**Task 2017-18 Disability assessment – country report**

Country: Germany

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# Part 1 – Main forms of disability assessment

The forms of disability assessment described below are currently in use in Germany for a variety of purposes. It should be mentioned at the outset that the assessment will change upon implementation of the new disability law, the Federal Act on Participation (Bundesteilhabegesetz).

**Example 1: Assessment for the disabled ID card and the level of disability**

Policy function: Assessment for multiple purposes, including access to disability benefits and eligibility for the disabled ID card; the type and level of disability is relevant for several participation services.

Benefits: Benefits in cash (e.g. pension); benefits in kind (e.g. services); beneficial treatment (e.g. eligibility to apply for quota jobs); discounts or concessions (e.g. tax allowances).

Specificity: Other.

Assessment for multiple purposes.

Responsible authorities: State authorities (office providers).

How to apply: The applicant must fill in an application form, describing their disabilities in detail; usually, an additional document from a doctor must be enclosed.

Type of assessment: assessment of impairments.

Qualifying criteria: type and specific level of impairment.

Method: Documentary evidence.

Assessor: Civil servant + medical expert for the assessment.

Supporting evidence: Evidence from a medical professional.

Decision maker: Civil servant on the basis of the assessment of the medical expert.

Further details of the assessment: The level of disability is established by the medical expert, who summarises the consequences of the disability or disabilities in all aspects of life (private and employment).

Notification of outcome: A letter explaining the outcome.

Appeal possible.

**Example 2: Assessment for individual rehabilitation needs (Ermittlung des individuellen Rehabilitationsbedarfes, §§ 12,13,17 and 19, Social Code Book IX))**

Policy function: Assessment for multiple purposes, including access to various disability benefits and services.

Benefits: Benefits in cash (e.g. pension); benefits in kind (e.g. services); beneficial treatment (e.g. eligibility to apply for quota jobs); discounts or concessions (e.g. tax allowances).

Specificity: Other.

Assessment for multiple purposes.

Responsible authorities: Several departments can be involved (e.g. social welfare bodies, integration offices and health insurance providers).

How to apply: The applicant has to provide information about their impairments and how they affect their level of participation, as well as about the aims of the specific benefits and services and the expected outcomes of meeting these aims (see <https://www.sozialgesetzbuch-sgb.de/sgbix/13.html>).

Type of assessment: assessment of need (e.g. for help / support).

Qualifying criteria: officially, no specific level of impairment is set, as the assessment depends on the person’s actual needs; it has not yet been evaluated how that will work in practice, however, as this is based on a new disability law that has only been in place since 1 January 2018.

Method: Combination of documentary evidence and personal interaction.

Assessor: Medical doctor, therapist (physical, occupational, etc.), other rehabilitation specialist, psychologist, social worker, public official / civil servant.

Supporting evidence: Evidence from a non-medical professional who knows the applicant; a medical note or letter from a doctor who treats the applicant; medical records automatically retrieved from healthcare system (e-health).

Decision maker: Different institutions can make the decision (and they should work together if cooperation is required).

For further details of the assessment, see <https://dejure.org/gesetze/SGB_IX>.

Notification of outcome: A letter explaining the outcome.

No appeal possible.

# Part 2 – Analysis and evaluation of specific assessments

Between 2015 and 2017, two new social laws were passed in Germany, which will influence the design of the assessment in a significant way. These are the Federal Long-Term Care Insurance Act (Pflegeversicherungsgesetz / SGB XI or Social Code Book IX) and the Federal Act on Participation[[1]](#footnote-1) (Bundesteilhabegesetz – BTHG, as part of SGB IX). In particular, the Act on Participation contains a new definition of the term ‘disability’, which is closer to the definition of ‘disability’ in paragraph (e) of the preamble to the Convention on the Rights of Persons with Disabilities (CRPD). This will lead to new methods of examining whether a person is entitled to receive compensation for disadvantages as described in the Act on Participation. The Long-Term Care Insurance Act, which was amended several times between 2015 and 2017, now includes new entitlements for care financed by the German social security system for persons with Alzheimer’s disease, other kinds of dementia and/or intellectual or psychosocial disabilities. So far, it has not been evaluated how the new laws and amendments are influencing the practice of assessing persons with disabilities. It will be very interesting to research whether the views and claims expressed by persons with disabilities and NGOs are being carefully considered (or not) by the competent authorities.

## Case study 1: Disabled ID cards and the level of disability

*(inclusion on a general register, status of disabled person(s) or comprehensive assessment for multiple purposes)*

An outline of the key features of this assessment process is provided in Part 1 of this report (see **Example 1**).

### Detailed description of the assessment process

*The main stages of the process, from application to decision, and appeal against decision, detailing the types of professionals involved and their responsibilities. Please also describe the administrative arrangements and the roles of the different institutions involved in the process. Please indicate what role the person being assessed plays in the procedure.*

Persons who have successfully applied to be assessed as severely disabled get a disability pass and are officially registered by the public support office (Versorgungsamt).

According to the Social Code Book ([Neuntes Sozialgesetzbuch SGB IX](http://www.gesetze-im-internet.de/sgb_9%22%20%5Ct%20%22_blank%22%20%5Co%20%22Die%20Verkn%C3%BCpfung%20%C3%B6ffnet%20ein%20neues%20Browser-Fenster%20...)), disability is defined as follows:

Persons are disabled when their physical functions, cognitive abilities or mental health is or will be limited with high probability for more than 6 months in a way that departs from the typical status of persons of the same age and thus limits their participation in life within society. They are at risk of disability when the impairment is expected to develop in the future.

In Germany, the assessment process is currently changing due to the new Federal Act on Participation (Bundesteilhabegesetz), the provisions of which will be implemented successively during the years to 2023. Thus, several different legal provisions are currently in effect, and the assessment process is changing.

The Social Code Book and the new Federal Act on Participation set out the assessment process. The official recognition of disability after an investigation and a provisional assessment is the central basis on which people apply for specific benefits. The formal procedure and the preconditions are regulated in § 152 of the Act on Participation. The disabled person has to apply for an assessment from the appropriate institution, which must process and respond to this application within a statutory timeframe; procedural provisions are set out in §§ 14ff of the act. Disability is established when the degree of restriction is assessed as being at least 20 %; severe disability is established if the restriction is 50 % or higher. The degree of disability (categorised as the percentage of disability to the nearest 10 %) is assessed on the basis of a medical examination; in the case of multiple impairments, the degree is assessed in regard to the overall consequences. The interaction between the person’s impairments and the limitations they face in daily life is taken into account. A disability assessment is not required if an assessment has already been made for the purposes of a pension approval certificate or a certificate from another competent authority.

In addition to the degree of disability, further details of the person’s specific impairments are recorded in the form of codes in their disability pass, for example by the Rhineland-Palatinate State Office of Social Affairs, Youth and Supply (Rheinland-Pfalz Landesamt für Soziales, Jugend und Versorgung), as follows:

G: difficulty walking;

aG: extreme difficulty walking;

B: accompanying person;

H: helplessness, complimentary transport;

BI: blind;

RF: television and radio charge exemption;

1.Kl: first-class transport;

Gl: deaf;

TBI: blind and deaf.

These codes and their corresponding compensation measures were established by the Ordinance on Passes for Severely Disabled Persons (Schwerbehindertenausweisverordnung, SchwbAwV §§ 1ff, available at

 <https://www.gesetze-im-internet.de/schwbawv/BJNR004310981.html>).

The new regulations under the Act on Participation, to be implemented over the next few years, are changing the preconditions of the assessment. Actual health and participation restrictions are becoming more relevant for the identification of disabilities. Furthermore, persons will be included if they are at risk of experiencing impairments (see Bundesministerium für Arbeit und Soziales, 2017, SGB IX). Persons who are at risk because of an illness or impairment which is expected to continue in the future can apply for a disability pass. In general, the new Act on Participation has changed disability definitions from a medical-oriented model to a model and classification system that is more oriented towards the International Classification of Functioning, Disability and Health (ICF). The old regulations covering mental, physical and cognitive impairments for a timeframe of more than six months have been kept, but the person’s actual health status, level of functioning and participation restrictions are also taken into account. The regulations for employment-related entitlement and benefits have hardly been altered. Persons with at least 50 % disability (or 30 % under certain circumstances) may obtain benefits (see Bundesarbeitsgemeinschaft für Rehabilitation, 2017).

### Sources of official guidance and assessment protocols

*Details of the guidance provided to assessors, methodology used, questionnaires, assessment scales, pro-forma used in the process, etc, with links to sources where available.*

There are several sets of guidelines that have been prepared by the authorities as well as by social associations to assist the assessment process.[[2]](#footnote-2)

The applicant must fill in their personal data and prepare a list of physical, mental and cognitive impairments with a duration of more than six months. Furthermore, medical treatment by doctors in hospitals and rehabilitation measures carried out during the past two years must be listed, as well as information on any use made of nursing care insurance or pension insurance. Any former assessment of disability by other authorities based on health impairment and degree of disability or based on reduction in earning capacity must also be reported in the form. All in all, the questionnaire is quite short and easy to fill in.

A decision is given after about three to four months. The authority (the public support office) requests reports from the attending physician to identify the form and degree of disability. Sometimes, further information regarding the person’s pension insurance or nursing care insurance or information from trade associations can be requested by the authority.

The legal basis for the assessment of the degree of disability lies in the regulations on research-based medicine (Versorgungsmedizin-Verordnung) and the guidelines for research-based medicine (Versorgungsmedizinische Grundsätze, available at [www.gesetze-im-internet.de](http://www.gesetze-im-internet.de/versmedv/BJNR241200008.html)). This is presented as a table of various health impairments with reference values and ranges.[[3]](#footnote-3)

New assessment tables are expected to be developed during the implementation of the Act on Participation, but their impact is not clear yet.

### Implementation and outcomes

*Evidence of the practical implementation, including where possible the number of persons assessed, average waiting times, and the assessment outcomes.*

According to the current statistics, by the end of 2015, 7.6 million persons were registered as severely disabled persons in Germany, which is 9.3 % of the general population.[[4]](#footnote-4) There is some indication from studies that more male than female disabled adults are officially registered.[[5]](#footnote-5)

The authors of this report could not find studies that focus on assessment practices but, in previous surveys, both disabled women and men described problems when authorities refused to recognise severe disability status and/or provide benefits.[[6]](#footnote-6) It would be of great value to evaluate this process scientifically, especially with the implementation of the new Act on Participation.

### Evaluation – fitness for purpose

*Analysis of the strengths and weaknesses of the assessment method, including, where possible, evidence from official or independent evaluations, studies etc. For example, the balance of medical and non-medical input, cost-effectiveness, administrative burden, claimant experience, compatibility with the CRPD. Please indicate if there is a regular evaluation of the assessment method and, if so, who carries that out. Please include references to evaluations which have been carried out.*

All changes and revisions stemming from the new Act on Participation will come into force successively by 2023 (see Bundesministerium für Arbeit und Soziales, 2018). According to the regulations in § 60 of Social Code Book IX (Eingliederungshilfe-Verordnung), new criteria will be formulated for the assessment of disability. The German Ministry of Labour and Social Affairs stressed that the criteria implemented under the Act on Participation are related to nine ICF criteria.[[7]](#footnote-7) One positive development is that the definitions of disability and disability assessment will be changing from a medical-oriented model to a more ICF-oriented model, with a classification system where the person’s actual health status and level of functioning and the restrictions on their participation will also be taken into account.

Because of the current transition, this report can only provide evaluative information on the former assessment practice. Although there is still a medical focus on impairments, that will change due to the new laws.

One of the assessment’s strengths is that it depends not just on the decision of medical experts but also on those of other relevant experts. Enhanced cooperation between several institutions might ease the bureaucratic burden of the procedure. Furthermore, the questionnaire for the disabled person is quite short and easy to fill in.

A problematic aspect of the new Act on Participation is that, from 2023 onwards, inclusion support from the local social services is intended to be restricted to persons who need support in at least five out of nine areas of life as defined by the law. Thus, the eligible population who could be included under the system may be greatly reduced. For example, a visually impaired student who only needs assistance for university lectures or the appropriate technical equipment, but otherwise does well enough on their own, would no longer receive support. This has attracted major criticism from the relevant associations, and these provisions may have to be amended by legislators during the implementation process. Further evaluation will show whether such problems actually arise or will be resolved.

### Promising practice

*If the case study includes examples of good practice, of interest to the EU and other countries, then identify and explain the most promising elements. Please indicate if disabled peoples’ organisations have been involved in developing or evaluating the assessment method.*

It is still unclear whether or not the new Act on Participation will lead to improved assessment practices. Thus, there is no information on good practice available at this time.

## Case study 2: Invalidity pension

(eligibility for invalidity pension, as defined according to the Mutual Information System on Social Protection (MISSOC)).

An outline of the key features of this assessment process is provided in Part 1 of this report (see **Examples 1 and 2**).

### Detailed description of the assessment process

*The main stages of the process, from application to decision, and appeal against decision, detailing the types of professionals involved and their responsibilities. Please also describe the administrative arrangements and the roles of the different institutions involved in the process. Please indicate what role the person being assessed plays in the procedure.*

In Germany, all opportunities that are relevant to the capacity and employability of a severely disabled person must be taken up before that person can be granted an invalidity pension (Deutsche Rentenversicherung Bund, 2017a, p. 17). The social medical service of the pension insurance institution assesses whether retirement can be postponed or prevented by rehabilitation (Deutsche Rentenversicherung Bund, 2017a, p. 17). For example, professional reorientation can help avoid a situation where an insured person has to stop working completely (Deutsche Rentenversicherung Bund, 2017a, p. 11). An application for medical or vocational rehabilitation automatically qualifies as an application for an invalidity pension either if the medical or vocational rehabilitation was rejected because the person’s earning capacity was already reduced on the presumption that rehabilitation would not have a positive effect on the person’s earning capacity, or if the medical or vocational rehabilitation was achieved, but the reduction in earning capacity persists (Deutsche Rentenversicherung Bund, 2017a, p. 18). If severely disabled people who are receiving sickness or unemployment benefits have been asked to apply for rehabilitation by their health insurance provider or by the Employment Agency (Bundesagentur für Arbeit), applicants cannot refuse an invalidity pension without the consent of these social service providers. Otherwise, they will be deprived of sickness or unemployment benefits (Deutsche Rentenversicherung Bund, 2017a, p. 21).[[8]](#footnote-8)

Both the invalidity pension and the old-age pension for people with disabilities come under the various types of pensions regulated in German Social Code Book IV (SGB VI) (Beauftragte a and b). If a person is entitled to an invalidity pension, it always depends on their capacity with regard to all activities in the general labour market.[[9]](#footnote-9) Capacity is determined for each individual concerned by the social security service of the pension insurance institution and is measured as the number of daily working hours that an insured person can work on the general labour market (Deutsche Rentenversicherung Bund, 2017, p. 23). Therefore, in addition to the full invalidity pension, there are also partial pensions. Depending on the source, the partial pension can be received as one third, a half or two thirds of the full pension (Ministerium für Inneres), because it may be assumed that a partial income can still be earned (BMAS, 2017, p. 75f).

In order to be entitled to an invalidity pension, a person is usually required to have a minimum insurance period of five years with three years of compulsory contribution in the last five years before the reduction in earning capacity occurred (BMAS, 2017, p. 76). However, even insured persons whose earning capacity was reduced before the general waiting period of five years and whose earning capacity will be reduced permanently are entitled to an invalidity pension if the special waiting period (minimum insurance period) of 20 years is fulfilled. This legal provision entitles people with disabilities, in particular, to invalidity pensions (Rentenberatung, 2018).

The regulations for insured persons who suffer from lasting health damage due to an accident at work, a commuting accident or an occupational disease are different. Their pensions are paid through accident insurance. In order to be entitled to an accident pension, the person’s earning capacity has to be reduced by at least 20 % and this has to continue for more than 26 weeks after the accident. Accident pensions are calculated according to the reduced earning capacity. Thus, a full or partial pension can be granted (BMAS, 2017, p. 76).

Invalidity pensions differ from old-age pensions in the case of severely disabled persons. An old-age pension is granted to severely disabled people (i) if they have reached the relevant age, (ii) if they are recognised as severely disabled at the beginning of the pension period (with a disabled person’s pass showing a degree of disability of at least 50 % or a notice of performance issued by the pension office (Versorgungsamt), and (iii) if they have built up 35 years of service (Deutsche Rentenversicherung Bund, 2017a, p. 30f). If a severe disability improves after retirement, the retirement pension will not be withdrawn. (Deutsche Rentenversicherung Bund, 2017a, p. 33).

Certain groups of people with disabilities who are considered as particularly worthy of protection are subject to compulsory statutory pension insurance (see Social Code Book VI). This applies to people with disabilities in sheltered workshops, to people with disabilities in other institutions with a set minimum working hours requirement (depending on the economic value of the manufactured product, but 15 hours per week on average), and to people with disabilities in institutions, the aim being to enable people with disabilities to work (Beauftragte c).

Benefits based on projected rights[[10]](#footnote-10) can be granted to claimants if they already depend on an invalidity pension before their old-age pension starts. They will not have paid any contributions for that time (Deutsche Rentenversicherung, 2017b, p. 24). The period of benefits based on projected rights begins once the person’s earning capacity has become reduced (Deutsche Rentenversicherung, 2017b, p. 25). From 2018, it will gradually be extended from the age of 62 to the age of 65 (Deutsche Rentenversicherung, 2017b, pp. 24 and 26). As with the standard old-age pension, the crucial factor is the year of birth of the claimant (Beauftragte, 2018a).

In Germany, different institutions are responsible for severely disabled people if they cannot work or are no longer employed. This is often covered by statutory pension insurance, although other branches of the German social security system can cover the costs. Pension insurance provides participation services and pays pensions for insured persons whose earning capacity is reduced or who are severely disabled. In addition, it compensates for legitimate disadvantages regarding contributions or insurance for disabled people. Accident insurance covers the costs if the disability was caused by an accident at work or an occupational disease (Deutsche Rentenversicherung Bund, 2017a, p. 4), and nursing care insurance is paid if the medical condition requires care. The health insurance organisations, the pension office (Versorgungsamt), the youth welfare offices, the social assistance institutions and the Federal Employment Agency (Bundesagentur für Arbeit) provide services for disabled people, too. Every social benefit institution has its own procedure for assessing the effects of disability in regard to the specific purpose of benefits or compensation (Deutsche Rentenversicherung Bund, 2017a, p. 4).

### Sources of official guidance and assessment protocols

*Details of the guidance provided to assessors, methodology used, questionnaires, assessment scales, pro-forma used in the process, etc, with links to sources where available.*

In the case of medical rehabilitation, the rehabilitation facility will prepare a discharge report once the rehabilitation measures are complete. At the end of these measures, the rehabilitation physician assesses whether and to what extent the insured person can be employed. The discharge report is an important basis for decisions on invalidity pension applications, and it is compulsory to make an application for this type of pension. In the case of reduced earning capacity, the pension insurance institution will, without request, inform the rehabilitation claimant about the possibility of applying for an invalidity pension (Deutsche Rentenversicherung Bund, 2017a, p. 18).

Rehabilitation service providers have set up a nationwide network of joint service centres. Severely disabled people can get advice and help at these centres regarding issues related to their rehabilitation needs caused by their disabilities. The rehabilitation service points (see [www.rehaservicestellen.de](http://www.rehaservicestellen.de)) work across different institutions. They provide applicants with information on the competent payment authorities, contact service providers, advise on possible benefits and receive applications. Other contacts may include the German pension insurance fund (if applicable) or social services, which may be found in hospitals, in rehabilitation facilities, in sheltered workshops for disabled people or in vocational retraining centres (*Berufsförderungswerke*). Integration services play an important role in occupational rehabilitation (Deutsche Rentenversicherung Bund, 2017a, pp. 21-22).

Assistance with applications can be obtained from volunteer workers at the German pension insurance company (Versicherungsälteste), at the insurance offices of municipalities, or from social associations (e.g. Sozialverband VdK, Sozialverband Deutschland or Stiftung MyHandicap). Applicants can also contact a pension consultant.

### Implementation and outcomes

*Evidence of the practical implementation, including where possible the number of persons assessed, average waiting times and the assessment outcomes.*

An invalidity pension is the main source of income for 30 % of people with disabilities. This especially applies to severely disabled people (42 %), rather than those with a degree of disability below 50 % (19 %) or chronically ill people (13 %). Basic income benefits are the main source of income for 15 % of people with disabilities, including 24 % of people with chronic illness, 14 % of people with disabilities and 10 % of people with a recognised disability of below 50 % (Deutsche Rentenversicherung Bund, 2017a, p. 203).

It is estimated that about 1.8 million people currently receive an invalidity pension. This number is growing continuously by 170 000 people each year. On average, people who retire due to reduced earning capacity are only 50 years old. Their pension entitlements are often very meagre. According to a calculation of German pension insurance in western Germany in 2015, the average pension was EUR 763 per month for men and EUR 729 per month for women (Achatz, 2018). According to the *Report on Participation* (*Teilhabebericht*), no gender-specific differences in pensions due to reduced earning capacity can be seen (BMAS, 2016, p. 234). The Federal Ministry of Labour and Social Affairs has provided the information that, in 2015, approximately 1.79 million pensions were pensions for reduced earning capacity. This is an increase of 8 % since 2005. The number of old-age pensions for people with severe disabilities was slightly higher in 2015, at approximately 1.8 million, an increase of 49 % since 2005. This can be explained in particular by the increasing number of women participating in the labour market, leading to more women being eligible for such pensions. However, the absolute figures show that, compared with the number of women, almost twice as many men are entitled to these pensions. One reason may be the long period of service (35 years) that people with severe disabilities require to build up in order to obtain old-age pensions (BMAS, 2016, p. 234).

Der Paritätische, a welfare association, provides some absolute figures. Disabled people who are employed in sheltered workshops and who are entitled to an invalidity pension after 20 years of service will get a monthly pension of EUR 467; after 35 years, this rises to EUR 817. After 40 years of employment in sheltered workshops, a disabled person’s pension would reach EUR 934 per month, only slightly above the current average basic income level of approximately EUR 836. However, because of their limitations, disabled people usually work for less than 40 years in sheltered workshops, meaning that the majority of them will continue to depend on transfer payments after retirement. Thus, at retirement age, a spiral of poverty prevails among the vast majority of employees (mainly women) in sheltered workshops (Arnade and Scheytt, 2017). Finally, according to German pension insurance records, the average monthly invalidity pension did not increase between 2000 and 2016: in 2000 it was EUR 706, in 2005 it was EUR 627, in 2010 EUR 600, in 2015 EUR 672 and in 2016 EUR 697 (Achatz, 2018). In 2016, a single person with a monthly net income of less than EUR 969 was considered to be living in poverty.

### Evaluation – fitness for purpose

*Analysis of the strengths and weaknesses of the assessment method, including, where possible, evidence from official or independent evaluations, studies etc. For example, the balance of medical and non-medical input, cost-effectiveness, administrative burden, claimant experience, compatibility with the CRPD. Please indicate if there is a regular evaluation of the assessment method and, if so, who carries that out. Please include references to evaluations which have been carried out.*

As stated by the Federal Government Commissioner for Matters relating to Persons with Disabilities, the invalidity pension has advantages over other forms of pension, especially with respect to retirement age and deductions (Beauftragte, 2018a). Usually, the deciding factors for invalidity pension are working capacity (hours per day) and the years of employment at the time a person becomes disabled. Changes have been made, however, to meet the needs of young people, for example, who have been affected by a reduction in their earning capacity due to disability. That is why, in some cases, an invalidity pension is granted based on projected rights, the minimum period of insurance (*Wartezeit*) is changed and deductions cannot (unlike other types of pensions) exceed 10.8 %.

According to the *Report on Participation*, participation opportunities partly depend on the stage of life at which impairments arise. If impairments are innate or occur at an early age, participation can be limited at an early stage due to the connection between impairment and unfavourable basic conditions. The social opportunities of child development as well as education and vocational training can then be limited right from the start. This affects access to employment, the level of earned income and social security rights (BMAS, 2016, p. 16). The degree of participation in employment determines the level of material living standards. The acquisition of personal income contributes significantly to material independence and thus to a potentially independent life. In addition, social security rights are acquired through regular work. If people with disabilities do not succeed or only partially succeed in assembling pension entitlements during their working age, they risk poverty in old age if no other assets are available (BMAS, 2016, p. 162).

Der Paritätische stresses that restrictive regulations make it almost impossible for some disabled people in Germany to accumulate wealth. If disabled people receive integration assistance, they need to contribute to its costs. They still have to invest income and assets from a certain amount. As a first step, the allowances increased in 2017. A new procedure is currently being applied (until 2020), which is linked to the income tax law and implies significantly higher exemption limits. At the same time, the income and assets of partners will not be waived before 2020, and the income or assets of children are still used. Thus, children with a disabled parent are more likely to be affected by poverty—they are burdened twice over. Parents (or one parent) with disabilities often earn inadequate wages, as their income is reduced to the standard rate if they are dependent on integration assistance due to their disability. Once their children have grown up and start to work, their income is used to provide social benefits to their parents. As a result, they maintain financial responsibility for their parents throughout their lives and they sometimes experience income restrictions for many years, which can make it difficult to fund their own pension (Arnade and Scheytt, 2017). This means—even with the new exemption limit of EUR 50 000—that solid old-age provision cannot be obtained in such cases (Arnade and Scheytt, 2017).

According to the social association Sozialverband VdK Deutschland (VdK), the topic of old-age poverty, and especially the high risk of poverty in cases of reduced earning capacity, has not yet been adequately acknowledged by politicians. Approximately 15 % of people with disabilities who retired due to reduced earning capacity are already dependent on additional ‘basic income’, as set out in Social Code Book XII (SGB XII, fourth chapter; VdK, 2017). According to the law, adults (i.e. those aged 18 and over) who are in need of help and whose earning capacity is permanently reduced, or who retired at the age of 65 but whose old-age pension cannot support their living expenses, can receive a basic income. (BMAS, 2016, p. 205f). From the point of view of the VdK, it is disappointing that people who have already retired due to reduced earning capacity will not benefit from the planned improvements (VdK, 2017). The i. a. association demands that the pension level should not decrease by more than 48 %. VdK regards the deductions of up to 10.8 % as contrary to the system. They should be waived, since people with reduced earning capacity do not retire voluntarily like people who decide to retire early (VdK, 2017). Accordingly, an essential and long overdue step to avoid disability-related poverty would be to separate participation benefits from social assistance and to create schemes that allow for participation benefits regardless of income and assets (Arnade and Scheytt, 2017).

### Promising practice

*If the case study includes examples of good practice, of interest to the EU and other countries, then identify and explain the most promising elements. Please indicate if disabled peoples’ organisations have been involved in developing or evaluating the assessment method.*

The assessment procedure for retirement pensions has itself been improved. Here, the intensified counselling and support opportunities are an example of promising practice. In particular, the nationwide network of joint service centres set up by the rehabilitation service providers provide people with advice and help regarding their rehabilitation needs caused by their disabilities. The rehabilitation service points, which work across several different institutions, provide applicants with information on the relevant payment authorities, contact service providers, advise on benefits and receive applications.

Furthermore, the new Act on Participation could bring improvements for the assessment process, as disabilities are now to be assessed in regard to concrete limitations and the interaction of impairments with the environment. Nevertheless, it might not be practical simply to count how many aspects of daily life limitations are present. The implementation process has not been fully completed, and practices have not yet been evaluated. Nevertheless, the intensified support for the process of applying for benefits and the improved coordination of state institutions might lead to concrete improvements.

## Case study 3: Assessment for individual rehabilitation needs

(eligibility for long-term care benefits as defined according to MISSOC).

An outline of the key features of this assessment process is provided in Part 1 of this report (see **Example 2**).

### Detailed description of the assessment process

*The main stages of the process, from application to decision, and appeal against decision, detailing the types of professionals involved and their responsibilities. Please also describe the administrative arrangements and the roles of the different institutions involved in the process. Please indicate what role the person being assessed plays in the procedure.*

Statutory care insurance is provided for people who are recognised as needing care and who live at home with home care services. They are entitled either to care benefits for basic care (for body care, nutrition, mobility and other aspects of daily life) and domestic care provided by care services, or to cash benefits for self-procured nursing assistants (usually relatives) (§§ 36 to 38, Social Code Book XI). It is also possible to combine care benefits and cash benefits for self-procured caregivers.

All persons in need of care, regardless of the recognised care grade, are entitled to additional support of EUR 125 per month (§ 45b, Social Code Book XI). This additional support can be used to pay for quality-assured professional services in order to relieve caregiving relatives or others. If care is required due to an impairment under § 1 of the Act on social assistance to war victims (the Federal Pensions Act or Bundesversorgungsgesetz), a care allowance is paid on the basis of § 35 of the act. In addition, the War Victims Fund (Kriegsopferfürsorge) provides care support to its circle of beneficiaries, in accordance with § 26c of the Federal Pensions Act. This benefit is subordinate to the benefits under Social Code Book XI, but it has priority over the care support provided through social welfare under chapter 7 of Social Code Book XII. Social welfare supports persons in need of care with incomes below the income threshold by partly or completely paying the costs associated with their care in so far as they are not carried by the care insurance provider.

As regards outpatient care, a person in need of care must submit an application personally or through a representative with a power of attorney or a care provider. Applicants can and should use their legal entitlement to care advice. The severity of the person’s illness is not decisive, but their actual need for basic care is. Benefits are granted independently of the income of the person in need of care.

Applications for care benefits can be made ‘formlessly’ under the care insurance of the responsible health insurance provider. ‘Formless’ means that they can be made by phone, by email or in writing. However, it is always useful to communicate in writing when dealing with the care insurance provider in order to have documentary evidence should any disagreements arise later.

A new care law (the Care Strengthening Act, or Pflegestärkungsgesetz) has been in force since 1 January 2017, and this has changed several conditions of the assessment. Instead of the previous three care grades, which were related to specific care tasks, there are now five care grades, which relate to the abilities of the person and are thus rather resource oriented. The classification takes place within the framework of the ‘new evaluation assessment’ (*Neues Begutachtungsassessment*). Under the examination procedure, the assessors from the medical service of the responsible health insurance provider (*Medizinischer Dienst* in cases of statutory insurance or MEDICPROOF in cases of private insurance) use a points-based system to determine a person’s ability to master everyday life tasks independently.

When applying for care funds for the first time, a formless application for a care level has to be submitted. The care insurance provider instructs the medical service of the health insurance provider (*Medizinischer Dienst* or MEDICPROOF) to examine the applicant’s independent abilities. The assessor comes into the person’s home to examine them with respect to six review areas (see below) and to form an opinion, which he/she passes to the care insurance provider. On the basis of the assessor’s recommendation and report, the care insurance provider finally decides on the person’s care grade.

The assessment procedure is set out in SGB XI § 15, and in two annexes.[[11]](#footnote-11)

The assessment of care grades is based on an instrument comprising modules for the following six aspects:

1) Mobility: In this module the degree of possible mobility is assessed.

2) Cognitive and communicative skills: This module captures the level of existing skills.

3) Behavioural or psychological problems: With this module, the frequency of occurrence of certain behaviours or mental problems is recorded.

4) Self-care: This module records the degree of independence in personal hygiene, eating and drinking and dressing.

5) Coping with and independent handling of illness-related or therapy-related requirements and burdens: This module measures the average frequency of medical or therapeutic measures per day.

6) Everyday life and social contacts: The module assesses the level of independent administration of everyday life and social contacts.

For each module, categories are listed in Annex 1 for the criteria applying to the various aspects considered. The categories represent different degrees of personal independence or ability. The categories are assigned care-related individual points, as shown in Annex 1.

In each module, the possible totals are determined according to the point ranges defined in Annex 2, reflecting the degree of severity of impairments or the degree of ability, expressed as follows:

Point class 0: No impairment of personal independence or ability;

Point class 1: Minor impairment of personal independence or ability;

Point class 2: Significant impairment of personal independence or ability;

Point class 3: Severe impairment of personal independence or ability;

Point class 4: Most severe impairment of personal independence or ability.

Each point class in a module is assigned weighted points, as specified in Annex 2. The weighted points are based on the severity of impairment and the following weights of the modules (see Annex 2 of § 15 SGB XI and Table X).

At § 18, Social Code Book XI sets out the procedure for determining the need for care (for which there are five grades). The medical service (*Medizinischer Dienst*) or an appointed assessor must examine the insured person in his/her living area. The determination cannot be agreed otherwise.

Within the scope of these examinations, the medical service has to determine the restrictions on the applicant’s activities within the meaning of § 14(4) of Social Code Book XI by carrying out an examination of the applicant, as well as assessing the type, extent and expected duration of the need for care and the applicability of the ‘substantially limited everyday competence’ conditions under § 45a.

The assessment and the decision on the application must be carried out within a period of five weeks after the application. Medical diagnoses or examinations by third parties are not required in order to determine the need for care.

For benefits under § 45a of Social Code Book XI regarding dementia-related disabilities, mental disabilities or mental illnesses (‘significantly restricted everyday competence’), a separate application is not required.

### Sources of official guidance and assessment protocols

*Details of the guidance provided to assessors, methodology used, questionnaires, assessment scales, pro-forma used in the process, etc, with links to sources where available.*

See description in the previous paragraph.

### Implementation and outcomes

*Evidence of the practical implementation, including, where possible, the number of persons assessed, average waiting times and the assessment outcomes.*

In 2014, EUR 12.34 billion was spent on ambulatory and semi-stationary care. Expenditure for out-patient care rose by 55 % between 2007 and 2014)[[12]](#footnote-12) The cost of additional care services was approximately EUR 480 million in 2014. Between 2007 and 2017, the expenses for relief care services rose dramatically, from EUR 30 million to EUR 480 million.[[13]](#footnote-13)

By the end of 2014, approximately 350 000 people had received financial support for care in accordance with Social Code Book XII. Approximately 253 000 people received this benefit when living in care establishments, and approximately 99 000 people who were not living in establishments received it. The number of recipients of care benefits increased by a total of 17 % within five years.

In 2014, the overall gross expenditure for care support in the context of social welfare under Social Code Book XII came to approximately EUR 4 billion (EUR 3.5 billion net)—approximately EUR 0.93 billion for those not in care establishments (23 %) and around EUR 3.08 billion for those living in care establishments (77 %). Since 2008, care spending has increased by 23 %. Here, as with care insurance, the expenses for getting help with care outside of institutions increased by 36 %, considerably more than expenses for care provided within institutions, which rose by 19 %. Thus, the expenses for care assistance have been changing less dynamically than care expenses under care insurance.[[14]](#footnote-14)

### Evaluation – fitness for purpose

*Analysis of the strengths and weaknesses of the assessment method, including where possible evidence from official or independent evaluations, studies etc. For example, the balance of medical and non-medical input, cost-effectiveness, administrative burden, claimant experience, compatibility with the CRPD. Please indicate if there is a regular evaluation of the assessment method and, if so, who carries that out. Please include references to evaluations which have been carried out.*

One of the strengths of the assessment is its focus on limitations and specific needs rather than on impairments. The new Care Strengthening Act that was implemented in 2017 led to higher expenditure on care benefits, but not all groups could benefit and improve their situation in the same way. The act led to partial improvements for elderly people with dementia and ambulatory care needs, as the new assessment includes care needs covering daily tasks for mentally and cognitively disabled persons. Furthermore, the new lowest grade for care assessment now enables people with a lower level of care needs to get benefits in order to prevent further burdens of illness and to enhance their autonomy. However, the new care assessment has the potential to worsen the situation of people with physical disabilities, as their care needs will be downgraded and will not be adequately assessed after the implementation of the new law. For those applicants who received care benefits before 2017, this could be prevented by an early application under their existing arrangements, but for those who apply for the first time from 2017, the amount of care benefits will be lower than they would have been before 2017.[[15]](#footnote-15) Users of stationary care—all people living in sheltered homes—now have to pay a uniform fee, whereas previously this depended on the level of care. This will lead to higher expenditure of up to EUR 500 for persons with lower care levels in sheltered homes.

All in all, the number of persons who receive care benefits has increased since the enactment of the new Care Strengthening Act, but the number of applicants who were declined was still high in 2017. According to an answer from the German Ministry of Health to a parliamentary question from the Left Party, in the first five months of 2017, 20 % of applications were declined. A further 25.5 % of applicants received only the first level of care—EUR 125 per month.[[16]](#footnote-16)

Social associations and NGOs have made the criticism that the new reform would worsen the situation of specific groups. The fact that disabled persons with care needs who live in shared flats should now be paid by the care insurance provider and no longer through social inclusion assistance could lead to a cut in their benefits. Those persons who are cared for on an outpatient basis will now receive less benefit (EUR 266 instead of EUR 1 612, according to calculations made by the Lebenshilfe social association).[[17]](#footnote-17) Together with the cost reservation regulation of the new Act on Participation, the reforms could lead to a reduction in the provision of ambulatory care and an increase in stationary care, in contradiction with the CRPD’s right to a free choice of living conditions. Another consequence of the reform seems to be that elderly persons who live in sheltered homes will get lower levels of care assessment under the new regulations, which leads to less adequate personal arrangements within institutions and thus could actually worsen the care situation for this group.[[18]](#footnote-18)

However, the new reforms and their outcome have not yet been investigated on an independent scientific basis; further independent evaluations and the large-scale disability survey currently being conducted in Germany will provide further detailed knowledge on the actual consequences of the process for specific groups of disabled people.

The reform of care law under the Care Strengthening Act appeared at first sight to be innovative with regard to its aims and the new assessment approach: the assessment of care benefits was intended to relate to resources and people’s ability to live independently, rather than depending on the timing of tasks, as before. Furthermore, the aim of providing care benefits for more people in need of care as well as more support and counselling for caring family members was, in principle, forward-looking. Part of the background to this reform was the high and increasing number of elderly and mentally ill people with care needs and the need to improve both their ambulatory and stationary care. The new Care Strengthening Act is the most far-reaching reform of care assessment since the mid-1990s.

With the implementation of the new care law, the benefits for care in kind increased, but at the same time the care subsidy was cut. Instead of the previous payment of EUR 104 for all persons in need of care and EUR 208 for persons with severe dementia, they will now all receive the same amount of EUR 125.[[19]](#footnote-19)

According to data from the Health Insurance Medical Service (Medizinischer Dienst der Krankenversicherungen, MDK), a higher number of persons who did not receive care benefits through the former assessment would have received benefits in 2017 following the reform (the data gives a rough estimate of 200 000 persons for 2017) due to a high number of persons being assessed for care grade 1. Those with lower grades of disabilities can now benefit from this by enhancing their domestic independence and avoiding, or at least not prolonging, their intensive care needs, for example by using improved technical aids or domestic equipment. For those more severely physically disabled persons who would benefit from being in the former care grades 1 and 2, the reform will lead to reduced care benefits.[[20]](#footnote-20) As explained above, the care situation in sheltered homes will worsen under the reform, as the care benefits for specific groups decrease.

### Promising practice

*If the case study includes examples of good practice, of interest to the EU and other countries, then identify and explain the most promising elements. Please indicate if disabled peoples’ organisations have been involved in developing or evaluating the assessment method.*

It is unclear whether some parts of the reform will provide examples of promising practice—and if so, which—as the consequences are different for the various specific target groups. This has to be proven by further research.

# Summary and conclusion

*Taking an overview of national approaches to disability assessment and including any recommendations. Considering the range of examples identified in Part 1, and the analysis of selected cases in Part 2, please reflect on the extent to which these various assessment systems are integrated (or not). For instance, to what extent are similar application processes, similar assessment methodology, or similar administrative processes used to determine eligibility for different benefits? How could the system in your country become more integrated, cost-effective, or result in an easier applicant journey through the processes? Please also indicate any explicit references to the CRPD in the assessment procedure or whether the CRPD has been taken into account in determining the assessment procedure to be used.*

All in all, the examples of the reforms to the German approach to assessment reveal contradictory results. The attempts to change the assessment procedure based on the terms and contents of the CRPD (resource-oriented and inclusion-based) seem promising, but they will only be cosmetic and superficial as long as persons with disabilities do not get the care benefits, they need and if only certain specific groups can improve their situation while others see their care situation deteriorate. A systematic and independent evaluation of the implementation process is necessary in order to find out whether the human rights of free choice and appropriate care are being realised for all persons in need of care. The Government must improve the applicable regulations and laws in order to genuinely improve the care situation of people in all groups in need of care and to guarantee their human rights in practice. This will be accompanied by higher costs for the state, especially to cover those with greater care needs and those with severe disabilities who prefer ambulatory home care.

However, human rights and adequate care should not be determined by cost arguments, especially not in one of the richest countries of the world.

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# Annex

Table A: Areas and percentages in care grade assessment

|  |  |  |
| --- | --- | --- |
| Area | Share of the total  | Examples |
| Mobility | 10 % | Changing positions in bed, getting up from sitting, climbing stairs, moving inside the living area |
| Cognitive and communicative abilities | 15 % taken together | Recognising people, temporal and spatial orientation, memory, making decisions, understanding information, identifying dangers, engaging in conversation |
| Behaviour/ psychological problems | Motor behavioural disorders, nocturnal restlessness, defence against help, delusions and hallucinations, listlessness, depressive mood, verbal aggression or abnormalities, inadequate behaviour |
| Self-care | 40 % | Body care, dressing and undressing, nutrition, excretion, food intake problems in babies |
| Coping with and independent handling of illness- or therapy-related requirements and burdens | 20 % | Taking medications, injections, cold and heat applications, wound care, remedies for excretion, visits to the doctor, home-based therapy, rubs, oxygenation |
| Everyday life and social contacts | 15 % | Designing the daily routine, resting and sleeping, employment, planning the future, social interaction, cultivating contacts |

From the weighted points of all modules, the total points are to be formed by addition. On the basis of the achieved total points (range 0 to 100 points) persons in need of care are classified in one of the care grades specified in Table B.

Table B: Overview of care grades, assessment points, and benefits (‘up to which’) an insured person is entitled to according to SGB XI[[21]](#footnote-21)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Grade of impairment of personal independence | Care grade 1: Low | Care grade 2: Significant | Care grade 3: Severe | Care grade 4: Worst | Care grade 5: Worst with special care needs |
| Assessment points | 12.5 - <27 | 27 - <47.5 | 47.5 - <70 | 70 - <90 | 90 - <100 |
| Benefit |  |  |  |  |  |
| Care relief services (euros per month) | 125 | 125 | 125 | 125 | 125 |
| Nursing in-kind transfers (euros per month) |  | 689 | 1,298 | 1,612 | 1,995 |
| Alternatively care allowance for home care (euros per month) |  | 316 | 545 | 728 | 901 |
| Subsidy for inpatient care (nursing home) (euros per month)  |  | 770 | 1,262 | 1,775 | 2,005 |
| Services for semi-stationary care (day and night care) (euros per month) |  | 689 | 1,298 | 1,612 | 1,995 |
| Short-term care (euros per year) |  | 1,612 | 1,612 | 1,612 | 1,612 |
| Respite care (euros per year) |  | 1,612 | 1,612 | 1,612 | 1,612 |
| Accommodation adjustment (euros once) | 4,000 | 4,000 | 4,000 | 4,000 | 4,000 |
| Nursing appliances for consumption (euros per month) | 40 | 40 | 40 | 40 | 40 |
| Subsidies to the home emergency call (euros once for the connection costs and euros per month for the operation) | 10.49 and 18.36 | 10.49 and 18.36 | 10.49 and 18.36 | 10.49 and 18.36 | 10.49 and 18.36 |

Annex 1 of § 15 SGB XI gives details on points totals in each module:

Module 1: Points in area 1) Mobility

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no.  | Criterion | [Autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Mostly [autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Predominantly dependent | Dependent |
| 1.1 | Changing positions in bed | 0 | 1 | 2 | 3 |
| 1.2 | Keeping a stable sitting position | 0 | 1 | 2 | 3 |
| 1.3 | Changing seats | 0 | 1 | 2 | 3 |
| 1.4 | Moving inside the living area | 0 | 1 | 2 | 3 |
| 1.5 | Climbing stairs | 0 | 1 | 2 | 3 |

Module 2: Points in area 2) Cognitive and communicative abilities

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no.  | Criterion | Ability / unimpaired | Mostly able | Able to a small extent | No ability |
| 2.1 | Recognition of persons in the immediate environment | 0 | 1 | 2 | 3 |
| 2.2 | Orientation - location | 0 | 1 | 2 | 3 |
| 2.3 | Orientation - time | 0 | 1 | 2 | 3 |
| 2.4 | Remembering essential events or observations | 0 | 1 | 2 | 3 |
| 2.5 | Managing / controlling multi-step everyday activities | 0 | 1 | 2 | 3 |
| 2.6 | Making decisions in everyday life | 0 | 1 | 2 | 3 |
| 2.7 | Understanding of issues and information | 0 | 1 | 2 | 3 |
| Code no.  | Criterion | Ability / unimpaired | Mostly able | Able to a small extent | No ability |
| 2.8 | Recognising risks and dangers | 0 | 1 | 2 | 3 |
| 2.9 | Communicating elementary needs | 0 | 1 | 2 | 3 |
| 2.10 | Understanding prompts | 0 | 1 | 2 | 3 |
| 2.11 | Participating in a conversation | 0 | 1 | 2 | 3 |

Module 3: Points in area 3) Behaviour/ psychological problems

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no.  | Criterion | Never or very rarely | Rarely (once or three times within two weeks) | Frequently (twice to several times a week but not daily) | Daily |
| 3.1 | Motor-influenced behavioural abnormalities | 0 | 1 | 3 | 5 |
| 3.2 | Nocturnal restlessness | 0 | 1 | 3 | 5 |
| 3.3 | Self-damaging and auto-aggressive behaviour | 0 | 1 | 3 | 5 |
| 3.4 | Damaging objects | 0 | 1 | 3 | 5 |
| 3.5 | Physically aggressive behaviour towards other persons | 0 | 1 | 3 | 5 |
| 3.6 | Verbal aggression | 0 | 1 | 3 | 5 |
| 3.7 | Other nurse-relevant vocal abnormalities | 0 | 1 | 3 | 5 |
| 3.8 | Defence of nursing and other supportive measures | 0 | 1 | 3 | 5 |
| 3.9 | Delusions | 0 | 1 | 3 | 5 |
| Code no.  | Criterion | Never or very rarely | Rarely (once or three times within two weeks) | Frequently (twice to several times a week but not daily) | Daily |
| 3.10 | Anxiety / Fears | 0 | 1 | 3 | 5 |
| 3.11 | Listlessness in a depressed mood | 0 | 1 | 3 | 5 |
| 3.12 | Socially inadequate behaviours | 0 | 1 | 3 | 5 |
| 3.13 | Other care-related inadequate actions | 0 | 1 | 3 | 5 |

Module 4: Points in area 4) Self-care

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Mostly [autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Predominantly dependent | Dependent |
| 4.1 | Wash the front torso | 0 | 1 | 2 | 3 |
| 4.2 | Body care in the area of the head (combing, dental care / denture cleansing, shaving) | 0 | 1 | 2 | 3 |
| 4.3 | Washing the genital area | 0 | 1 | 2 | 3 |
| 4.4 | Showering and bathing including washing the hair | 0 | 1 | 2 | 3 |
| 4.5 | Dressing and undressing the upper body | 0 | 1 | 2 | 3 |
| 4.6 | Dressing and undressing of the lower body | 0 | 1 | 2 | 3 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Mostly [autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Predominantly dependent | Dependent |
| 4.7 | Preparation of food and pouring of drinks | 0 | 1 | 2 | 3 |
| 4.8\* | Eating | 0 | 3 | 6 | 9 |
| 4.9\* | Drinking | 0 | 2 | 4 | 6 |
| 4.10\* | Using a toilet or a commode chair | 0 | 2 | 4 | 6 |
| 4.11\*\* | Coping with the consequences of urinary incontinence and dealing with indwelling catheter and urostomy | 0 | 1 | 2 | 3 |
| 4.12\*\* | Coping with the consequences of fecal incontinence and dealing with stoma | 0 | 1 | 2 | 3 |
| Parenteral nutrition |  | Not applicable (regular and daily parenteral nutrition or tube feeding is not required for a period of at least six months or a parenteral nutrition or tube feeding can be done independently without the help of others) | Partly (parenteral nutrition or tube feeding to avoid malnutrition by means of daily and in addition to oral intake of food or liquid) | Completely (ingestion of food or liquid exclusively or almost exclusively parenterally or via a tube) |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Mostly [autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Predominantly dependent | Dependent |
| 4.13\*\*\* | Nutrition parental or via tube feeding | 0 | 6 | 3 |  |
| Children up to 18 months old |  |  |  |  |  |
| 4.K\*\*\* | Serious problems with feeding, which cause an exceptionally care-intensive need for help | 20 |  |  |  |

\* The cyphers 4.8, 4.9, and 4.10 are weighted more heavily because of their special significance for nursing care.

\*\*The points for the cyphers 4.11 and 4.12 are included in the calculation only if the assessment of the insured is additionally ‘predominantly incontinent’ or ‘completely incontinent’ or an artificial discharge of stool or urine occurs.

\*\*\*In children up to 18 months instead of cyphers 4.1 to 4.13 cypher 4.K is applicable.

Module 5: Points in area 5) Coping with and independent handling of illness- or therapy-related requirements and burdens

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Not applicable or autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Number of measures per day | Number of measures per week | Number of measures per month |
| 5.1 | Medication | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |
| 5.2 | Injections (subcutaneous or intramuscular) | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |
| 5.3 | Supply of intravenous access (port) | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |
| 5.4 | Suctioning and oxygenation | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |
| 5.5 | Rubbings or cold and heat applications | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |
| 5.6 | Measurement and interpretation of body conditions | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Not applicable or autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Number of measures per day | Number of measures per week | Number of measures per month |
| 5.7 | Body-close aids | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |
| Sum of all frequencies for cyphers 5.1 to 5.7 |  |  |  |  |  |

Frequency coding for the average number of measures per day:

0: None or less than once a day

1: At least once to a maximum three times a day

2: More than three times to a maximum of eight times a day

3: More than eight times a day

For each of the cyphers 5.1 to 5.7, the average number of measures taken on a daily / weekly / monthly basis over a period of at least six months are recorded in the columns per day / per week / per month. Only measures that cannot be carried out independently by the insured person are taken into account.

The average number of daily, weekly and monthly interventions is summed up for cyphers 5.1 to 5.7 (for example, drug administration three times daily - cypher 5.1 - and once blood glucose measurement - cypher 5.6 - means four measures per day) and is converted into an average value per day. For the conversion of the measures per week into measures per day, the sum of the measures per week is divided by 7. For the conversion of the measures per month into measures per day, the sum of the measures per month is divided by 30.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Not applicable or autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Number of measures per day | Number of measures per week | Number of measures per month |
| 5.8 | Dressing change and wound care | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |
| 5.9 | Care with stoma | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |
| 5.10 | Regular one-time catheterisation and use of laxative methods | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |
| 5.11 | Therapy measures at home | 0 | 0,1,2,3 | 0,1,2,3 | 0,1,2,3 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Not applicable or autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Number of measures per day | Number of measures per week | Number of measures per month |
| Sum of all frequencies for cyphers 5.8 to 5.11 |  |  |  |  |  |

Frequency coding for the average number of measures per day:

0: Not applicable or less than once a week

1: Once to several times a week

2: Once to less than three times a day

3: At least three times a day

For each of the cyphers 5.8 to 5.11, the average number of measures taken on a daily / weekly / monthly basis over a period of at least six months are recorded in the columns per day / per week / per month. Only measures that cannot be carried out independently by the insured person are taken into account.

The average number of daily, weekly and monthly interventions is summed up for cyphers 5.8 to 5.11 (for example, drug administration three times daily - cypher 5.1 - and once blood glucose measurement - cypher 5.6 - means four measures per day) and is converted into an average value per day. For the conversion of the measures per week into measures per day, the sum of the measures per week is divided by 7. For the conversion of the measures per month into measures per day, the sum of the measures per month is divided by 30.

The average weekly or monthly frequency of time-consuming and technically intensive domestic activities that persist for a period of at least six months is assessed as follows:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Not applicable or autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Daily | Weekly frequency multiplied by | Monthly frequency multiplied by |
| 5.12 | Time and technology intensive measures at home | 0 | 60 | 8.6 | 2 |

For cypher 5.12, first the number of regular and average frequency measures that occur on a weekly basis and the number of regular and average frequency measures that occur on a monthly basis are recorded. If measures are provided regularly on a daily basis, 60 points are awarded. Each regular weekly activity is rated with 8.6 points. Each regular monthly measure is rated with two points.

The average weekly or monthly frequency of measures under cyphers 5.13 to 5.K are assessed as follows:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Not applicable or autonomous](https://dict.leo.org/englisch-deutsch/autonomously) |  | Weekly frequency multiplied by | Monthly frequency multiplied by |
| 5.13 | Doctor visits | 0 |  | 4.3 | 1 |
| 5.14 | Visits to other medical or therapeutic facilities (up to three hours) | 0 |  | 4.3 | 1 |
| 5.15 | Extended visits to other medical or therapeutic facilities (longer than three hours) | 0 |  | 8.6 | 2 |
| 5.K | Visits to facilities for early childhood education | 0 |  | 4.3 | 1 |
| Sum of all frequencies for cyphers 5.13 to 5.15 or 5.K, respectively |  |  |  |  |  |

For each of the cyphers 5.13 to 5.K, first the number of regular and average frequency visits occurring weekly and permanently, for a minimum of six months, is recorded. Then the number of regular and average frequency visits occurring monthly and permanently, for a minimum of six months, is recorded.

Each regular weekly visit is valued at 4.3 points. For extended doctor visits or visits to other medical or therapeutic facilities, they are double counted. Each regular monthly visit is valued as one point.

Module 6: Points in area 6) Everyday life and social contacts:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no.  | Criterion | [Autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Mostly [autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Predominantly dependent | Dependent |
| 6.1 | Design of the daily routine and adaptation to changes | 0 | 1 | 2 | 3 |
| Code no.  | Criterion | [Autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Mostly [autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Predominantly dependent | Dependent |
| 6.2 | Rest and sleep | 0 | 1 | 2 | 3 |
| 6.3 | Self-occupation / dealing with oneself | 0 | 1 | 2 | 3 |
| 6.4 | Making future-oriented plans | 0 | 1 | 2 | 3 |
| 6.5 | Interacting with people in direct contact | 0 | 1 | 2 | 3 |
| 6.6 | Maintaining contact with people outside the direct environment | 0 | 1 | 2 | 3 |

The points of the cyphers 5.12 to 5.15, in children up to 5.K, are added. The sum of points obtained is evaluated as follows:

|  |  |
| --- | --- |
| Sum | Points |
| 0 - <4.3 | 0 |
| 4.3 - <8.6 | 1 |
| 8.6 - <12.9 | 2 |
| 12.9 - <60 | 3 |
| 60+ | 6 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Code no. | Criterion | [Not applicable or autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Mostly [autonomous](https://dict.leo.org/englisch-deutsch/autonomously) | Predominantly dependent | Dependent |
| 5.16 | Compliance with a diet and other disease or therapy-related behavioural rules | 0 | 1 | 2 | 3 |

Table C: System (sum of points and weighted points) assessing the severity of impairment of personal independence or abilities in the modules (acc. Annex 2 of § 15 SGB XI)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Module | Weight | 0No | 1Low | 2Signifi-cant | 3Severe | 4Worst |  |
| Mobility | 10 % | 0-1 | 2-3 | 4-5 | 6-9 | 10-15 | Sum of points for Module 1 |
|  | **0** | **2.5** | **5** | **7.5** | **10** | Weighted points for Module 1 |
| Cognitive and communicative abilities | together 15 % | 0-1 | 2-5 | 6-10 | 11-16 | 17-33 | Sum of points for Module 2 |
| Behaviour/ psychological problems | 0 | 1-2 | 3-4 | 5-6 | 7-65 | Sum of points for Module 3 |
| Highest value from Module 2 or Module 3 | **0** | **3.75** | **7.5** | **11.25** | **15** | Weighted points for Module 2 and Module 3 |
| Self-care | 40 % | 0-2 | 3-7 | 8-18 | 19-36 | 37-54 | Sum of points for Module 4 |
|  | **0** | **10** | **20** | **30** | **40** | Weighted points for Module 4 |
| Coping with and independent handling of illness- or therapy-related requirements and burdens | 20 % | 0 | 1 | 2-3 | 4-5 | 6-15 | Sum of points for Module 5 |
|  | **0** | **5** | **10** | **15** | **20** | Weighted points for Module 5 |
| Everyday life / social contacts | 15 % | 0 | 1-3 | 4-6 | 7-11 | 12-18 | Sum of points for Module 6 |
|  | **0** | **3.75** | **7.5** | **11.25** | **15** | Weighted points for Module 6 |
| Out-of-home activities |  | A module evaluation is unnecessary, since the representation of the qualitative characteristics in the individual criteria is sufficient to derive indications for a care and nursing plan. |  |
| Housekeeping |  |  |

1. <https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=104028&p_count=2&p_classification=05>. [↑](#footnote-ref-1)
2. For a recent example of a form, see

 <http://www.lasv.brandenburg.de/media_fast/4055/Antragsformular_SchwbR_Stand%2002_2018.pdf>. [↑](#footnote-ref-2)
3. An interactive table can be found at <https://versorgungsmedizinische-grundsaetze.de/GdS-Tabelle.html>. It describes in detail specific impairments and the aspects that have to be proven in regard to their character and consequences. The guidelines and the table are documented at <https://www.bmas.de/SharedDocs/Downloads/DE/PDF-Publikationen/k710-versorgundsmed-verordnung.pdf?__blob=publicationFile>. [↑](#footnote-ref-3)
4. See [https://www.rehadat‑statistik.de/de/behinderung/Schwerbehindertenstatistik/index.html](https://www.rehadatstatistik.de/de/behinderung/Schwerbehindertenstatistik/index.html). [↑](#footnote-ref-4)
5. Schröttle et al., 2013; Puchert et al., 2013. [↑](#footnote-ref-5)
6. Ibid. [↑](#footnote-ref-6)
7. Bundesministerium für Arbeit und Soziales, 2018; Bundesvereinigung Lebenshilfe e.V., 2017. [↑](#footnote-ref-7)
8. A person can be entitled to an invalidity pension but still prefer to start or continue working instead (e.g. for financial reasons). Once the invalidity pension procedure has started, it is not just up to the person who is entitled to the invalidity pension to decide whether or not (s)he wants to become a retired person. This is extremely important if the procedure was started automatically (due to the person’s health status) and not by the person himself/herself. [↑](#footnote-ref-8)
9. The degree to which a person is entitled to an invalidity pension depends on their working capacity if they were employed on the general labour market and also on the job they have been trained for. What can they do in a job, despite their disability? Are there jobs they can do, do they need to be employed in sheltered workshops, or is it not possible for them to be employed at all? [↑](#footnote-ref-9)
10. This becomes relevant when people are or become disabled and are unable to work at a young age. At that stage, they will have no or almost no pension rights, because they will not have worked before at all or will have worked for only a few years. On that basis, they would get no pension or almost no pension. Benefits based on projected rights therefore apply in such cases. [↑](#footnote-ref-10)
11. SGB XI — Sozialgesetzbuch Soziale Pflegeversicherung, [www.sozialgesetzbuch-sgb.de/sgbxi/15.html](http://www.sozialgesetzbuch-sgb.de/sgbxi/15.html) (accessed 11.09.2018); SGB XI, §15 and annexes, [www.pflege-grad.org/pflegeversicherung/15-sgb-xi.html](http://www.pflege-grad.org/pflegeversicherung/15-sgb-xi.html) (accessed 12.09.2018). [↑](#footnote-ref-11)
12. Statistik des Bundesministeriums für Gesundheit: Geschäfts- und Rechnungsergebnisse der sozialen Pflegeversicherung, bezogen auf die Empfängerzahl am Jahresende, Berechnung des ISG. [↑](#footnote-ref-12)
13. Geschäfts- und Rechnungsergebnisse der sozialen Pflegeversicherung 2007 bis 2014, Darstellung des ISG. [↑](#footnote-ref-13)
14. Sozialhilfestatistik 2008 bis 2014, Berechnung des ISG. [↑](#footnote-ref-14)
15. <https://www.focus.de/finanzen/versicherungen/pflegeversicherung/pflegereform-2017-foerderkatalog-aendert-sich-wer-gewinnt-und-wer-besser-jetzt-noch-handeln-sollte_id_6181116.html>. [↑](#footnote-ref-15)
16. <https://www.svz.de/deutschland-welt/politik/jeder-fuenfte-antrag-auf-pflegegeld-wird-abgelehnt-id17440861.html>. [↑](#footnote-ref-16)
17. <https://deutsch.medscape.com/artikelansicht/4905127>. [↑](#footnote-ref-17)
18. <https://www.merkur.de/politik/bilanz-mit-gewinnern-und-verlierern-nach-einem-halben-jahr-pflegestaerkungsgesetz-ii-8485272.html>. [↑](#footnote-ref-18)
19. <https://www.rbb-online.de/rbbpraxis/rbb_praxis_service/pflege/pflegestaerkungsgesetz-zwischenbilanz.html>. [↑](#footnote-ref-19)
20. According to an unpublished care insurance paper; see <https://www.rbb-online.de/rbbpraxis/rbb_praxis_service/pflege/pflegestaerkungsgesetz-zwischenbilanz.html>. [↑](#footnote-ref-20)
21. SGB XI — Sozialgesetzbuch Soziale Pflegeversicherung. Online [www.sozialgesetzbuch-sgb.de/sgbxi/15.html](http://www.sozialgesetzbuch-sgb.de/sgbxi/15.html) (accessed 11.09.2018). [↑](#footnote-ref-21)