ESPN Thematic Report on Challenges in Long-Term Care

Germany

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Thomas Gerlinger
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Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

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European Social Policy Network (ESPN)

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Thomas Gerlinger
Bielefeld University

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Summary

Long-term care (LTC) in Germany is provided within the institutional framework of long-term care insurance (LTCI). LTCI was established in 1995 and is organised alongside the healthcare system. Since 2009, insurance has been mandatory for every citizen. In LTCI the principle that 'long-term care insurance follows healthcare insurance' applies – i.e. statutory health insurance members are insured under the social LTCI scheme and all members with private health insurance are insured under the private scheme. By the end of 2016, 71.95 million people were covered under the social LTCI scheme and 9.32 million under the private one. Some 2.94 million people were in receipt of LTCI benefits, 2.75 million of them under the social LTCI. Under the social LTCI, 71.9% of benefit recipients were being cared for at home, most of them by female family members or unpaid carers.

With effect from 2017, the legal provisions for access to LTCI benefits were put on a new footing. Since then benefits have been paid on the basis of five care grades that take account not only of physical disabilities, but also of mental and psychological disabilities, thereby extending eligibility particularly to persons suffering from dementia. The structure and level of benefits does not differ between social and private LTCI. LTCI expenditure has increased steadily, growth rates being exceptionally high in 2017 (25.6% over the previous year), mainly due to the considerable expansion of eligibility. In 2017, total expenditure on benefits paid under the social LTCI scheme was EUR 35.54 billion. Contribution rates for the social LTCI were raised by an average of 0.5 percentage points between 2015 and 2017, reaching 2.55% (2.80% for childless people) in 2018. The most recent reforms were aimed at:

- extending eligibility for benefits by reforming the definition of 'in need of care' and the associated assessment method;
- improving benefits and allowing more flexibility in combining different types of benefits;
- strengthening municipalities' powers to plan the local and regional infrastructure for long-term care and for providing care counselling; and
- enhancing the attractiveness of the care professions by reforming the legislation on care training.

The comprehensive redefinition of the term 'in need of care', including the methods of assessing individual needs, represents a crucial improvement in access to and adequacy of LTC. Further measures taken to date should, to some degree, help to improve LTC. However, they are not likely to remedy the shortage of care workers or improve care quality. This also applies to the measures envisaged in the agreement on another grand coalition in the current legislative period.

In order to meet the challenges facing LTC, the following policy recommendations should be implemented:

- All necessary efforts should be made to enhance the attractiveness of long-term care as a field of employment. To this end, above all, working conditions should be improved and wages raised significantly.
- Social and private LTCI should be merged into one system, based on the principle of solidarity, in order to make the financing of LTCI fairer and to achieve financial sustainability. At the same time, the income threshold for contribution assessment should be raised or even abolished.
- LTCI benefits have to be raised, at least in line with the increase in care costs (up to full coverage), thus relieving the burden on benefit recipients and reducing their dependence on social welfare grants.
- Employees' individual right to balance work and family care should be strengthened.

1 Description of the main features of the country's long-term care system(s)

In Germany, as in most other EU Member States, society is ageing, and that is creating considerable social policy challenges for the years and decades to come. According to the latest projection by the German Federal Statistical Office, the share of people aged 65-79 in the total population will rise from 15% to 20% in the period 2013 to 2060; and for those aged 80 and over it will rise from 5% to 13% (Statistisches Bundesamt, 2015a). Though the prognoses on future care needs differ (Rosenbrock and Gerlinger, 2014), experts agree that the number of people requiring care will rise considerably. Rothgang et al. (2014: 72-76), for example, estimate that the number will reach almost 4.58 million by 2060 (2015: 2.86 million). Against the backdrop of an ageing society and rising demand for long-term care services, a long-term care insurance (LTCI) scheme was established in 1995.

1.1 Organisation of LTCI and insured persons

The LTCI in Germany is organised alongside the healthcare system (Rosenbrock and Gerlinger, 2014). Since 2009, insurance has been mandatory for every citizen. In LTCI, the principle that 'long-term care insurance follows healthcare insurance' applies – i.e. statutory health insurance (SHI) members are insured under the social LTCI scheme and all members with private health insurance (PHI) are insured under the private scheme. In 2017, 72.7 million citizens were covered by social LTCI and 9.4 million citizens (2015) by private LTCI (see Figure 1).

1.2 Benefits

In contrast to the SHI, the LTCI covers only part of long-term care costs. The remaining costs have to be covered by the persons in need of care or their children or, if they are unable to do so, by social welfare grants provided by the municipalities. All persons in need of care (disabled children, adults and old people) are eligible for the LTCI care scheme, irrespective of age. Long-term care benefits are granted on the basis of the level of care required (until 2016) or the assessed grade of care (with effect from 2017) and of the care arrangements put in place (either at home or in a residential home for the elderly). Regardless of the level of care, assistance may be provided for prevention and rehabilitation, which are given priority over care. Accordingly, all possible ways of maintaining or regaining individual capabilities are to be exploited in order to avoid long-term care. Home care is also given priority over residential care, i.e. as far as possible, people in need of care should be cared for at home, their individual right of choice between home care and residential care notwithstanding. LTCI benefits do not differ between regions and are not time limited.

Until 2016, people were eligible for long-term care if, because of a physical, mental or psychological illness or disability, they required frequent or substantial assistance with normal day-to-day activities for an estimated period of 6 months or longer. A distinction was made between three levels of care based on physiological deficits and the expected care time needed. The levels of care were formally assessed by an independent Medical Review Board (MDK) convened by the Statutory Health Insurance Funds.

With effect from 2017, the legal provisions for access to LTCI benefits were put on a new footing (Nakielski and Winkel, 2017). The previous definition of three care levels has been replaced by five care grades based on physical, mental and psychological disabilities. Accordingly, the assessment of need has changed profoundly: the condition of being 'in need of care' is determined by impairments of independence or incapacitation in six areas (modules), which are weighted as follows: mobility (10%), cognitive and communicative abilities (15%), behaviour patterns and psychological problems (15%), level of self-sufficiency (40%), health restrictions, demands and stress of treatment (20%) and structure of everyday life and social contacts (20%). Anyone already in receipt of LTCI benefits was automatically transferred to the new system. The five grades of care need were combined with changes in the levels of benefit paid, whether in cash or

in kind (see Table 1). The grade of care will continue to be formally assessed by the independent Medical Review Board (MDK).

In general, a recipient may choose from three different arrangements – care allowance, home care (in kind) or residential care:

- Care allowance refers to so-called informal care, i.e. the person in need of care receives only monetary support, typically lives at home and is cared for by close relatives.
- Home care (in kind) means that a professional care provider visits the recipient regularly at home. The provider is under contract to the LTCI fund and is paid directly by LTCI.
- Residential care refers to a stay in a nursing home. The long-term care insurance will pay expenses for basic care, social support for informal care, aids and 'medically prescribed care', i.e. LTC services provided by carers based on a doctor's prescription (e.g. care of wounds and bed sores and blood pressure measurement). As with home nursing care, people in need of care are responsible for paying the costs of accommodation and food..

There are additional benefits provided under LTCI:

- If the person who provides care at home goes on holiday or is otherwise unable to provide care, persons in need of care are entitled to a stand-in for a maximum of 6 weeks a year.
- Part-time institutional care refers to care in a facility that provides day or night care. The LTCI fund pays the costs of care, social support and medical treatment.
- Short-term care is provided in appropriate institutional facilities if the people in need of care only need full-time institutional care for a certain period of time, notably to cope with crises in care at home or following a stay in hospital.
- Nursing aids (such as a special bed) and allowances to pay the cost of modifying the home to accommodate the nursing care needs.

Benefits under LTCI are granted not only to those in need of care but also to those delivering informal care, e.g. carers are covered by statutory pension insurance for the period during which they are providing care for a minimum of 14 hours a week in a person's home, if they are not employed elsewhere or do not work more than 30 hours per week. The contribution rate depends on the level and length of care provided. Nursing care courses are also provided for relatives.

1.3 Benefit recipients

The total number of people in need of help and care in Germany is unknown. Only those persons in need of care and drawing benefits from a long-term care insurance scheme are statistically recorded. According to the latest official statistics, around 2.86 million people required long-term care in 2015. They included around 0.78 million people (27.3% of the total) living in nursing homes. The remaining 2.1 million people were being cared for at home by close relatives, mostly women, including 0.7 million persons assisted by outpatient care services (see Figure 2).

Between 1996 and 2015, the number of people in need of care rose by more than 72%. Data show that the risk of being in need of care depends to a high degree on age: nearly two thirds (66.1%) of people aged 90 and over are in need of care, although the majority of them are still being cared for at home (see Figure 3). The share of people in need of care and living in residential homes has changed only slightly in recent years. It was 27.9% in 1999 and 27.4% in 2015 (see Figure 4).

Most of the people in need of care who receive benefits or services from the LTCI are in receipt of a care allowance. They accounted for 46.6% of all recipients in 2016 (60.0% if combined benefits are included) (see Table 2 and Figure 5). Conversely, inpatient care in

residential homes is the most expensive form of care and accounts for almost 40% (2016) of total expenditure (see Figure 10). The number of people 'in need of care' staying in residential homes is not rising as quickly as the number of those being cared for at home (see Figure 5).

With regard to benefits, there are no differences between social and private LTCI. Rather than being calculated on the basis of income, premiums for private long-term care insurance are graded, as with private health insurance, according to age, while legislation caps contributions. The premiums for men and women are the same. Children receive free cover, as they do under social long-term care insurance.

1.4 Care providers

The long-term care insurance funds conclude contracts with care providers in outpatient and residential care. On the supply side, the long-term care market in outpatient care is dominated by private providers, whether for-profit (self-employed professionals and their employees) or non-profit (charity organisations), while in the residential care home market the municipalities play a somewhat greater role. In 2015, there were around 13,600 nursing homes and 13,300 home care providers. Some 41% of all nursing homes were private and for profit, 54% were private and not for profit and 6% were public. In home care, up to 63% of providers were private and for profit, 36% were private and not for profit and 1% were public (Statistisches Bundesamt, 2017a). Around 355,000 (mostly skilled) persons are employed in home care services and around 730,000 (also mostly skilled) are employed in nursing homes (see Figure 6). The large majority of employees (mostly women) work part time (71.8% – see Figure 7).

As outlined above, the great majority of people in need of care are still attended to, and cared for, by their family members – mostly spouses, daughters and daughters-in-law, around 60% of whom are employed (Geyer and Schulz, 2014).

2 Analysis of the main long-term care challenges in the country and the way in which they are being tackled

The challenges for long-term care in Germany are numerous and wide-ranging. Though many reforms have been launched in recent years, severe problems continue to exist and require further action.

2.1 Access and adequacy

2.1.1 Eligibility for benefits

The previous restriction of eligibility to physical disabilities (including the assessment of need in minutes per day) was the object of intense criticism. The comprehensive reform of the term 'in need of care', as well as of the methods of assessing individual need (see above), extends eligibility particularly to people suffering from dementia, and thus represents a crucial improvement in access to LTC. Nevertheless, it remains to be seen how the new term 'in need of care' will be implemented in practice (Hesse, 2016).

2.1.2 Partial coverage

As noted above, LTCI covers only part of the costs of long-term care. Moreover, from 1995 to 2008 increases in LTCI benefits failed to keep pace with the rising prices of goods and services. Consequently, the purchasing power of benefits decreased considerably. The increases in benefits to date have not compensated for this decline in purchasing power. In 2014, the private costs of long-term care amounted to EUR 17.13 billion (36.6% of total expenditure on LTC) (Rothgang et al., 2016: 135). In May 2017, benefit recipients had to pay EUR 1,691 per month on average for residential care (Rothgang et al., 2017: 30).

The introduction of long-term care insurance considerably reduced the number of recipients depending on social welfare grants in order to pay for their long-term care. Between 1994 (the last year before LTCI was introduced) and 1998, it decreased by 48.7%, from 563,000 to 289,000; but the number has since risen again, to 440,000 in 2016 (Statistisches Bundesamt, 2015b; 2017b). Thus, those in need of care still include a number of social welfare grant recipients. In the light of forecasts of rising poverty among the elderly (Bertelsmann Stiftung, 2017), this problem is set to get worse. Moreover, if working conditions are to be improved and workers' earnings are to be raised (as is envisaged), the residual costs to be paid by benefit recipients will rise, unless the current legal provisions on LTCI coverage are changed.

2.1.3 Regional inequalities

In recent years, the number of outpatient care service providers and residential homes has increased significantly. However, the care market is not transparent in terms of quantity, quality and performance (Hackmann et al., 2016; Ehrentraut et al., 2015). The expansion has not taken place in a planned and coordinated manner. Moreover, the number of regions characterised by an undersupply of longer-term care services is rising; they are primarily remote regions with poor economic performance and infrastructure. Besides the overall improvement in working conditions, attempts to solve these problems have to take into account particular regional characteristics, such as the effects of social and demographic change on care, which differ considerably from region to region. In many cities and neighbourhoods, and especially in rural areas, there are still supply shortages, many of which are likely to increase if no action is taken (Hagen and Rothgang, 2014).

2.1.4 Supporting informal care at home

Facilitating the reconciliation of paid work and care responsibilities is one of the major objectives of long-term care policies in Germany. To be cared for at home by close relatives is less expensive than relying on professional care services. Moreover, the overwhelming majority of people in need of care, as well as their relatives, want their care to be provided in this way. Last but not least, strengthening informal care is seen as an important way of coping with the overall shortage of LTC professionals.

Informal care provided mainly by close relatives (mostly women) has hitherto been the main pillar of long-term care, with more than two thirds of people in need of care receiving care in this way. In 2016, around 2.94 million people required long-term care. Of these, around 0.78 million were living in nursing homes (28.1%). The remaining 2.11 million (71.9%) were being cared for at home (BMG, 2017b) by close relatives (mostly women, i.e. spouses, daughters or daughters-in-law), including (in 2015) 0.69 million assisted by outpatient care services (see Figure 2). However, informal care is under threat from societal change (increasing mobility, family instability, increasing female employment).

In order to facilitate the reconciliation of care and paid work, employees are entitled by law to reduce their working hours (by at least 15 hours) for up to 24 months, including a maximum of 6 months' time off work (Reuyß, 2017). In addition, employees are entitled to short-term care leave of up to 10 working days a year without prior notice. However, the statutory right to the 6 months' care leave applies only to employees in companies with more than 15 workers, and the statutory right to work part time for up to 24 months applies only to employees in companies with more than 25 workers. Thus, a considerable proportion of employees are excluded from rights provided for by law. Moreover, the obligation to repay income replacement benefits when reducing working hours or claiming care leave is a strong disincentive to claiming these rights. Thus, the impact of these measures is weak. Statistical data show that, up to 2015, only about 6,000 persons had made use of short-term care leave, and only 313 had claimed the credit-financed benefit (Schwesig, 2015).

2.2 The quality challenge

The quality of long-term care is a matter of major concern in Germany. In general, severe flaws in LTC quality do exist. According to the latest LTC quality report submitted by the Medical Review Board of the National Association of Statutory Health Insurance Funds (MDS), in 2016 many residential homes and outpatient services met the requirements of good care, but severe flaws continued to exist, e.g. the recording of pain management and wound care in residential homes was inadequate, as were intensive care (24-hour care for people in most need of care) and care counselling in outpatient care (for more details see: MDS, 2017).

A severe shortage of care professionals and poor working conditions are major factors in the quality flaws. High-quality care requires adequate staffing, in both quantitative and qualitative terms; but the lack of qualified carers for the elderly, which has been a problem for many years now, has still not been resolved and the situation has actually deteriorated (Bogai, 2014). Moreover, there is concern about the quality of care delivered by informal carers. Thus, since 2008, LTCI organisations have been obliged to offer free training courses in LTC for family members and unpaid carers. People receiving informal LTC are required to make use of counselling services offered by accredited care facilities or counselling centres, in order to ensure the quality of such care.

The Care Professions Reform Act, passed in the summer of 2017, contains provisions intended to improve the situation. In their coalition agreement for the 19th legislative period (2017-2021) the CDU/CSU and the SPD political parties agreed to launch an immediate action programme that should generate 8,000 new jobs in long-term care, to improve working conditions and to increase pay, among other things by supporting the adoption of collective-bargaining arrangements throughout the long-term care sector (CDU et al., 2018: 95-96). However, neither the measures already taken nor those envisaged are likely to tackle the shortage of care workers and improve care quality.

2.3 The employment challenge

There are no valid data on the question of how far informal long-term care affects (female) employment or vice versa. However, it is obvious that the simultaneous promotion of informal care and women’s employment are competing objectives, since a family-based care regime implicitly presupposes that women will play their traditional roles as non-working housewives, mothers or daughters (Wetzstein et al., 2015). Either the objective of increasing the female employment rate, especially among older women, will be undermined or else relatives in need of long-term care will have to be admitted to a residential home, even though they could remain at home if appropriate care were provided. In the light of the increasing number of women in work, including older women, there is a need to facilitate the reconciliation of work and family care (Kesselheim et al., 2013; Geyer and Schulz, 2014).

2.4 The financial sustainability challenge

Statutory long-term care insurance is financed through income-related contributions paid equally by employers and employees. Childless contributors are required to pay an additional 0.25%. Children and spouses with income of less than EUR 450 per month are co-insured at no extra cost. Pensioners’ contributions have to be paid in full by pensioners themselves. In 1996 – the first year to allow for all-year benefits – the contribution rate was 1.7% of gross income; by 2017 it had risen to 2.55% (2.80% for childless LTCI members) (see Figure 8). Under the grand coalition that governed from 2013 to 2017, the contribution rate was raised by 0.5 percentage points, including 0.2 percentage points with effect from 2017, mainly due to the extension of access based on the new definition of ‘in need of care’ and the increases in benefits.

Statutory LTCI expenditure has steadily increased in recent years, from EUR 14.3 billion in 1997 to EUR 28.3 billion in 2016. In 2016, 24.0% of total expenditure was attributable to care allowances, 13.4% to home care (in kind) and 38.5% to residential care (for the absolute numbers see Figure 10). Nevertheless, since 1997 LTCI has recorded revenue

surpluses. In 2016, the difference between income from contributions and total expenditure was 3.13%; the reserves totalled EUR 9.3 billion (see Figure 9). The favourable macroeconomic conditions in Germany have had a positive impact on the evolution of contribution revenues. Due to the new legislation coming into force (see above), 2017 saw an extraordinary increase in expenditure to EUR 35.54 billion (BMG, 2018).

LTCI expenditure and contribution rates are expected to increase in the years ahead, due mainly to the rising number of recipients and the simultaneous decrease in the number of contributors. Moreover, the share of persons requiring professional outpatient or residential care is set to increase. Recent legislation, in so far as it is intended to contain costs, seeks to facilitate the provision of informal care and offers incentives for providers. However, due to windfall gains, it is difficult to evaluate how far these attempts have been successful. Obviously, the introduction of short-term care leave and the credit-financed benefit have had, at best, little impact (see section 2.2).

Achieving financial sustainability is linked to another characteristic of the German LTCI system, namely the divide between social and private LTCI. The dual LTCI system allows people with, on average, higher income and lower health risks (with demand for LTC occurring, on average, later in life) not to contribute to the collective financing of social LTCI. A unitary people's LTCI would reduce contribution rates for employers and employees, particularly if it went hand in hand with the raising (or even abolition) of the LTCI income threshold for contribution assessment (Rothgang and Domhoff, 2017).

2.5 Recent reforms and future reform plans

Since its introduction in 1995, the LTCI has been the subject of intensive legislation. From 2015 to 2017, three so-called 'long-term care strengthening acts' came into force and a Health Professions Reform Act was passed. The most recent reforms were aimed at:

- extending eligibility for benefits by amending the definition of 'in need of care' and the associated assessment method (see above);
- improving benefits and allowing more flexibility in combining different types of benefits, mainly in order to increase opportunities for relatives to provide informal care at home;
- strengthening municipalities' powers to plan the local and regional care infrastructure to provide care counselling; and
- enhancing the attractiveness of the care professions by reforming the legislation on care training (see Gerlinger, 2017).

In addition, the most recent coalition agreement between the CDU/CSU and the SPD for the 19th legislative period (until 2021) includes an immediate action programme for long-term care that should generate 8,000 new jobs, an improvement in working conditions and an increase in wages (CDU et al., 2018: 95-96).

2.6 Policy recommendations

- In order to meet the challenges outlined above, the following recommendations for long-term care policy should be implemented:
- All necessary efforts should be made to enhance the attractiveness of long-term care as a field of employment. To this end, priority should be given to improving working conditions and raising wages significantly.
- Social and private LTCI should be merged into a unitary people's LTCI (*Pflegebürgerversicherung*), based on the principle of solidarity. At the same time, the income threshold for contribution assessment should be raised or even abolished.

- LTCI benefits should be raised (up to full coverage) at least in line with the increase in care costs, thus easing the burden on benefit recipients and reducing their dependence on social welfare grants.
- Employees' individual rights to reconcile work and family care must be improved.

3 Analysis of the indicators available in the country for measuring long-term care

The availability of data on LTC at the national level differs considerably depending on the matter of interest. In general, the available data refer mainly to the structure of LTC; the data on process quality and outcomes are inadequate. The data on the number of insured individuals, age groups, gender, benefit recipients and levels/degree of care, as well as on revenue, expenditure and type of benefits, can be regarded as adequate for LTC. The equivalent data available for private LTCI are far less differentiated. As for quality, the LTC quality reports by the Statutory Health Insurance Funds' Medical Review Board (MDS) are important sources of information. This report includes some indicators that may be relevant to LTC outcomes. Moreover, the Research Institute of the Local Health Insurance Organisations (Wissenschaftliches Institut der Ortskrankenkassen) conducts regular surveys on various topics related to health and long-term care.

However, there is a particular lack of valid information on the overall impact of LTC on those people affected and their children (or relatives). Availability of data is poor for the perceived or actual burdens in terms of finance (e.g. deductibles to be paid) or time (spent on family care), the interaction between employment responsibilities and family care, differences linked to socio-economic status, education or gender and membership of social or private LTCI. To a certain extent, the shortcomings in the official statistics are compensated for by socio-economic panel data.

In general, LTC outcomes are difficult to measure, particularly if they are to be compared across the various systems in the EU. Possible indicators of LTC outcomes include:

- the quality of certain services (e.g. wound care, bed sore prevention, care of bed sores, hydration);
- the extent to which the capabilities of LTC recipients are regained, maintained or improved;
- satisfaction of LTC recipients and their relatives with the services provided;
- number of and reason for complaints; and
- carers' satisfaction with working conditions.

Table 3 presents the indicators of long-term care currently available in Germany.

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Appendix: Tables and figures

TABLE 1: MONTHLY BENEFITS OF THE LTCI, 2018 in EUR

Type of benefits	Care-Grade1	Care-Grade 2	Care-Grade 3	Care-Grade 4	Care-Grade 5
Care allowance	125*	316	545	728	901
Outpatient care benefits in kind	0	689	1,298	1,612	1,995
Day and night care	125*	689	1,298	1,612	1,995
Inpatient care benefits in kind	125	770	1,262	1,775	2,005
Substitute care up to 6 weeks a year					
- close relatives	0	474	817.5	1,092	1,351.5
- other persons	0	1,612	1,612	1,612	1,612
Short-term care up to 8 weeks a year	125*	1,612	1,612	1,612	1,612

** Relief amount*
Source: BMG (2017a).

TABLE 2: LTCI RECIPIENTS AND TYPES OF BENEFITS 1996-2016

	1996	1998	2000	2002	2004	2006	2008	2010	2012	2014	2016
Total in millions	1.56	1.79	1.88	1.97	1.98	2.06	2.18	2.35	2.45	2.78	2.94
LTCI recipients by types of benefits in % of all LTCI recipients											
Care allowance											
	60.4	53.6	50.7	49.6	48.4	47.4	46.4	44.8	43.9	45.1	46.6
Outpatient care benefits in kind											
	6.8	7.5	8.5	8.4	8.5	8.8	8.4	7.8	6.9	5.3	6.0
Combined benefits											
	8.7	9.6	10.3	10.4	10.3	10.1	11.2	13.3	15.5	15.1	13.4
Substitute care											
	0.4	0.2	0.3	0.4	0.6	0.9	1.4	2.0	3.0	3.8	4.5
Day and night care											
	0.2	0.4	0.5	0.7	0.8	0.8	0.9	1.5	1.9	2.4	2.8
Short-term care											
	0.4	0.3	0.4	0.4	0.5	0.6	0.7	0.7	0.8	0.7	0.8
Inpatient care											
	22.7	25.2	26.3	27.0	27.7	28.0	27.6	26.5	26.2	24.4	22.9
Inpatient care in nursing homes for disabled											
	0.4	3.2	3.0	3.1	3.3	3.3	3.4	3.5	3.3	3.1	3.0

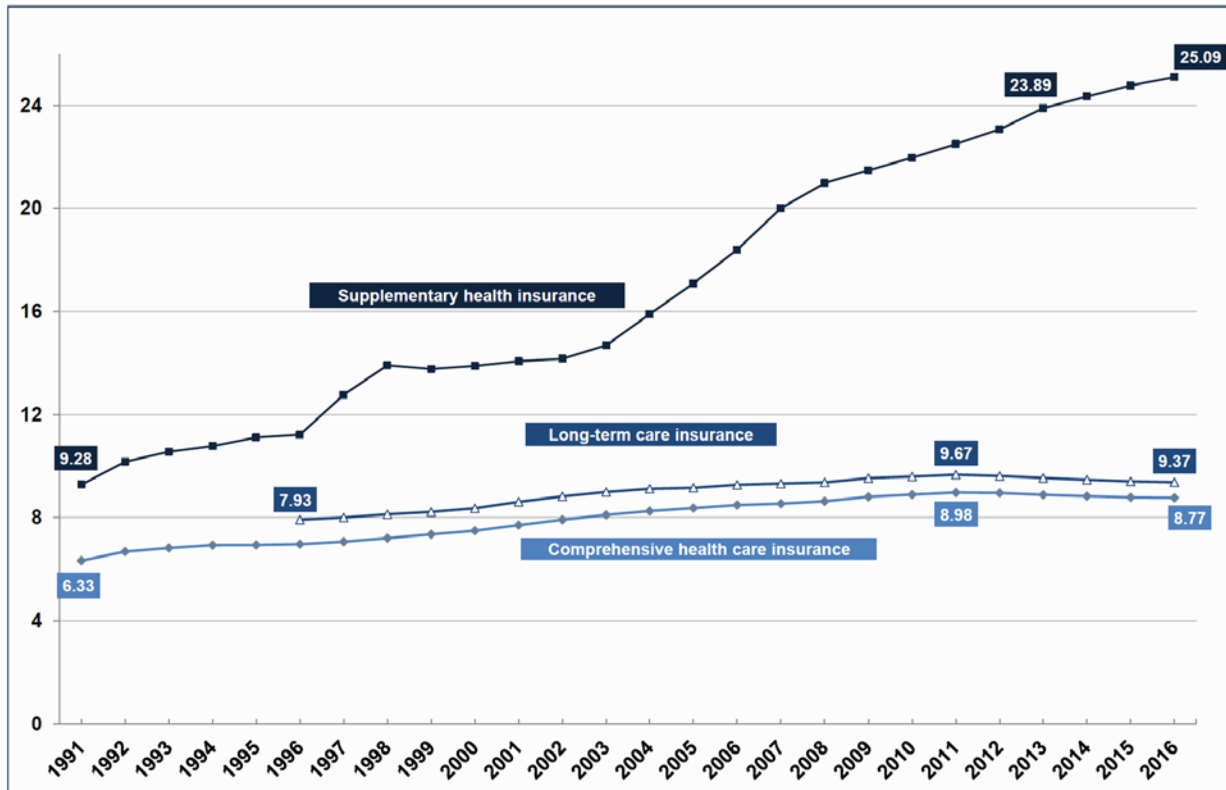
Source: BMG (2017b).

TABLE 3: LIST OF INDICATORS OF LONG-TERM CARE

Indicator	English	Definition	Source	Years available	Frequency	Website address
Leistungen	LTCI benefits	All types of LTCI benefits	Bundesministerium für Gesundheit	Current year	Annual	https://www.bundesgesundheitsministerium.de/themen/pflege/pflegeversicherung-zahlen-und-fakten.html#c3218
Zahlen und Fakten	Data and facts	Overview of total number of benefit recipients (by level of care); revenues and expenditure, number of care providers (residential and outpatient services), number of employees	Bundesministerium für Gesundheit	1995/2002-2016	Annual or biennial	https://www.bundesgesundheitsministerium.de/themen/pflege/pflegeversicherung-zahlen-und-fakten.html#c3218
Versicherte soziale Pflegeversicherung	Insured persons (social LTCI)	Insured persons total, female and male by age groups and level of care	Bundesministerium für Gesundheit	1995-2016	Annual	https://www.bundesgesundheitsministerium.de/themen/pflege/pflegeversicherung-zahlen-und-fakten.html#c3218
Versicherte private Pflegeversicherung	Insured persons (private LTCI)	Insured persons total	Verband der privaten Krankenversicherung	1997/98-2015	Annual	https://www.pkv.de/service/zahlen-und-fakten/archiv-pkv-zahlenbericht/
Leistungsempfänger soziale Pflegeversicherung	Social LTCI benefit recipients	Benefit recipients total, female and male by age groups, level of care and type of benefit	Bundesministerium für Gesundheit	1995-2016 resp. 2009-2016	Annual	https://www.bundesgesundheitsministerium.de/themen/pflege/pflegeversicherung-zahlen-und-fakten.html#c3218
Leistungsempfänger private Pflegeversicherung	Private LTCI benefit recipients	Benefit recipients total	Verband der privaten Krankenversicherung	1997/98-2015	Annual	https://www.pkv.de/service/zahlen-und-fakten/archiv-pkv-zahlenbericht/
Begutachtung Antragsteller private Pflegeversicheru	Assessment of claimants private LTCI	Benefit recipients by level of care	Medicproof	Current year	Annual	https://www.medicproof.de/unternehmen.html#c754

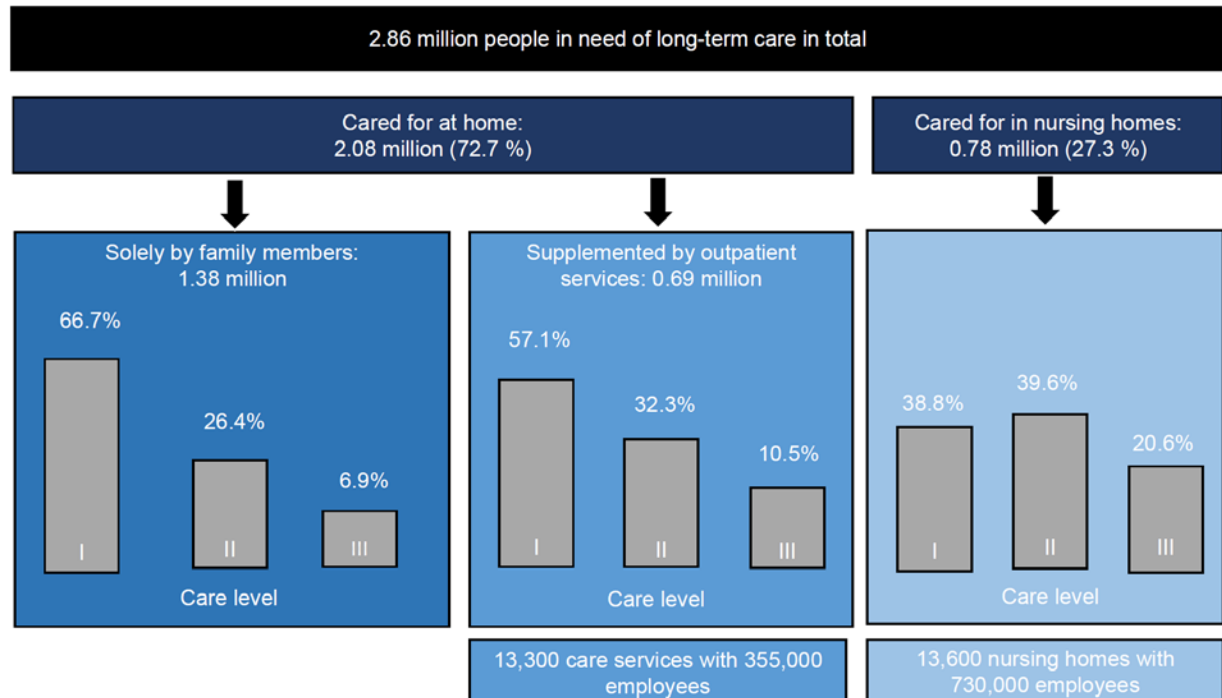
ng						
Pflegequalität	LTC quality	Quality of structure, processes and outcome in residential and outpatient care, person- and institution-related; satisfaction with care	Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen	2012-2016	Annual	https://www.mds-ev.de/richtlinien-publikationen/pflegeversicherung/mds-pflege-qualitaetsberichte.html
Finanzentwicklung soziale Pfegeversicherung	Financial development (social LTCI)	Revenues by origin; expenditure by type of benefit	Bundesministerium für Gesundheit	1995-2016	Annual	https://www.bundesgesundheitsministerium.de/themen/pflege/pflegeversicherung-zahlen-und-fakten.html#c3218
Ausgaben für Pflege und Pflegeversicherung	Expenditure on LTC and LTCI	Total expenditure	Statistisches Bundesamt	1995-2015	Annual	https://www.destatis.de/DE/ZahlenFakten/GesellschaftStaat/Gesundheit/Gesundheitsausgaben/Gesundheitsausgaben.html
Hilfe zur Pflege	Social welfare grants for LTC	Grant recipients and total expenditure	Statistisches Bundesamt	Current year	Annual	https://www.destatis.de/DE/ZahlenFakten/GesellschaftStaat/Soziales/Sozialleistungen/Sozialhilfe/Sozialhilfe.html

Figure 1: Persons insured in private health and private long-term care insurances, 1991-2016, in millions



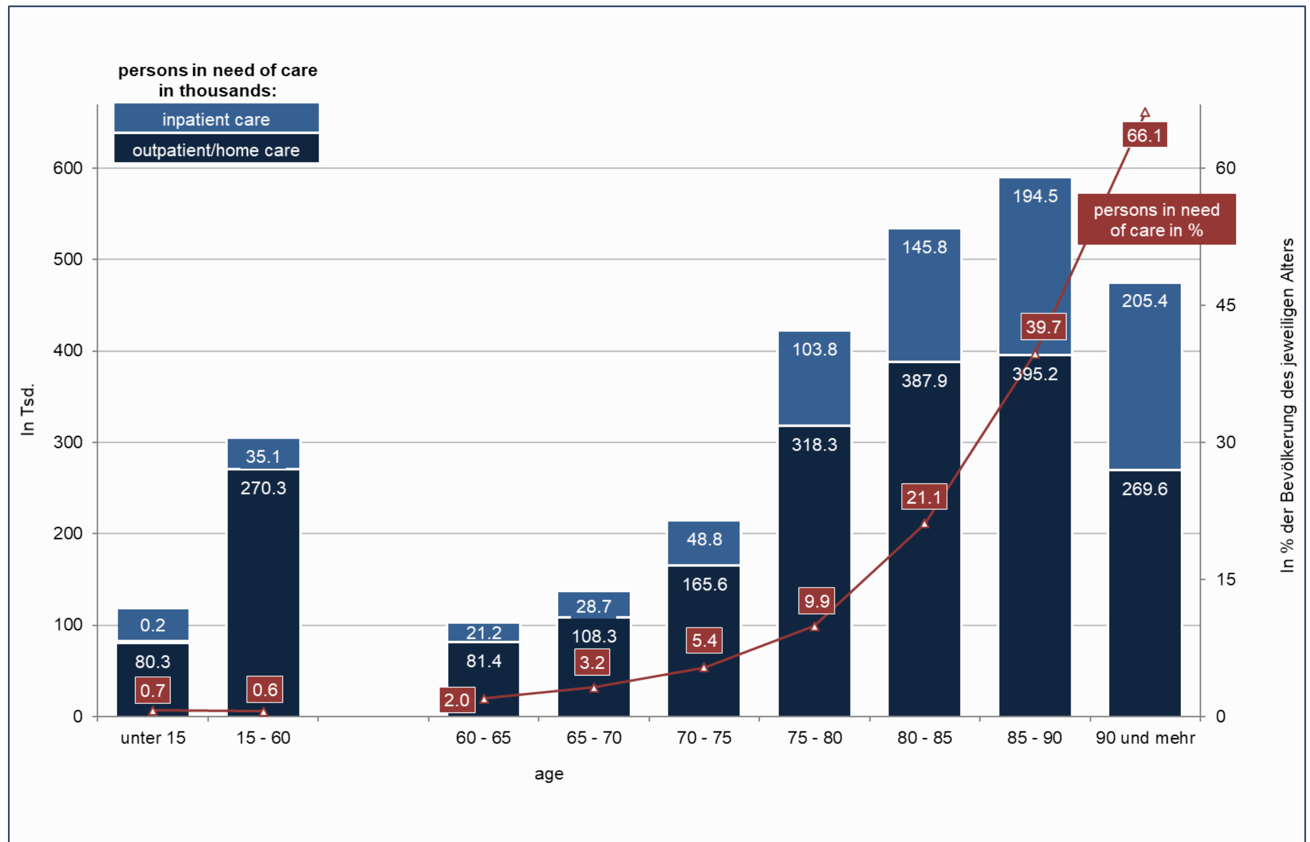
Source: Verband der privaten Krankenversicherung (2017).

Figure 2: People in need of long-term care, benefit types, care level and staff, 2015



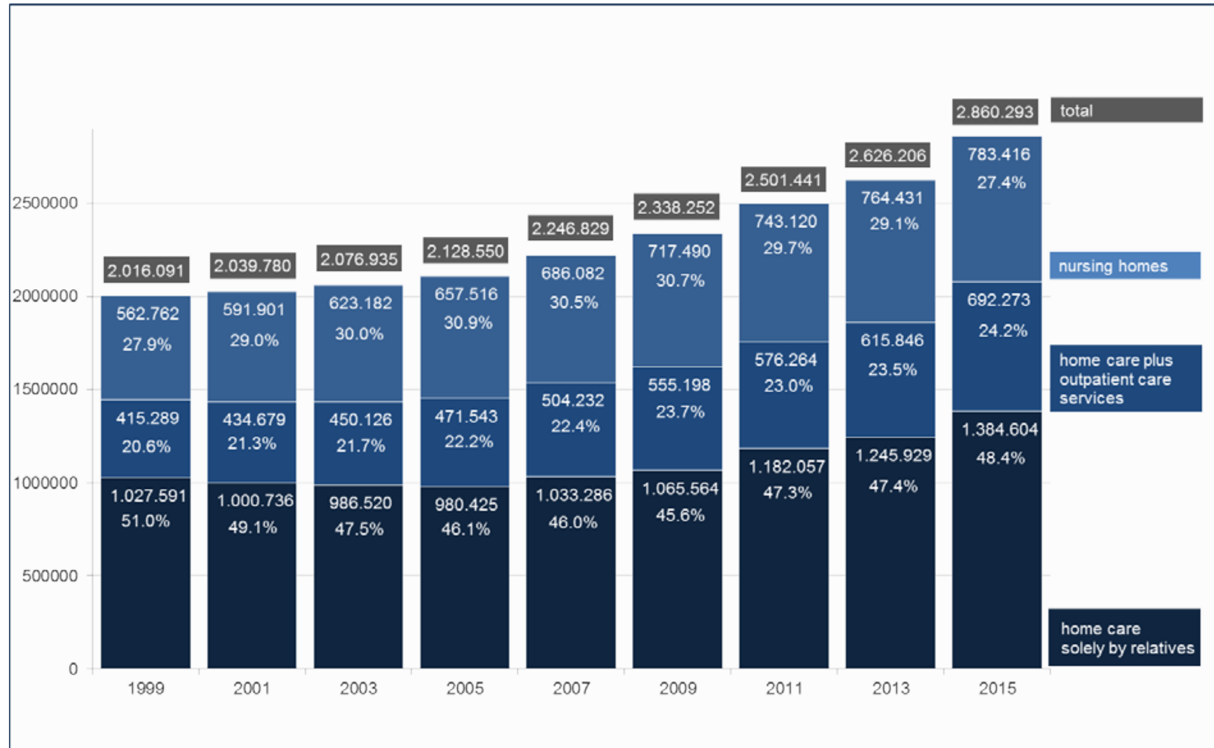
Source: Statistisches Bundesamt (2017a).

Figure 3: Persons in need of long-term care by age groups, 2015



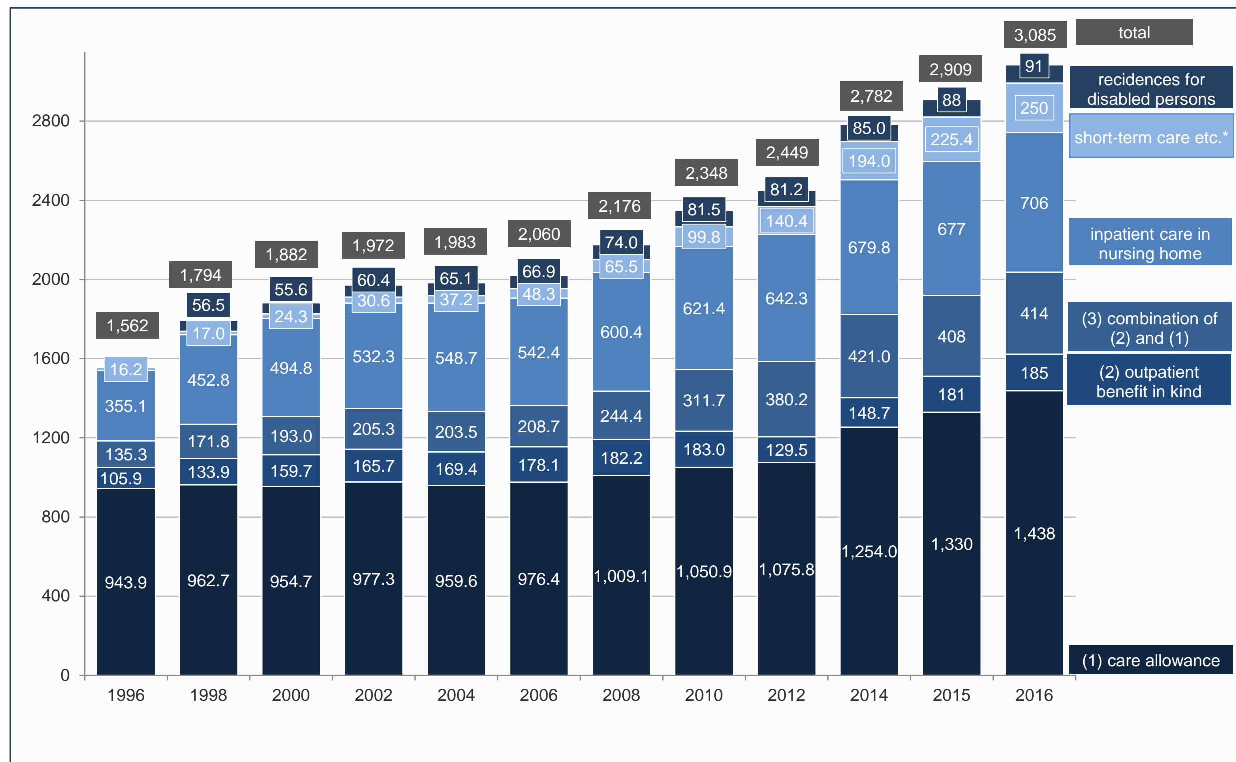
Source: Statistisches Bundesamt (2017a).

Figure 4: People in need of long-term care by type of provision, 1999-2015



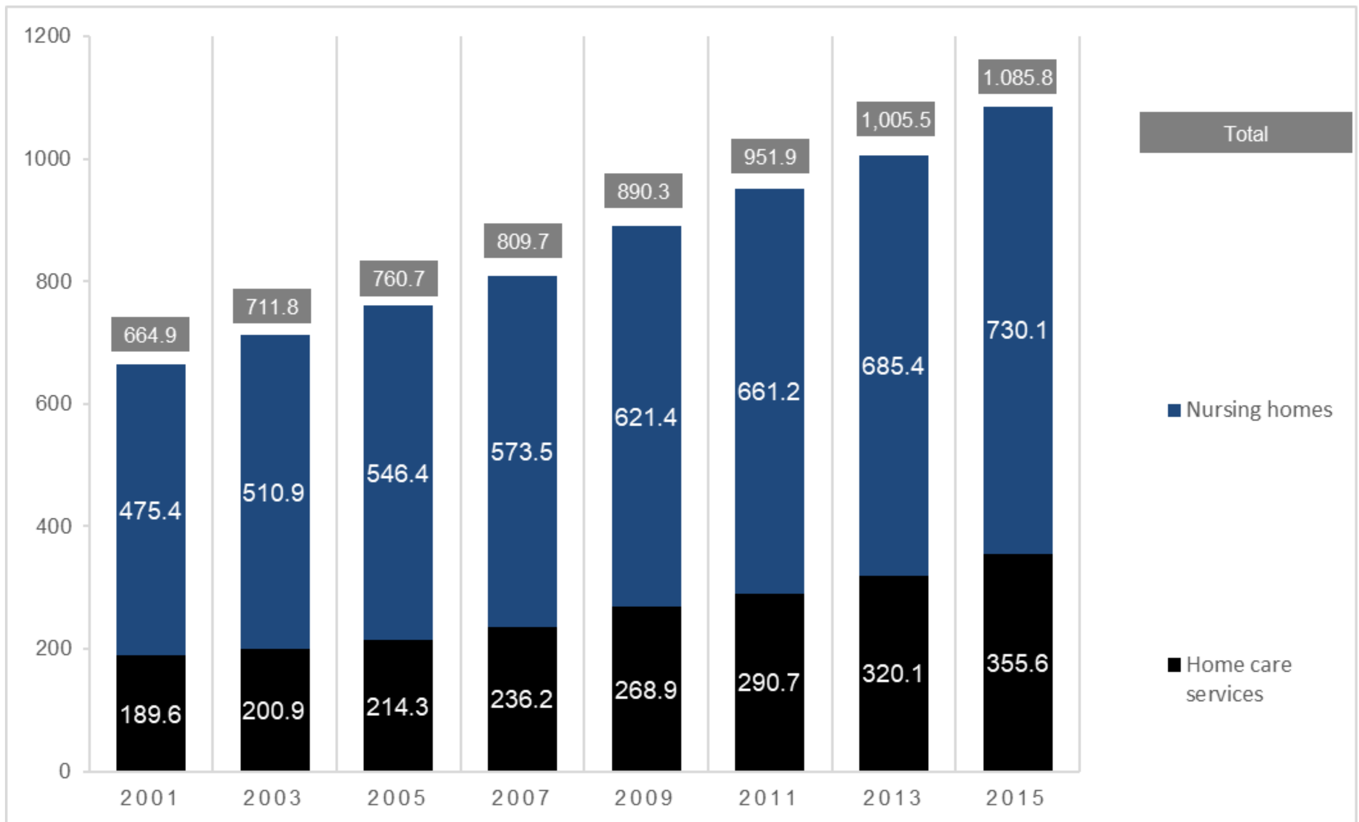
Source: Statistisches Bundesamt (2017a).

Figure 5: Recipients of the LTCI by type of benefit, 1996-2016, in thousands



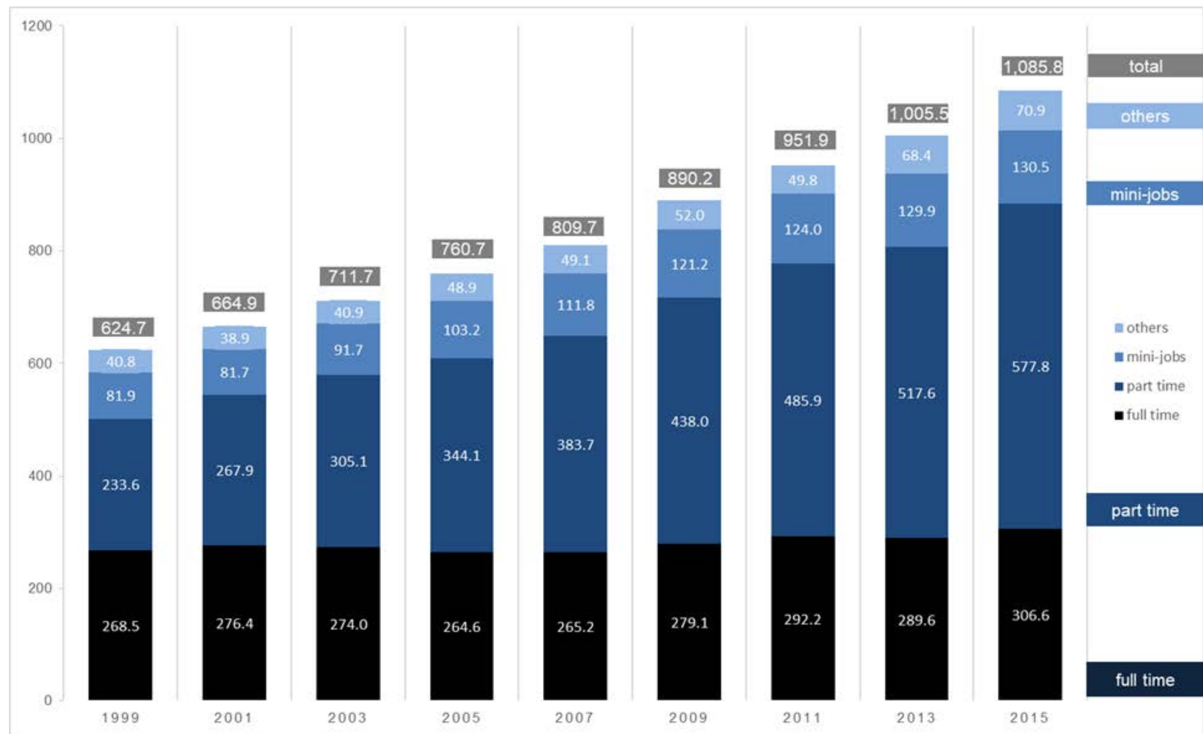
** substitute care, short-time care, day and night care*
Source: BMG (2017b).

Figure 6: Employees in outpatient and inpatient care, nursing homes and home care services, 1999-2015, in thousands



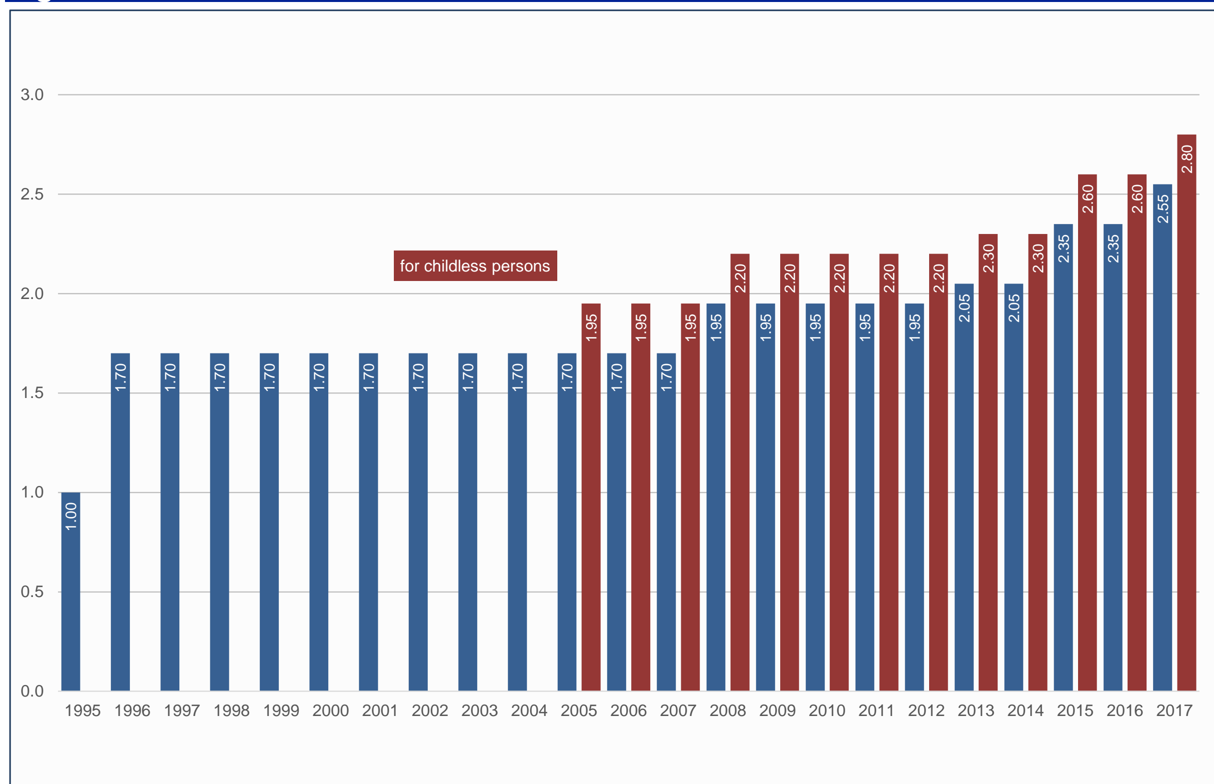
Source: Statistisches Bundesamt (2017a).

Figure 7: Employees in outpatient and inpatient care, 1999-2015, in thousands



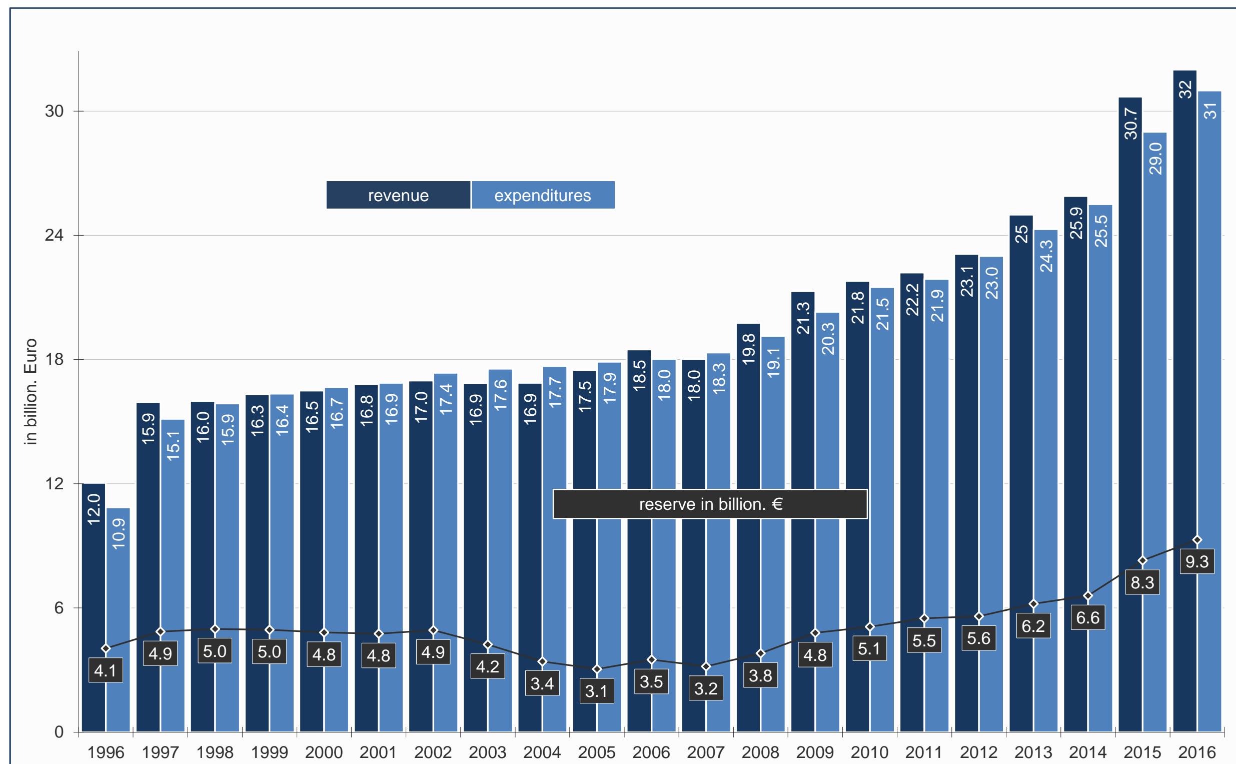
Source: Statistisches Bundesamt (2017a).

Figure 8: LTCI contribution rates, 1995-2017, %



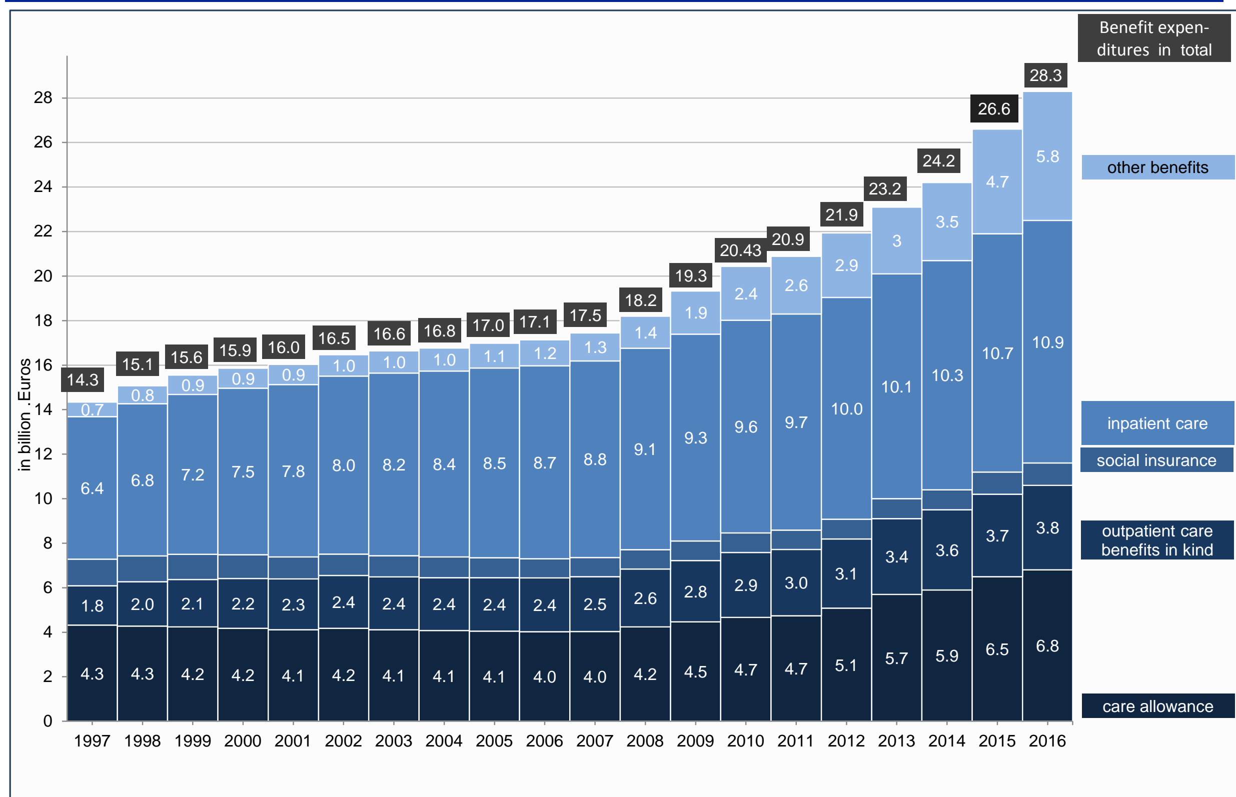
Source: BMG (2017a).

Figure 9: LTCI – Revenue, expenditure and reserves, 1996-2016, EUR billion



Source: BMG (2017b).

Figure 10: LTCI – Expenditure development by type of benefit, 1997-2016, EUR billion



Source: BMG (2017b).