros when volunteers and self-help groups are sustain-

able integrated into the work. In total, the long-term care insurance funds will make 60 million Euros in funding available nationwide by the end of June 2011.

As of 1 January 2009, every person in need of care has a legal claim to help and support through a long-term care counsellor. Counselling for persons in need of care and their relatives will be provided by case managers employed by long-term care insurance funds at a long-term care support bases or through qualified experts. Suitably qualified personnel with professional training and working experience are essential in the complex field of long-term care counselling. Therefore, also training courses (in the fields of social law, nursing science, and social work) will be offered. The Federal Association of Long-term care Insurance Funds has submitted the corresponding recommendations pertaining to both the number and the qualifications of care counsellors.

Furthermore, a better discharge management ensures the seamless transition of patients into outpatient care, rehabilitation programmes or nursing homes. Counselling already begins in the hospital. Especially trained employees of the discharging hospital, for example, will address the problems facing the person requiring long-term care and begin planning further steps together with the person affected, the relatives and the case manager.

Another step forward to more integration is the new §92b Social Code Book XI: Integrated Care: Long-term care insurance funds and care providers (together with other partners) can enter into a contract dealing with integrated care.

4.3 Recent reforms and the current policy debate

The LTCI reform, which entered into force on 1 July 2008, provides tangible and concrete improvements for people requiring long-term care, their relatives, and care givers. The benefits will be gradually increased by 2012, and the circle of those entitled to benefits will be expanded. Informal carer will be entitled to claim long-term care leave benefits. As mentioned above, an individual and comprehensive claim to care counselling (case management) will be established and long-term care support bases will be created. A series of measures will contribute to the improvements of the quality of long-term care in institutions and at home. In order to finance the current steps of the reform, the contribution rate was increased as of 1 July 2008 by 0.25%, i.e. from the previous level of 1.7% (which was unchanged since the introduction of the LTCI system in 1995) to the current level of 1.95% (2.2% for the insured age 23 and older without children).

More financial support

The benefits for home care as well as for institutional care will be increased (see Table 1). Benefits in cash for home care will rise from 215 up to 235 Euro in 2012 (care level I), from 420 to 440 Euro (care level II), respectively from 665 to 700 (care level III). Benefits for professional home care services will be increased from 420 to 450 Euro (care level I), 980 to 1100 Euro (care level II), 1470 to 1550 Euro (care level III), but will remain stable for hardship cases (1918 Euro). The benefits for full-time institutional care will only be increased for people with care level III and hardship cases: from 1470 to 1550 Euro (care level III) respectively from 1750 to 1918 Euro (hardship cases). The government will review the level of

benefits every three years beginning from the year 2014 onwards. They will prove if a further increase is required (SCBXI, §30).

Benefits for people with limited competence in everyday life tasks

People whose competence in coping with everyday life is considerable impaired require more extensive assistance and support than is normally required. As of 1 January 2002 such – mostly demented people – who are cared for an outpatient basis – can apply for additional benefits for care giving, but until July 2008 the amount was limited to 460 Euro per year. This money is intended as compensation for expenditures required for day or night care, short-time care, care provided by an approved long-term care service or for care by approved low-threshold support offers. As of 1 July 2008, the amount has increased: Those affected will receive up to 100 Euro per month (basic benefit) or up to 200 Euros (augmented benefit). People who require a comparatively low degree of general support receive the basic benefit, people with a high degree of support the augmented benefit. The criteria for being accorded to one of these benefits will be determined by guidelines developed by the Federal Association of the LTCI funds. Additionally, and that is new, also people suffering from dementia, but not fulfilling the criteria for care level I, can also apply for these benefits.

Nursing homes will be supported if they want to provide additional supervision and activating activities for demented people. They can apply for benefits to employ additional nurses and nurse assistants for these activities for demented people.

Long-term care leave

With the reform of long-term care insurance in 2008, the reconciliation of family care and work has been improved (Law on Nursing Care Time). People employed in companies with at least 15 employees can take leave for a period of up to six months. During this period they will receive no pay, but they will continue to be covered by social insurance. During the care leave, contributions to pension insurance will be paid by the LTCI fund, as long as the care giver provides care for at least 14 hours per week. Health insurance and long-term care insurance will be covered through the family insurance. If this is not the case, the care givers must voluntarily continue their health insurance coverage by paying the minimum contribution. Upon request, the LTCI fund can reimburse the care givers up to the minimum contribution. In cases of the unexpected occurrence of a special care situation, employees are entitled to stay away from work for a period of up to 10 working days in order to make provisions of the care of a close relative.

New forms of living

Beside the possibility for persons sharing the same residence to pool their claims to benefits in kind, the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth supports innovative new forms of living, for example the so called “more generation houses”. The Ministry provides 3 million Euro for 30 projects in this field.

Long-term care support bases and counselling

The long-term care support bases will serve as an initial portal for people seeking help. The support bases will provide help to people in need of care and their relatives. A case manager

will coordinate the required measures to provide long-term care along with medical and social assistance and support. The LTCI funds will establish such support bases when the Land in question opts for them. As of 1 January 2009, LTCI funds will be required to provide comprehensive counselling and support through qualified experts in a support bases or elsewhere.

Improving the quality of care

The long-term care reform takes steps to improve the quality and the quality control of long-term care in institutions and in outpatient care. The reform includes the development of expert standard, which have to be continually updated. The standards are expected to concretely define what is generally recognised as the current state-of-the-art in term of medical and nursing care on a variety of topics and provide support, certainty, and practical expertise for professional care givers when performing everyday tasks.

The frequency of quality assurance audits of outpatient and inpatient care will be increased. As of 2011, audits will be carried out each year. In the meantime every facility will be inspected once until the end of 2010. The audits take place without previous notice. The inspections will be carried out by the Medical Advisory Services of the Health Insurance Funds. They focus on the physical state of the person in need of care and the effectiveness of the care and support measures. The underlining guidelines have to be regularly adapted to the newest innovations in medical and nursing care so that the most recent scientific findings in terms of appropriate patient care play a role in the inspection.

The results of the audits must be published in a manner that is easily understandable and consumer friendly. Homes will be required to post the last audit results in a highly visible location. An easily understandable assessment system will be developed, so that the public can recognise “at a glance” whether or not a facility provide good quality care. It was decided to introduce an assessment system according to the school grade, e.g. from “very good” to “poor”.

Recipients of benefits in cash have to call for professional carer to review the activities in personal care and the situation at home: beneficiaries with care level I and II have to call for review twice a year, beneficiaries with care level III every quarter. The aim is to ensure, that due to the review and counselling informal care giving at home are of good quality, and to support informal carer. The costs will be covered by the LTCI funds. If a recipient does not call for a review, the level of benefits can be shorten or as a last step suspended.

Increasing voluntary activity and civic engagement

Self-help groups and volunteers make an important contribution to caring people in need of care. Through the promotion of involvement in civil society with regard to care, a “new culture of helping” will be furthered. Volunteerism will thus be enhanced to an even greater extent that in the measures already anchored in the law. The long-term care reform will increase the support for low-threshold support offers up to 25 million Euros per year. Low-threshold support offers include such measures as groups that provide supervision, day care and helper’s circles, which offer relief for hours at a time to relatives who provide care. Together with co-financing provided by the Länder and municipal governments, this results in a total of 50 million Euros per year now being made available. In addition, the expenses incurred by volunteers can also be taken into consideration in remuneration for long-term care facilities.

Prospects for the future: New definition of the concept of being in need of care.

Deficits in the provision of long-term care are often related to the definition of "need of care". In particular in view of the situation of people with cognitive impairments, who often need special advice and support, the definition of "need of care" will be changed. Thus, a new assessment procedure has been tested and the first results have been published in January 2009 (Federal Ministry of Health 2009). It is planned that the criterion for assessing the need of care will not be the time needed to provide care, but rather the degree of independence in performing activities, coming to terms with aspects of everyday life or in individual settings. The new assessment method includes six modules. Every module includes several items:

- Mobility: locomotion about short distance and dislocation of the body
- Cognitive and communicative abilities
- Modes of behaviour and psychological problem areas
- Ability to care for oneself
- Dealing with the demands of illness and therapy
- Performing of activities of daily living and maintaining social contacts

The result of every of the six modules will be consolidated to one points score. The resulted value leads to one of the new five care levels (low, considerable, severe, very severe, hardship cases). A study on the impact of the new assessment system on the structure of care recipients in nursing homes shows, that the new assessment process will lead to a shift to a higher care level (Rothgang et al.2009). But these are only the first results.

4.4 Critical appraisal of the LTC system

The long-term care reform was a step forward, but this step is not enough to ensure the financial sustainability in the long run. In view of the increasing number of the elderly in particular the oldest old who experience often multi-morbidity and mental illnesses new ways of long-term care provision are required. This requires among other things more flexible living arrangements. As the experience in Denmark shows the preventive home visits may reduce the probability that elderly at home receive no help or the needed help to late. Thus, preventive home visits can help to reduce the share of people with severe or very severe disabilities and may save money.

Additional, the interchange between home care and care giving in institutions has to strengthen as well as the connection between the acute care sector and the long-term care sector. In particular the transition from a hospital into care giving at home or care giving in nursing homes has to be improved. The family doctor has to be involved in this system.

The new definition of the concept of being in need of care has to be enforced as soon as possible.

Another problem is the expected shortage of nurses, in particular of qualified nurses, but also other care giving staff. To meet the increasing demand on nursing staff the standing of this profession has to strengthen and the payment has to increase to be more attractive.

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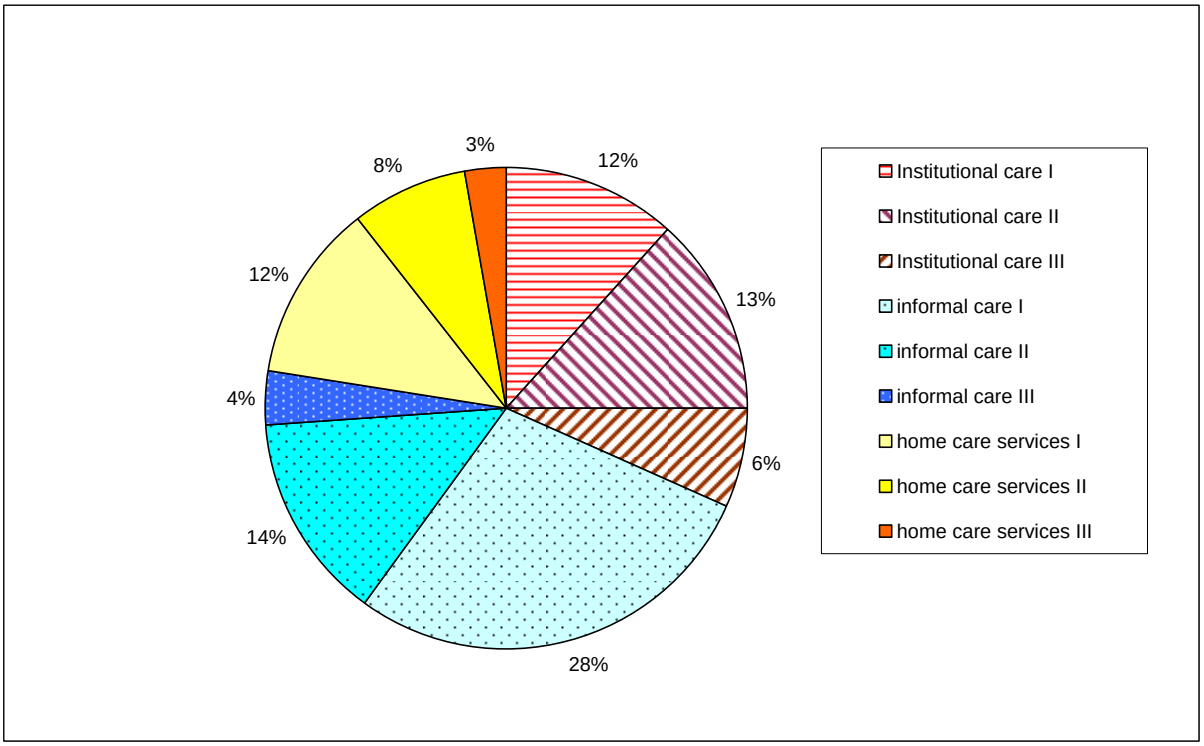
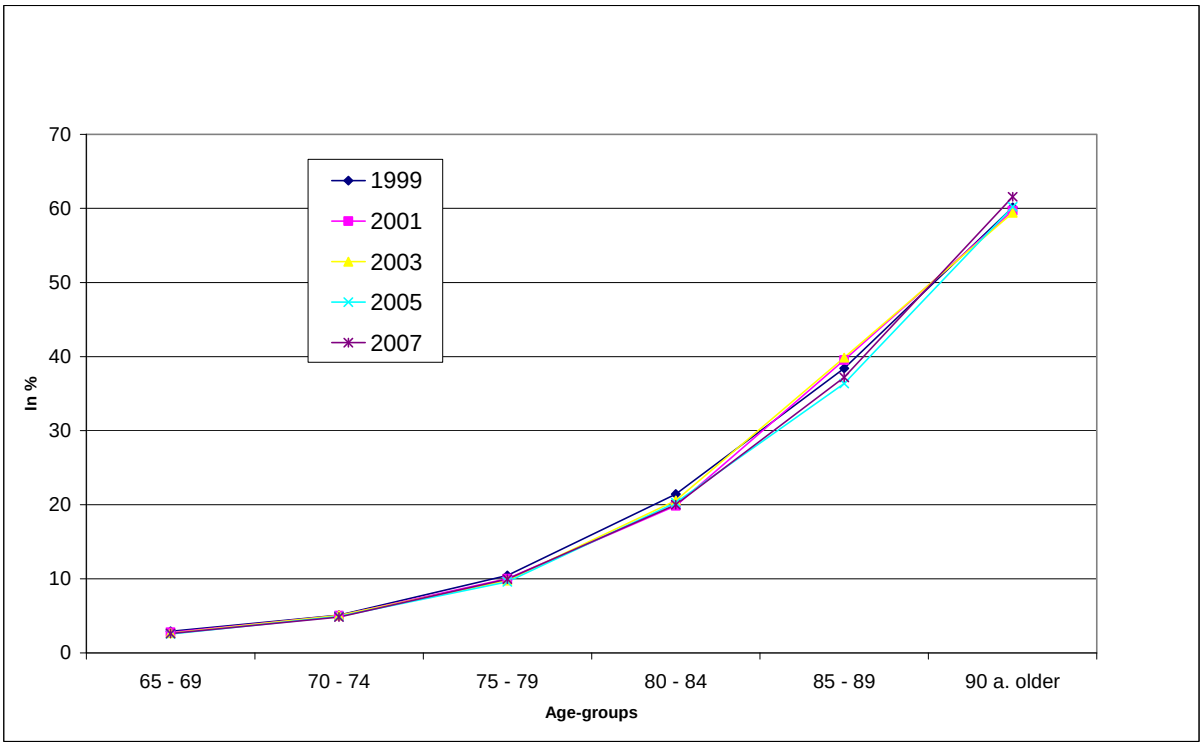
Figure 1
Beneficiaries of the Long-term care insurance funds by care level in 2007



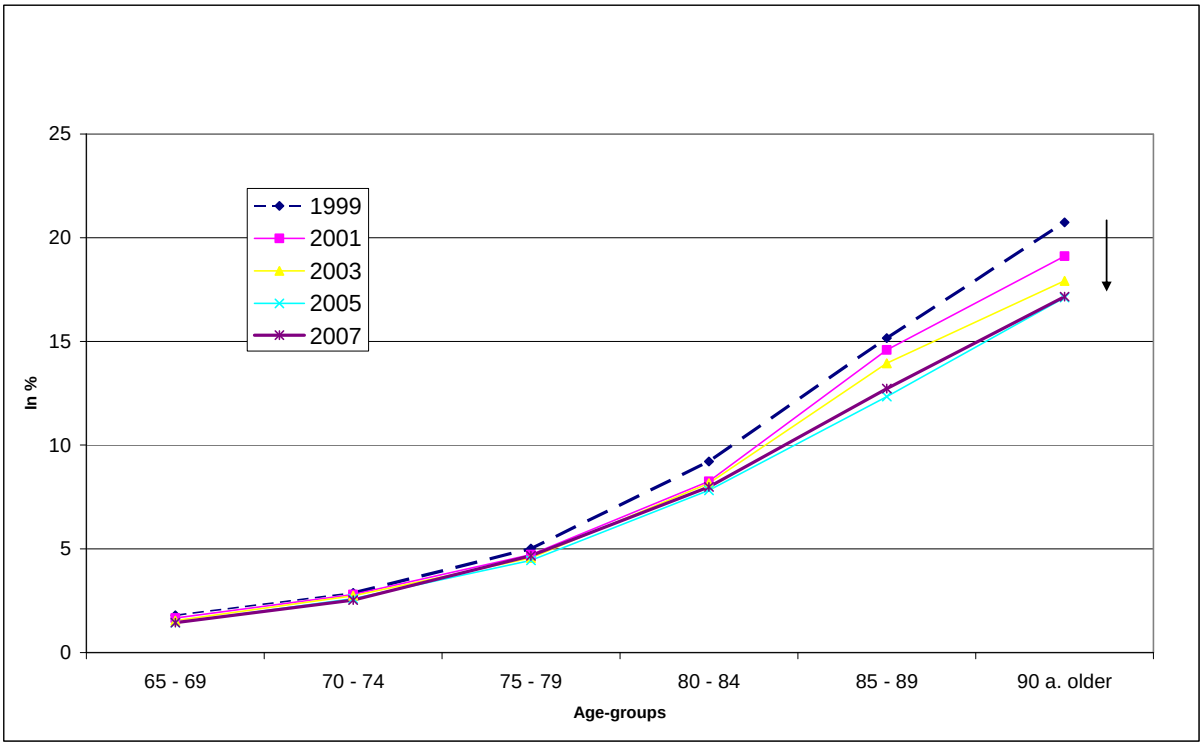
Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Figure 2
Share of long-term care recipients in total population by age-groups in Germany 1999 to 2007



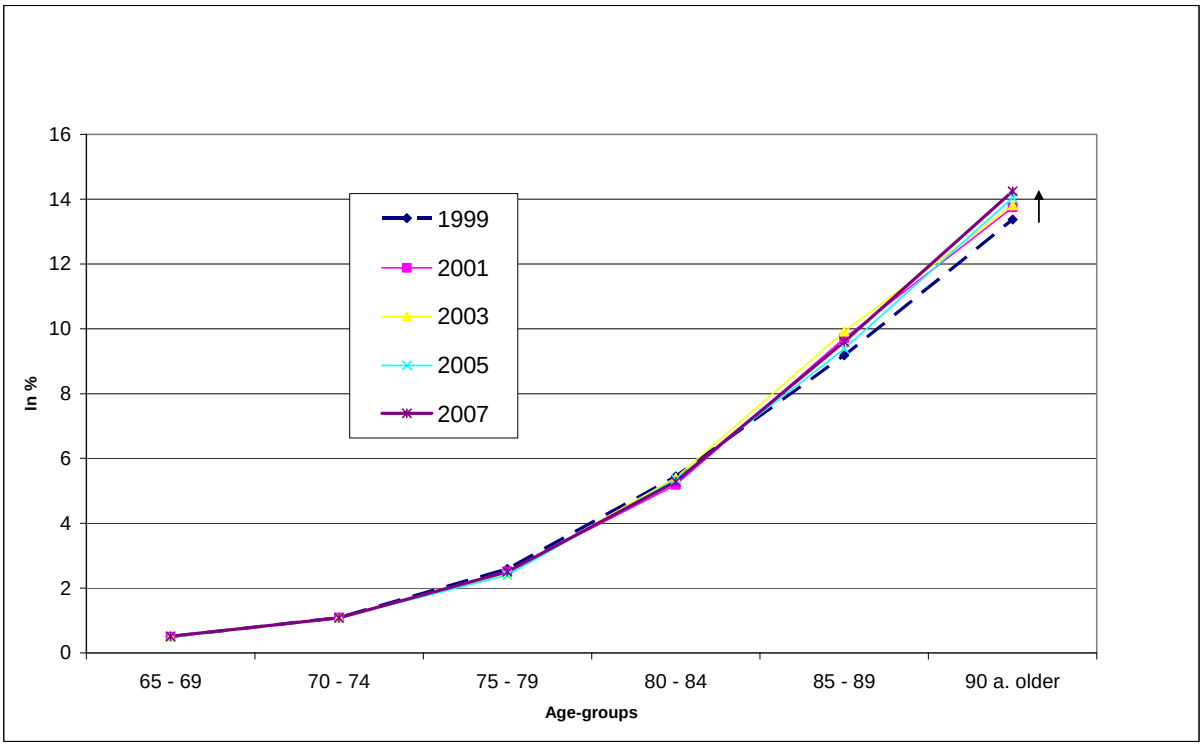
Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Figure 3
Share of recipients of benefits in cash in total population by age-groups 1999 to 2007



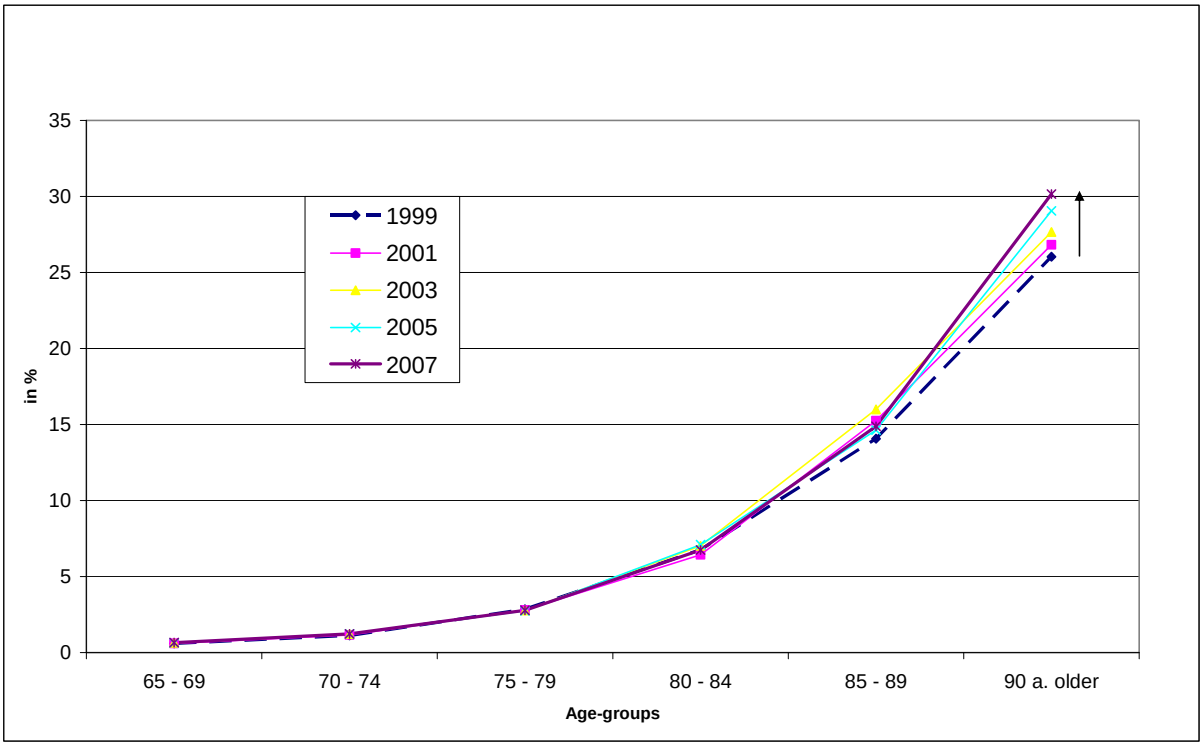
Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Figure 4
Share of beneficiaries of professional home care services in total population by age-groups 1999 to 2007



Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Figure 5
Share of beneficiaries in institutions in total population by age-groups 1999 to 2007



Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 1

Benefits provided by the Long-term care insurance scheme

		previously	As of 1.7.2008	2010	2012
Home care	*Care allowance*	up to per month in Euro			
Benefits in cash	Care level I	205	215	225	235
	Care level II	410	420	430	440
	Care level III	665	675	685	700
	Care Assistance	up to per month			
Benefits in kind	Care level I	384	420	440	450
	Care level II	921	980	1040	1100
	Care level III	1432	1470	1510	1550
	hardship cases	1918	1918	1918	1918
Respite Care	up to four weeks per year up to ...				
by near relatives 1)	Care level I	205	215	225	235
	Care level II	410	420	430	440
	Care level III	665	675	685	700
by other persons	Care level I to III	1432	1470	1510	1550
Short-time care	up to four weeks per year up to ...				
	Care level I to III	1432	1470	1510	1550
Part-time institutional care	up to ... per month				
	Care level I	384	420	440	450
	Care level II	921	980	1040	1100
	Care level III	1432	1470	1510	1550
Supplementary benefits for people with consi-derable genral need for care	up to per year				
	Care level I to III	460	1200	1200	1200
			2400	2400	2400
Full-time institutional care	lump sum per month				
	Care level I	1023	1023	1023	1023
	Care level II	1279	1279	1279	1279
	Care level III	1432	1470	1510	1550
	Hardship cases	1688	1750	1825	1918
Care provided in full-time institutions for the disabled	long-term care expenses amounting to	10% of the fee for the institutional care, but not more than 256 Euro per month			
Consumable aids	up to per month	31 Euro			
Technical aids		mostly provided by a loan basis, otherwise cost coverage 90%, 10% co-payment up to 25 Euro per item			
Measures to improve the living invironment	up to per measure	2557 Euro, considering a reasonable co-payment			

Table 2

Development of the long-term care expenditure of the social LTCI funds 2001 to 2007(billion euros)

Revenues/Expenses	2001	2002	2003	2004	2005	2006	2007
Revenues							
Contributions	16,56	16,76	16,61	16,64	17,38	18,36	17,86
thereof							
Contributions to LTCI	13,66	13,57	13,30	13,28	13,98	14,94	14,44
Contributions to equalisation funds	2,90	3,19	3,31	3,36	3,40	3,42	3,42
other revenues	0,25	0,22	0,25	0,23	0,12	0,13	0,16
Total	**16,81**	**16,98**	**16,86**	**16,87**	**17,49**	**18,49**	**18,02**
Expenses							
Expenditure for benefits	16,03	16,47	16,64	16,77	16,98	17,14	17,45
thereof							
benefits in cash	4,11	4,18	4,11	4,08	4,05	4,02	4,03
benefits in kind	2,29	2,37	2,38	2,37	2,40	2,42	2,47
respite care	0,11	0,13	0,16	0,17	0,19	0,21	0,24
day/night care	0,07	0,08	0,08	0,08	0,08	0,09	0,09
additional benefits for mentally ill		0,00	0,01	0,02	0,02	0,03	0,03
short time institutional care	0,15	0,16	0,16	0,20	0,21	0,23	0,24
Contributions to social security of informal carers	0,98	0,96	0,95	0,93	0,90	0,86	0,86
Medical equipment and technical aids	0,35	0,38	0,36	0,34	0,38	0,38	0,41
Full-time institutional care	7,75	8,00	8,20	8,35	8,52	8,67	8,83
Full-time institutional in homes for the disabled	0,21	0,21	0,23	0,23	0,23	0,24	0,24
Half of the costs for the services of the Medical Board	0,25	0,26	0,26	0,27	0,28	0,27	0,27
Administration expenses	0,57	0,58	0,59	0,58	0,59	0,62	0,62
Other expenses	0,02	0,01	0,06	0,07	0,00	0,00	0,00
Total	**16,87**	**17,36**	**17,56**	**17,69**	**17,86**	**18,03**	**18,34**

Source: Federal Ministry of Health.

Table 3

Beneficiaries of the social and private LTCI funds 1999 to 2007

Year	Total	Men	Women
	All ages		
1999	2.016.091	631.822	1.384.269
2001	2.039.780	641.881	1.397.899
2003	2.076.935	662.893	1.414.042
2005	2.128.550	690.272	1.438.278
2007	2.246.829	728.946	1.517.883
	65 years and older		
1999	1.610.643	412.390	1.198.253
2001	1.645.951	428.445	1.217.506
2003	1.689.687	452.455	1.237.232
2005	1.751.243	485.274	1.265.969
2007	1.861.304	528.406	1.332.898

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 4

Characteristics of people in need of care with care level 0 at home in Germany 2002

	in %		in %
Gender		**Family status**	
male	34	married	42
female	64	widowed	36
		divorced	5
Age-groups		single	17
under 40	10		
40-64	23	**Household Size**	
65-74	26	1 Person	41
75-85	26	2 Persons	40
85 and older	16	3 Persons	11
		4 + Persons	8

Source: Schneekloth and Leven 2003.

Table 5

Proportion of people in need of care by age-groups in 2007 (%)

Age from ... up to under ... years	Total	Men	Women
Under 5	0,34	0,34	0,33
5 - 10	0,67	0,71	0,62
10 - 15	0,65	0,69	0,62
15 - 20	0,53	0,55	0,50
20 - 25	0,40	0,42	0,37
25 - 30	0,33	0,35	0,31
30 - 35	0,32	0,33	0,30
35 - 40	0,33	0,34	0,32
40 - 45	0,39	0,39	0,39
45 - 50	0,51	0,51	0,52
50 - 55	0,70	0,70	0,70
55 - 60	1,04	1,06	1,02
60 - 65	1,64	1,72	1,56
65 - 70	2,62	2,76	2,48
70 - 75	4,85	4,80	4,89
75 - 80	9,95	8,85	10,75
80 - 85	20,01	15,58	22,23
85 - 90	37,21	27,55	40,71
90 and older	61,56	38,93	68,76
Total	2,73	1,81	3,62
65 and older	11,27	7,61	13,92
80 and older	30,92	21,37	35,01

*) Beneficiaries of the social and private LTCI funds.

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 6
Beneficiaries of the LTCI funds by care level 1999 to 2007

Year	Total	Care level I	Care level II	Care level III	Hardship-cases	Not jet classified
	Number of beneficiaries - all ages					
1999	2.016.091	926.476	784.824	285.264	4.254	19.527
2001	2.039.780	980.621	772.397	276.420	4.407	10.342
2003	2.076.935	1.029.078	764.077	276.126	4.755	7.654
2005	2.128.550	1.068.943	768.093	280.693	5.551	10.821
2007	2.246.829	1.156.779	787.465	291.752	6.556	10.833
	Changes between 1999 and 2007					
Number	230.738	230.303	2.641	6.488	2.302	-8.694
%	11,44	24,86	0,34	2,27	54,11	-44,52
	Share of beneficiaries (all ages) by care level					
1999	100,00	45,95	38,93	14,15	0,21	0,97
2001	100,00	48,07	37,87	13,55	0,22	0,51
2003	100,00	49,55	36,79	13,29	0,23	0,37
2005	100,00	50,22	36,09	13,19	0,26	0,51
2007	100,00	51,48	35,05	12,99	0,29	0,48
	Number of beneficiaries 65 years old and older					
1999	1.610.643	749.379	631.478	213.241	2.117	16.545
2001	1.645.951	801.805	628.536	206.815	2.092	8.795
2003	1.689.687	847.931	627.896	207.387	2.388	6.473
2005	1.751.243	889.077	638.728	214.105	3.134	9.333
2007	1.861.304	970.367	657.942	223.668	4.056	9.327
	Changes between 1999 and 2007					
Number	250.661	220.988	26.464	10.427	1.939	-7.218
%	15,56	29,49	4,19	4,89	91,59	-43,63
	Share of elderly beneficiaries by care level					
1999	100,00	46,53	39,21	13,24	0,13	1,03
2001	100,00	48,71	38,19	12,57	0,13	0,53
2003	100,00	50,18	37,16	12,27	0,14	0,38
2005	100,00	50,77	36,47	12,23	0,18	0,53
2007	100,00	52,13	35,35	12,02	0,22	0,50

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 7

Beneficiaries of the LTCI funds by kind of benefits 1999 to 2007

Year	Total	Cash benefits	Home care services 1)	In institutions
	Number of beneficiaries all ages			
1999	2.016.091	1.027.591	415.289	573.211
2001	2.039.780	1.000.736	434.679	604.365
2003	2.076.935	986.520	450.126	640.289
2005	2.128.550	980.425	471.543	676.582
2007	2.246.829	1.033.286	504.232	709.311
	Share of beneficiaries by kind of benefits			
1999	100,00	50,97	20,60	28,43
2001	100,00	49,06	21,31	29,63
2003	100,00	47,50	21,67	30,83
2005	100,00	46,06	22,15	31,79
2007	100,00	45,99	22,44	31,57
	Number of beneficiaries under 65 years old			
1999	405.448	314.642	40.760	50.046
2001	393.829	302.901	42.156	48.772
2003	387.248	294.936	43.308	49.004
2005	377.307	284.041	44.508	48.758
2007	385.525	288.062	47.917	49.546
	Share of 'young' beneficiaries by kind of benefits			
1999	100,00	77,60	10,05	12,34
2001	100,00	76,91	10,70	12,38
2003	100,00	76,16	11,18	12,65
2005	100,00	75,28	11,80	12,92
2007	100,00	74,72	12,43	12,85
	Number of beneficiaries 65 years old and older			
1999	1.610.643	712.949	374.529	523.165
2001	1.645.951	697.835	392.523	555.593
2003	1.689.687	691.584	406.818	591.285
2005	1.751.243	696.384	427.035	627.824
2007	1.861.304	745.224	456.315	659.765
	Share of elderly beneficiaries by kind of benefits			
1999	100,00	44,26	23,25	32,48
2001	100,00	42,40	23,85	33,76
2003	100,00	40,93	24,08	34,99
2005	100,00	39,77	24,38	35,85
2007	100,00	40,04	24,52	35,45

1) Including beneficiaries at home receiving a combination of benefits in cash and in kind.

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 8

Recipients of benefits in cash (solely) by care level 1999 to 2007

Year	Total	Care level I	Care level II	Care level III
	Number of recipients - all ages			
1999	1.027.591	559.603	370.517	97.471
2001	1.000.736	574.455	336.529	89.752
2003	986.520	588.039	313.820	84.661
2005	980.425	597.751	301.605	81.069
2007	1.033.286	638.846	308.997	85.443
	Changes between 1999 and 2007			
Number	5.695	79.243	-61.520	-12.028
%	0,55	14,16	-16,60	-12,34
	Share of recipients by care level			
1999	100,00	54,46	36,06	9,49
2001	100,00	57,40	33,63	8,97
2003	100,00	59,61	31,81	8,58
2005	100,00	60,97	30,76	8,27
2007	100,00	61,83	29,90	8,27
	Number of recipients 65 years old and older			
1999	712.949	415.099	247.157	50.693
2001	697.835	429.359	222.989	45.487
2003	691.584	441.360	208.393	41.831
2005	696.384	452.903	203.056	40.425
2007	745.224	490.012	211.279	43.933
	Changes between 1999 and 2007			
Number	32.275	74.913	-35.878	-6.760
%	4,53	18,05	-14,52	-13,34
	Share of elderly recipients by care level			
1999	100,00	58,22	34,67	7,11
2001	100,00	61,53	31,95	6,52
2003	100,00	63,82	30,13	6,05
2005	100,00	65,04	29,16	5,80
2007	100,00	65,75	28,35	5,90

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 9

Long term care recipients at home by family status 2003

Age-groups	Family status					
	Total		Never married	Married	Widowed	Divorced
	in 1000	in %				
			Men			
under 25	57	100	100	0	0	0
25-60	91	100	55,3	34,2	1,1	9,4
60-70	85	100	9,7	78,9	5,6	/
70-75	64	100	/	79,7	11,5	/
75-80	68	100	/	74,3	18,4	/
80-85	61	100	/	71,4	25,1	/
85-90	52	100	/	48,9	45,4	/
90 and older	34	100	/	38,1	60,6	/
total	513	100	24,7	55	16,6	3,6
			Women			
under 25	46	100	100	0	0	0
25-60	80	100	44,9	42	3,7	9,4
60-70	80	100	12,5	54,9	24	/
70-75	76	100	/	43,2	40,7	/
75-80	137	100	7,5	32,9	55,5	/
80-85	168	100	4,6	20,7	70,2	4,5
85-90	188	100	5	9,1	82,6	/
90 and older	147	100	/	5	87,4	/
total	922	100	14,2	23,3	57,6	4,9

Source: Federal Statistical Office of Germany, Micro-census 2003, calculation by DIW Berlin.

Table 10

Long term care recipients at home by size of household 2003

Age-groups	Number of persons in the household				
	Total		1	2	3 +
	in 1000	in %			
			Men		
under 25	57	100	/	/	90,3
25-60	91	100	22,4	31,6	46
60-70	85	100	16,4	67,6	16
70-75	64	100	15,7	76,4	/
75-80	68	100	19,8	71,8	/
80-85	61	100	23,7	67,1	/
85-90	52	100	34,6	50,9	14,5
90 and older	34	100	49	40,1	/
total	513	100	21	52,7	26,3
			Women		
under 25	46	100	0	/	93,6
25-60	80	100	16,2	39,5	44,3
60-70	80	100	32,3	54,1	13,6
70-75	76	100	44,8	46,4	/
75-80	137	100	52,5	36,6	10,8
80-85	168	100	61,4	26,4	12,2
85-90	188	100	68,1	13,9	18
90 and older	147	100	65,2	11,7	23,1
total	922	100	51,2	27,2	21,6

Source: Federal Statistical Office of Germany, Micro-census 2003, calculation by DIW Berlin.

Table 11

Average hours of personal care and help with practical duties per week for people in need of care at home in 2002

Average hours per week 1)	Total	With mental illnesses	Without
Beneficiaries of LTCI funds			
Care level I	29,4	31,4	28,1
Care level II	42,2	43,7	40
Care level III	54,2	61,9	46,6
Total	36,7	39,7	33,7
People in need of help			
Care level 0 total	14,7	19,3	13,2

1) From the household self assessed time of care and help.

Source: Schneekloth and Leven 2003; Infratest-Survey 2002.

Table 12

Recipients of benefits in kind at home by care level 1999 to 2007

Year	Total	Care level I	Care level II	Care level III	Hardship cases
			Number of recipients - all ages		
1999	415.289	190.300	165.368	59.621	1.343
2001	434.679	209.613	166.717	58.349	1.396
2003	450.126	224.732	167.558	57.836	1.376
2005	471.543	240.086	172.937	58.520	1.411
2007	504.232	264.527	178.532	61.173	1.603
			Changes between 1999 and 2007		
Number	88.943	74.227	13.164	1.552	260
%	21,42	39,01	7,96	2,60	19,36
			Share of recipients by care level		
1999	100,00	45,82	39,82	14,36	0,32
2001	100,00	48,22	38,35	13,42	0,32
2003	100,00	49,93	37,22	12,85	0,31
2005	100,00	50,91	36,67	12,41	0,30
2007	100,00	52,46	35,41	12,13	0,32
			Number of recipients 65 years old and older		
1999	374.529	175.563	150.905	48.061	497
2001	392.523	193.390	152.268	46.865	488
2003	406.818	207.512	153.105	46.201	471
2005	427.035	221.834	158.310	46.891	532
2007	456.315	244.051	163.178	49.086	640
			Changes between 1999 and 2007		
Number	81.786	68.488	12.273	1.025	143
%	21,84	39,01	8,13	2,13	28,77
			Share of elderly recipients by care level		
1999	100,00	46,88	40,29	12,83	0,13
2001	100,00	49,27	38,79	11,94	0,12
2003	100,00	51,01	37,63	11,36	0,12
2005	100,00	51,95	37,07	10,98	0,12
2007	100,00	53,48	35,76	10,76	0,14

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 13
Recipients of a combination of benefits in kind and in cash at home in 1999 and 2007

	1999			2007		
	Total	Men	Women	Total	Men	Women
Number of people	153.828	48.194	105.634	234.140	78.714	155.426
under 65 years old	14.583	7.058	7.525	22.893	10.696	12.197
65 years old and older	139.245	41.136	98.109	211.247	68.018	143.229
80 years old and older	88.959	22.252	66.707	139.836	37.468	102.368
90 years old and older	23.929	5.149	18.780	33.499	7.234	26.265
Share in beneficiaries of ambulant care	37,04	41,06	35,46	46,43	49,98	44,82
under 65 years old	35,78	36,60	35,04	47,78	44,79	50,74
65 years old and older	37,18	41,94	35,49	46,29	50,91	44,38
80 years old and older	36,80	40,99	35,58	45,53	51,19	43,76
90 years old and older	35,99	38,95	35,25	44,12	48,66	43,02
Share in beneficiaries of benefits in cash solely and of both, in cash and in kind	13,02	10,91	14,28	18,47	16,45	19,70
under 65 years old	4,43	3,95	5,00	7,36	6,75	8,00
65 years old and older	16,34	15,64	16,65	22,09	21,25	22,51
80 years old and older	18,37	20,19	17,83	25,01	26,52	24,49
90 years old and older	18,83	21,88	18,14	26,82	30,13	26,03

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 14
Beneficiaries by kind of institutional care in 2007

Age-groups	Total	Full-time institutional care	Short-time institutional care	Day care	Night care
Total	709.311	671.080	15.002	23.196	33
Men	171.624	159.462	4.439	7.706	17
Women	537.687	511.618	10.563	15.490	16
Aged 65 and older	659.765	624.085	14.102	21.547	31
Men	142.756	131.862	3.967	6.912	15
Women	517.009	492.223	10.135	14.635	16
Aged 80 and older	487.600	464.951	10.009	12.624	16
Men	74.789	69.637	2.260	2.885	7
Women	412.811	395.314	7.749	9.739	9

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 15

Long term care recipients in institutions by family status 2003

	Family status					
Age-groups	Total		Never married	Married	Widowed	Divorced
	in 1000	in %				
				Men		
under 25	/	100	/	0	0	0
25-60	15	100	81,2	/	/	/
60-70	24	100	41,3	/	/	30,8
70-80	32	100	26,4	29,3	36,1	/
80-90	37	100	/	31,5	54,1	/
90 and older	17	100	/	/	62	0
total	126	100	28,9	22,1	37,8	11,2
				Women		
under 25	/	100	/	0	0	0
25-60	11	100	/	/	/	/
60-70	22	100	38,5	/	38,8	/
70-80	86	100	19	11,3	63,5	/
80-90	219	100	13,1	4,1	78,9	4
90 and older	130	100	12,4	/	82,1	/
total	469	100	16,2	5,1	73,1	5,4

Source: Federal Statistical Office of Germany, Micro-census 2003, calculation by DIW Berlin.

Table 16

Long term care recipients in institutions by care level 1999 to 2007

Year	Total	Care level I	Care level II	Care level III	Hardship cases	Not jet classified
	Number of recipients - all ages					
1999	573.211	176.573	248.939	128.172	2.911	19.527
2001	604.365	196.553	269.151	128.319	3.011	10.342
2003	640.289	216.307	282.699	133.629	3.379	7.654
2005	676.582	231.106	293.551	141.104	4.140	10.821
2007	709.311	253.406	299.936	145.136	4.953	10.833
	Changes betweeen 1999 and 2007					
Number	136.100	76.833	50.997	16.964	2.042	-8.694
%	23,74	43,51	20,49	13,24	70,15	-44,52
	Share of recipients (all ages) by care level					
1999	100,00	30,80	43,43	22,36	0,51	3,41
2001	100,00	32,52	44,53	21,23	0,50	1,71
2003	100,00	33,78	44,15	20,87	0,53	1,20
2005	100,00	34,16	43,39	20,86	0,61	1,60
2007	100,00	35,73	42,29	20,46	0,70	1,53
	Number of recipients 65 years old and older					
1999	523.165	158.717	233.416	114.487	1620	16545
2001	555.593	179.056	253.279	114.463	1604	8795
2003	591.285	199.059	266.398	119.355	1917	6473
2005	627.824	214.340	277.362	126.789	2602	9333
2007	659.765	236.304	283.485	130.649	3416	9327
	Changes betweeen 1999 and 2007					
Number	136.600	77.587	50.069	16.162	1.796	-7.218
%	26,11	48,88	21,45	14,12	110,86	-43,63
	Share of elderly recipients by care level					
1999	100,00	30,34	44,62	21,88	0,31	3,16
2001	100,00	32,23	45,59	20,60	0,29	1,58
2003	100,00	33,67	45,05	20,19	0,32	1,09
2005	100,00	34,14	44,18	20,19	0,41	1,49
2007	100,00	35,82	42,97	19,80	0,52	1,41

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 17

Length of stay of people living in nursing homes 1994 and 2005 (%)

Length of stay	1994			2005		
	Total	Men	Women	Total	Men	Women
up to 6 month	18	18	20	22	17	29
6 to 12 month	11	9	12	9	8	17
1 to 2 years	10	12	7	15	14	16
2 to 3 years	11	10	13	10	10	9
3 to 4 years	12	8	24	11	11	9
4 to 5 years	10	10	9	10	11	6
5 to 10 years	14	15	12	16	19	7
10 years and more	14	18	3	6	9	4
no answer				1	1	2
Average in years	4.7	5.2	2.9	3.4	3.9	2.2

Source: Schneekloth and von Törne 2007, nursing home surveys 1994 and 2005.

Table 18

Characteristics of informal care givers at home in Germany 2002

	Care giving to people with care level			Care giving to people with care level	
	I-III	0		I-III	0
Gender			**Family status**		
male	27	30	married	69	78
female	73	70	widowed	12	8
			divorced	5	4
Age-groups			single	12	10
under 40	11	13			
40-54	27	26	**Activity status**		
55-64	27	23	Full time employed	19	32
65-79	26	28	Part time employed	15	15
80 and older	7	4	Marginally employed	6	3
NA	3	6	Not employed	60	50

Source: Schneekloth and Leven 2003.

Table 19

Impact of care giving on the employment status of informal carers 2002 (%)

Changes in employment status	Beneficiaries on LTCI funds		People in need of help (care level 0)	
	1991	2002	1991	2002
At the beginning of care giving ...				
not employed	52	51	45	48
employed and carer				
give up the job	14	10	5	4
reduced working time	12	11	5	5
continue to work	21	26	44	40
No answer	1	2	2	3

Source: Schneekloth and Leven 2003; Infratest-survey 2002.

Table 20

Living place of main informal carer in 2002

People in need of care live in	Distance to people in need of care	
	total	living alone
Same household	62	0
Same house	8	20
a distance up to 10 minutes	14	37
a distance up to 30 minutes	5	14
a longer distance	3	7
no private helper	8	21

Source: Schneekloth and Leven 2003.

Table 21
Professional home care services and number of people cared for

	1999	2001	2003	2005	2007
	Number of home care services				
Private	5.504	5.493	5.849	6.327	6.903
Charitable	5.103	4.897	4.587	4.457	4.435
Public	213	204	183	193	191
Total	10.820	10.594	10.619	10.977	11.529
	Number of people cared for				
Private	147.804	164.747	184.754	203.142	228.988
Charitable	259.648	261.365	257.564	259.703	265.296
Public	7.837	8.567	7.808	8.698	9.948
Total	415.289	434.679	450.126	471.543	504.232
	Number of people cared for per care service				
Private	26,9	30	31,6	32,1	33,2
Charitable	50,9	53,4	56,2	58,3	59,8
Public	36,8	42	42,7	45,1	52,1
Total	38,4	41	42,4	43	43,7

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 22
Staff in home care services 1999 to 2007

Years/Employees	Total	Men	Women
1999	183.782	27.377	156.405
2001	189.567	26.579	162.988
2003	200.897	26.295	174.602
2005	214.307	26.429	187.878
2007	236.162	29.330	206.832
		2007	
Management	14.859	2.494	12.365
Nurses	163.580	17.011	146.569
Home helpers	33.140	3.195	29.945
Administration	12.349	2.834	9.515
Other	12.234	3.796	8.438

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 23
Staff in home care services by working time 1999 to 2007

Year	Total	Full-time	Part-time	more than 50%	less than 50%	marginal	Other
2007	236.162	62.405	167.479	77.762	36.683	53.034	6.278
2005	214.307	56.354	151.138	68.141	35.040	47.957	6.815
2003	200.897	57.510	136.124	60.762	32.797	42.565	7.263
2001	189.567	57.524	123.158	55.008	30.824	37.326	8.885
1999	183.782	56.914	117.069	49.149	28.794	39.126	9.799
	Changes between 1999 and 2007						
Number	52.380	5.491	50.410	28.613	7.889	13.908	-3.521
%	28,50	9,65	43,06	58,22	27,40	35,55	-35,93

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 24
Service bundles of home care services – Example: Selected services in Rheinland-Pfalz in 2007

Service bundles (selected services)	Category	Price (Euro)
Brief morning/evening toilet	Personal care	11.5
Intensive morning/evening toilet	Personal care	16.11
intensive morning/evening toilet with bathing	Personal care	20.71
Bathing	Personal care	13.41
Help with eating	Personal care	11.5
Mobilisation	Personal care	7.14
Help with leaving the dwelling	Personal care	2.66
Heating the dwelling	help with housework	2.58
Cleaning the dwelling (usually daily work)	help with housework	5.21
Ironing	help with housework	7.79
Shopping	help with housework	6.49
Preparing the meals (without meals on wheals)	help with housework	11.70
First visit	help with housework	26.82

Source: Federal Ministry of Health 2008.

Table 25
Nursing homes and places in nursing homes 1999 to 2007

Kind of provider	1999	2001	2003	2005	2007
	Number of nursing homes				
Private	3.092	3.286	3.610	3.974	4.322
Charitable	5.017	5.130	5.405	5.748	6.072
Public	750	749	728	702	635
Total	8.859	9.165	9.743	10.424	11.029
	Places in nursing homes				
Private	166.637	188.025	215.901	245.972	275.257
Charitable	406.705	415.725	431.743	448.888	469.574
Public	72.114	70.542	65.551	62.326	54.228
Total	645.456	674.292	713.195	757.186	799.059
	Places per home				
Private	53,9	57,2	59,8	61,9	63,7
Charitable	81,1	81,0	79,9	78,1	77,3
Public	96,2	94,2	90,0	88,8	85,4
Total	72,9	73,6	73,2	72,6	72,5

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 26
Employees in nursing homes in 2007

Kind of employees	Total	Men	Women
Employees in total			
Total	573.545	87.551	485.994
Nurses	393.772	51.834	341.938
Social workers	22.405	3.600	18.805
Home helpers	102.547	8.331	94.216
Utilities management	15.057	13.847	1.210
Management, administration	31.754	7.448	24.306
Other	8.010	2.491	5.519
Thereof: Full-time employees			
Total	202.764	44.196	158.568
Nurses	148.190	25.527	122.663
Social workers	5.370	1.162	4.208
Home helpers	25.053	4.485	20.568
Utilities management	7.461	7.174	287
Management, administration	14.859	5.190	9.669
Other	1.831	658	1.173

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 27

Employees in nursing homes by working time 1999 to 2007

Year	Total	Full-time	Part-time	more than 50%	less than 50%	marginal	other
2007	573.545	202.764	327.992	184.596	84.666	58.730	42.789
2005	546.397	208.201	296.108	162.385	78.485	55.238	42.088
2003	510.857	216.510	260.733	140.488	71.066	49.179	33.614
2001	475.368	218.898	226.432	120.218	61.843	44.371	30.038
1999	440.940	211.544	198.441	100.897	54.749	42.795	30.955
	Changes between 1999 and 2007						
Number	132.605	-8.780	129.551	83.699	29.917	15.935	11.834
%	30,07	-4,15	65,28	82,95	54,64	37,24	38,23

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.

Table 28

Average per diem rates for long-term care in nursing homes in 2007

Institutional Care	Kind of provider			
	Private	Charitable non-profit	Public	Total
Full-time institutional care	Euros per person per day			
Care level I	41	43	46	43
Care level II	54	58	60	57
Care level III	67	73	74	71
Board and lodging	19	20	19	20
Short-time institutional care				
Care level I	45	50	50	48
Care level II	56	63	60	60
Care level III	68	76	72	73
Board and lodging	19	21	19	20

Source: Federal Statistical Office of Germany, Statistics on long-term care, calculation by DIW Berlin.