Foresight Future of an Ageing Population - International Case Studies

Case Study 8: Long term care insurance in Germany

Foresight Theme: Adapting financial systems

Context

The population of Germany is both declining in size and ageing in its structure.

Since the mid 1970s, the total fertility rate of 1.4 – 1.6 is well below replacement value and net migration rates in recent years have been insufficient to make up the difference. In earlier decades Germany had high levels of net migration which reduced the impact of population ageing and delayed the process of population decline but this has been greatly reduced and, in 2008 and 2009 more people emigrated from Germany than migrated inwards.[1]

People aged 65 and over currently make up about 20% of the population of Germany but this is anticipated to rise to 29% by 2030 and to more than one third (34%) by 2060.[1]

In common with the rest of Europe, later life mortality and overall life expectancy has improved, with life expectancy at age 65 (17.8 years for men and 20.9 years for women) being comparable to that in the UK (18.3 years for men and 20.9 years for women).[2] Healthy life expectancy (years spent in good health) is however less good with, at age 65, men in Germany expecting to spend just 6.9 years in good health (without activity limitations) compared with 10.9 years in the UK and women in Germany at age 65 expecting 7.1 years of good health compared with 11.8 years in the UK.[2]

Unlike the UK, Germany has a history of institutionalised early retirement which has only recently started to reverse. This was due to labour market and welfare state policies aimed to reduce youth unemployment.[3] Involuntary retirement in Germany occurs mainly among those in their 50s. This is due to a high incidence of ill-health-related retirement with involuntary retirement in Germany being largely a male phenomenon, particularly common in larger German firms.[3]

Germany has a tradition of family responsibility for its older population and the construction of long-term care insurance (LTCI) strived to combine universalism, cost containment and ageing in place embedded in family support.[14]

History

Before the implementation of social long-term care insurance, long-term care was covered only for those most in need through the community-based, means-tested programme (Hilfe zur Pflege) which only provided benefits if the recipient had exhausted all private assets and income resources. In addition private care insurance had been available in Germany since the mid-1980s but prior to

[1] German Federal Ministry of the Interior (2012), *Demography Report*

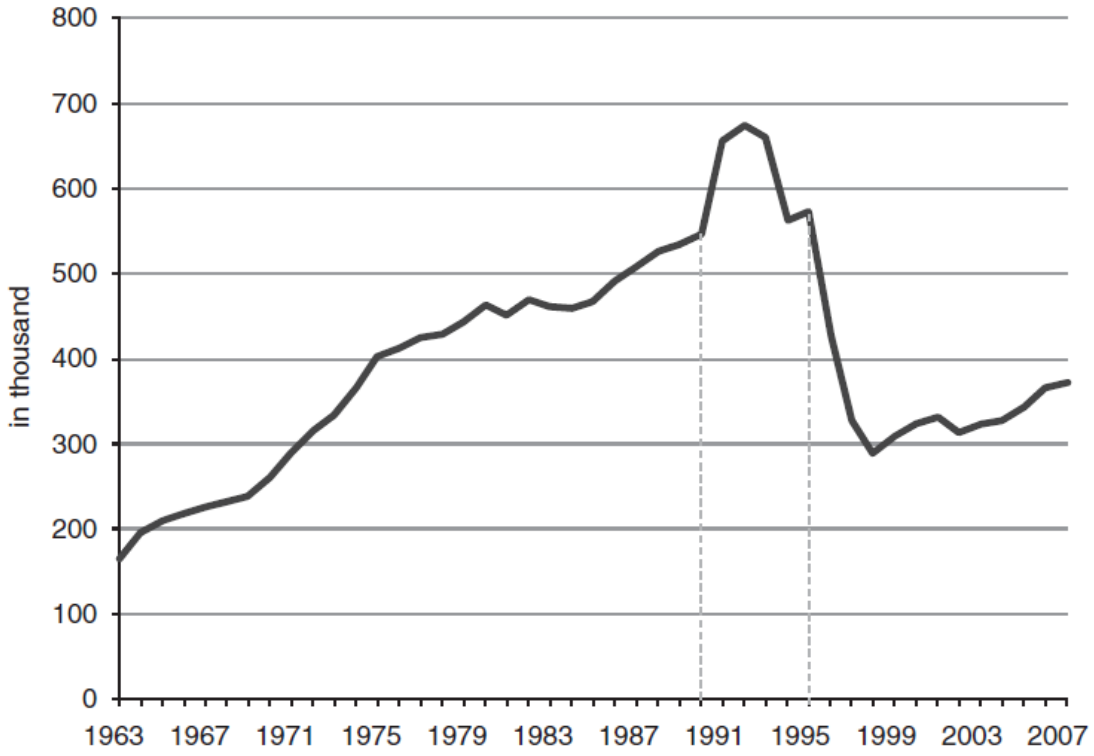
[2] Luijben, Galenkamp and Deeg (2012*) Mobilising the potential of active ageing in Europe: Trends in Healthy Life Expectancy and Health Indicators Among Older People in 27 EU Countries*

[3] Hofäker, Schröder, Li and Flynn (2016), *Trends and determinants of work-retirement transitions under changing institutional conditions: Germany, England and Japan Compared*, Journal of Social Policy, 45,1,39-64

1995 played only a minor role in covering long-term care risk with only 250,000 private contracts purchased.[4]

Most of the chronically ill or older people in need of long-term care were dependent on payments from social assistance. Being 'in need of care' was not explicitly defined and the means-tested benefit was, in most federal states, provided by municipalities.[11] Approximately 80 per cent of nursing home residents financed their care by means-tested social assistance.[4]

Long-term care was a large and increasing financial burden for communities, exacerbated by German Reunification.



Recipients of social assistance for long-term care (Hilfe zur Pflege) 1963–2007 (Statistisches Bundesamt, 2009, Table D7). [From Zuchandke, 2010]

Figure 1

One of the reasons for introducing long-term care insurance in Germany was to reduce the burden on German local authorities of these social assistance payments.

Compulsory long-term care insurance was implemented in Germany in 1995 as the 'fifth pillar' of the social security system (after unemployment insurance, health insurance, pensions and accident insurance) to protect against the financial hardships associated with disability and chronic illness.

Reforms in 2008 included improved guidance and counselling for benefit claimants, the introduction of a new long-term care level "Grade 0" entitling patients with dementia to long-term care benefits

[4] Zuchandke A et al (2010) , *Impact of the Introduction of the Social Long-Term Care Insurance in Germany on Financial Security Assessment in Case of Long-Term Care Need*, The Geneva Papers, 35, 626-643

and the reduction of the period of payments before becoming eligible to claim benefits from five to two years .

Reforms in 2014 and 2015 made a large number of changes including revising the assessment mechanism, improving coverage for people with dementia, introducing an earnings replacement scheme for up to 10 days to allow family caregivers to organise care, introducing rehabilitation benefits to avoid or delay the need for long-term care, improving access to short-term and respite care and improving quality assurance for care services.[5, 6]

Implementation

German social long-term care insurance is a compulsory 'pay-as-you-go' system with contributions, based on salary, split equally between employer and employee. To compensate employers for the additional cost, one German public holiday (the day of repentance) was declared as a working day.[7,8] The contribution rate has since been increased a number of times to meet shortfalls in funding and as the scheme's remit expanded. The initial contribution rate of 1% of salary in 1995 was increased to 1.7% in 1996, 1.95% in 2008 and stood at 2.05% in 2014. As part of the 2014/15 reforms the base contribution rate will rise to 2.35% in 2015 and 2.55% in 2017. In addition employees aged 23 and over who are without children pay an extra 0.25% of salary.

The rationale behind this supplementary payment for adults without children is not to improve the financial viability of the system and that, having fewer family commitments, these employees are better placed to pay extra, but that fundamentally the responsibility for long-term care lies with the family, and adults without children, in the absence of support from their offspring, are more likely to need paid for support from carers outside the family.[9]

Ninety percent of the German population are covered by the scheme, including most employees and their children, retired people and recipients of social welfare and unemployment benefit. Almost all of the remaining 10%, including civil servants, self-employed or employed with a wage income above the social security threshold, are covered by private long-term care insurance (PLTCI). Only about 0.5 % of the German population, for example the homeless, are not covered by any long-term care insurance. Since 2004, pensioners pay the full LTCI rate from their pensions.[7]

Although separate, the German long term care insurance scheme is administered by the pre-existing health insurance funds with administration costs at 3.5% of total expenditure in 2012. [7]

Although German long-term care insurance is essentially a pay-as-you-go system, the 2015 reforms set up a provident fund using 0.1 percentage points of the base rate contribution (1.2bn euros per year) to stabilise the contribution rate from 2035 when 'baby boomers' are expected to need long-term care. [5,6]

[5] http://www.bmg.bund.de/en/long-term-care/the-german-bundestag-adopted-the-first-act-to-strengthen-long-term-care.html
[6] http://www.bmg.bund.de/en/long-term-care/second-bill-to-strengthen-long-term-care.html
[7] Busse R, Blümel M. Germany: health system review. *Health Systems in Transition*, 2014, 16(2):1–296
[8] Heinicke and Thomsen (2010), *The social long-term care insurance in Germany: Origin, situation, threats and perspectives*, Centre for European Economic Research
[9] Forder J and Fernandez J-L (2011), *What works abroad*, LSE and Bupa

Unlike German health insurance, German long-term care insurance is not intended to cover all costs but just basic needs. Recipients of long-term care are expected to make a contribution themselves, or apply for means-tested welfare benefits.[10,11] For example the 'hotel' cost element of residential care is not covered.

Prior to 2015, the level of co-payments made by individuals for the care element of residential care was dependent on the level of care received, a source of worry for those needing the greatest levels of care. The 2015 reforms mean that the co-payments for all nursing-home residents on care levels 2-5 are the same amount.

Anyone with a physical or mental illness or disability, who has made contributions for at least two years (reduced from five years in 2008), can apply for benefits.[12] The German LTC Insurance does not limit the beneficiaries to particular age groups but a need for care of six months or longer has to be established before payments are made.

The provision of long-term care benefits is by application and, each year, around 30% of applications are rejected. In 2011 2.5 million people, (3.1% of the population of Germany) were entitled to benefits from social long-term care insurance. Of these around 70% received care at home and 30% were in residential care.[7]

Assessment is by doctors and nurses mandated by SHI medical review boards, with half of the cost of assessments charged to the state long-term care insurance(SLTCI) fund and half to the state health insurance (SHI) fund. In 2012 the cost of assessment to the SLTCI fund was 0.3 billion euros (1.3% of total expenditure).[7,8]

Initially assessment for benefits was based not on the degree of dependency on nursing care but the estimated time to perform selected care activities. This gave rise to regional variations in eligibility not explained by any epidemiological or demographic factors. The initial assessment tool was also weak in assessing the support requirements of dementia and other forms of cognitive impairment.[13]

A new assessment tool Neues Begutachtungsassessment zur Feststellung der Pflegebedürftigkeit (NBA) was developed and tested[13] and introduced as part of the 2015 reform package.

Six areas of assessment - Mobility; Cognitive and communication skills; Behaviour and mental health; Self-care; Ability to deal with illness/therapy related demands and burdens; and Managing everyday life and social contacts - are independently assessed and weighted (Mobility 10%, Cognition and behaviour 15%, Self-care 40%, Management of illness-related demands 20%, Everyday life and social contacts 15%) to produce one of five levels of dependency. [6,13]

[10] Robertson R, Gregory S and Jabbal J; The Kings Fund (2014), *The social care and health systems of nine countries*

[11] Arntz M and Thomsen S (2010), *The social long-term care insurance: A frail pillar of the German social insurance system*

[12] Blümel M and Busse R (2014) *The German Health Care System, 2014 In: Mossialos et al (Eds) 2014 International Profiles Of Health Care Systems,* LSE and The Commonwealth Fund

[13] Büscher A, Wingenfeld K and Schaeffer D (2011), *Determining eligibility for long-term care - lessons from Germany*, International Journal of Integrated Care, vol 11, May 2011

The amount of care provided depends on the needs of the individual but is limited in value according to the assigned level of dependency and available services included in a pre-defined catalogue.[8]

Benefits received can be not only in kind, in the form of care services, but also as cash payments to the individual to support family carers and others. Except for at the lowest level of care need where, under the 2015 reforms the non-residential cash benefit is set at the same as the amount for residential care, these cash payments are set at a value of roughly 50% of the equivalent benefit in kind.[6, 9] It may be that, while seeking to support family care, this reflects the expectation that the long-term care of family members is a duty for the family.

In 2009, two thirds (65.7%) of beneficiaries living at home chose a cash payment.[14] Cash benefits, in 2012, made up 23% of all SLTCI expenditure on benefits and 50% of non-residential care benefit expenditure.[8]

State service providers are licensed by the SLTCI funds and sign provision contracts, however individuals in receipt of cash payments may purchase their services from any provider.[8]

End-of –life care and hospice care is covered by State Health Insurance and is not within the Long-Term Care Insurance scheme.[12]

Impact

The introduction of long-term care insurance in Germany in 1995 led to an immediate and dramatic fall in social assistance payments by the Lände. [Figure 1]

The introduction of LTCI increased the number of care recipients who were able to stay in their own homes. While 41% of insurance beneficiaries were living with their children in 1997, this dropped to 35% in 2002.[14]

Analysis of data from the German Socio-Economic Panel Study (SOEP) to 2008, shows that the introduction of the German long-term care insurance scheme increased the sense of financial security for people needing long-term care, particularly for those on middle incomes.[4]

Since the introduction of SLTCI in 1995 the number of benefit claimants has increased steadily and, depending on the assumptions made, is estimated to be around 3 million by 2040.[11] The 2014/15 reforms aim to stabilise contributions while accommodating this level of demand.[5,6]

[14] Theobald H (2011), *Long-term care insurance in Germany: Assessments, benefits, care arrangements and funding*