



# **ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives**

## **Germany**

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Gerhard Bäcker  
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**European Social Policy Network (ESPN)**

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work-life balance measures  
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with dependent relatives**

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## Summary/Highlights

(1) In Germany, predominantly elderly people are at high risk of being in need of care. Dementia sufferers face special problems. Those who appear in the statistics are those who take up benefits from long-term care insurance (LTCI). In 2013, around 2.6 million people were in need of long-term care. Of these, around 770,000 people (29%) lived in nursing homes. The remaining 1.8 million were being cared for at home by close relatives, including 600,000 persons assisted by outpatient care services. In recent years, the number of people in need of care has constantly increased.

(2) The vast majority of people in need of care are attended to and cared for by family members, mostly spouses, daughters and daughters-in-law. Some 7% of women and 4% of men of working age take care of dependent persons for at least one hour a day; around 60% of them are employed. However, a distinction must be made between the main caregiver, whose time load is significantly higher, and other family members who are also involved.

(3) The long-term care regime in Germany is decisively shaped by LTCI. This can be classified as the fifth pillar of the national statutory insurance system, with benefits based on insurance claims. It is characterised by similar structures as the health system and Statutory Health Insurance (SHI): those entitled to benefits are all (insured) persons in need of care, irrespective of age or other criteria. The benefits of LTCI do not differ between regions and are not limited in time. The expenditure is financed through contributions that are scaled according to income.

(4) LTCI distinguishes between three levels of care and three different arrangements. A recipient can choose from: care allowance, home care (in kind) and residential care. Care allowance refers to so-called informal care, i.e. he/she lives at home and is looked after by close relatives. The recipients of benefits in cash (and also in kind) are those being cared for, not the carers. 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. In addition to the basic in-kind benefits, there are specific outpatient and semi-inpatient services and facilities: holiday stand-ins, part-time day and night care, and short-term care. LTCI is a "part insurance cover". It pays the same fixed benefits according to the level of care, and takes no account of the actual price of the goods and services. Thus, the person in need of care has to bear any difference.

(5) Currently there are four different regulations for carer's leave: (a) temporary absence: introduction of an entitlement to 10 days off work to care for a close relative; (b) care leave: option of being released from work for a maximum period of six months; (c) part-time care leave: employees are entitled to reduce their weekly working hours to at least 15 hours for a maximum period of two years; (d) end-of-life care leave: leave to accompany a close relative in the final phase of life, up to three months.

(6) Employees with care responsibilities who take up (b), (c) and (d) can apply for a credit-financed benefit (interest-free loan) that must be paid back gradually. Employees who take up short-term leave (a) can apply for a "care support benefit", which is an earnings-replacement benefit.

(7) Up to now, the response to existing care leave schemes has been poor: the obligation to repay the loan is a major barrier to reducing working hours or claiming care leave. The basic problem is that there are no wage-replacement benefits, such as parental allowance. And the restriction of the legal entitlement to employees of companies with more than 15 staff (or 25 in the case of part-time care leave) means that a substantial proportion of employees are not protected.

(8) The provision of quantitatively and qualitatively adequate outpatient and semi-inpatient services and facilities is a cornerstone of a better reconciliation of working life with care obligations. Indeed, these services have strongly expanded in recent years. But supply gaps have not yet been resolved. In many cities and neighbourhoods, and in particular in rural areas, there are still supply deficits with regard to people's needs. The

only partial nature of the coverage of costs by LTCI leads to enormous cost-pressure in the field of outpatient and inpatient care. The lack of time from which both the nursing staff and patients suffer is an essential characteristic of professional care in Germany. Long-term care is a personnel-intensive service. High-quality care requires adequate staff, in both quantitative and qualitative terms. The long-term care branch can be classified as an employment sector that is expanding greatly. But the worrying chronic shortage of skilled staff in Germany has not been solved; the problem has even intensified in recent years.

(9) The maxim that home care must be given priority over institutional care in nursing homes is undisputed. But that does not mean that long-term care in nursing homes will become less important. The percentage of women (and men!) who remain without children for their whole life is increasing. And constantly growing spatial and occupational mobility leads to large distances between the places of residence of the elderly and of their children. Furthermore, we have to consider that the willingness and possibility of home care and of reconciliation of employment with care depend on several framework conditions in the family of the carer(s).

(10) If the conditions prove hard or impossible to meet, then home care – and even more so the combination of home care and employment – can very quickly reach its limits. The task of fulfilling care obligations in parallel to work is therefore closely related to living conditions **and** working conditions. What is required in working life is a temporary reduction in working time, or else leave/time off. But neither option is acceptable without an income replacement benefit. Also necessary is reliable and flexible working time. It is evident that these complex connections and interdependencies cannot be managed solely by statutory regulations. They must be complemented by collectively agreed and/or company regulations.

# 1 Description of Main Features of Work-lifeBalance Measures for Working-age People with Dependent Relatives

## 1.1 Overall description of long-term care regime

In Germany – as in all other European countries – the number of people who are not able to manage their lives independently and without external support is growing significantly. Elderly people, and predominantly the very old, are at high risk of disease and subsequently of physical and mental impairment. These impairments can lead to slight problems in everyday activities (like walking, climbing stairs, housekeeping, cooking, etc.) so that occasional help/assistance from other persons is necessary. They can also lead to severe functional loss and a status of need of care. Dementia sufferers face special problems.

The total number of people in need of help and in need of care in Germany is unknown. It is estimated that there are about 7.9 million persons (2011) who are restricted in their normal daily activities (Geyer and Schulz 2014; data base EU-SILC). Those who appear in the statistics are those people in need of care who take up benefits from long-term care insurance (LTCI): the law (Social Code Book XI) defines persons as eligible for long-term care if they require frequent or substantial help with normal day-to-day activities on a long-term basis (that is, for an estimated six months or longer) because of a physical, mental or psychological illness or disability. The age of the person in need of care is irrelevant; all dependent persons (disabled children, adults and old people) are eligible for the LTC care scheme.

According to the latest official statistics, around 2.6 million people required long-term care in 2013. Of these, around 770,000 people (29%) lived in nursing homes. The remaining 1.8 million were being cared for at home by close relatives, mostly women. This figure included 600,000 who were assisted by outpatient care services (see Figure 1 in the Annex). In recent years, the number of people in need of care has risen significantly – by around 66% between 1996 and 2014. The data show that the risk of being in need of care depends to a high degree on age: nearly two-thirds (64.4%) of people aged 90 years and over are in need of care; however, these very elderly people are still cared for at home, the share being 54.5%. In contrast, the number and proportion of disabled children under 15 (74,000 – 0.7%) and of persons between 15 and 60 years (284,000 – 0.6%) who receive benefits from the LTCI are very small (see Figure 2 in the Annex).

The quota of people in need of care and living in nursing homes has changed only slightly in recent years: it rose from 27.9% in 1999 to 29.1% in 2013 (see Figure 3 in the Annex).

Projections indicate that the number of people in need of care will rise to 3.4 million in 2030 and to 3.7 million in 2050 (Statistisches Bundesamt 2011), which corresponds to an increase of more than 40%.

Overall it can be stated that the vast 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. Some 7% of women and 4% of men of working age take care of dependent persons for at least one hour a day; around 60% of these people are employed (Geyer and Schulz 2014). However, a distinction must be drawn between the main caregivers (mostly women), whose timeload is significantly higher, and other family members, relatives and neighbours who are also involved (Wetzstein et al. 2015). The empirical findings show that men are the main caregivers as husbands, or are involved in supporting their wives who care for their parents (in law) (Schmid and Schneekloth 2012).

However, this family-based care regime, which was typical in Germany for a long period of time, is becoming unsustainable, as it implicitly presupposes that women play their traditional roles of non-working housewives, mothers or daughters: the period of child-rearing is followed some years later by a period of caring for close relatives when gainful



employment is given up again. The consequences are obvious: either the objective of increasing the rate of employment among women (in particular women of higher working age) is impaired, or relatives in need of long-term care will have to be admitted to a nursing home, although they could remain in their homes if appropriate care were provided. At the same time, the risk of need of care is concentrated on the age groups 80 years and older. The children of these very elderly persons have reached an average age of around 60 years. The available empirical findings indicate that the employment rate of women aged 55–60 has increased significantly in recent years – from 59.1% in 2008 to 72.4% in 2014 (and from 25.1% in 2008 to 46.0% in 2014 for women aged 60–65) (see Figure 4 in the Annex). This corresponds to an increase of 13.3 and 20.9 percentage points, respectively. This upward trend will continue as the statutory retirement age of the Statutory Pension Insurance (SPI) is gradually raised to 67 years.

According to the maxim of German policy on long-term care (LTC), in future home care must also be given priority over institutional care in nursing homes. This political priority corresponds with the wishes of the people in need of care, who want to live in their familiar surroundings for as long as possible.

There is no legal obligation for relatives to take on care responsibilities for a dependent person, but for children or parents who would otherwise be legally required to provide maintenance need to top up the money. This applies only in those cases where the benefits of the LTCI and the income and assets of the person in need of care are insufficient to cover the costs of outpatient care services or of care in nursing homes. The question is whether the German long-term care regime is appropriate to achieving the objective of priority home care, despite the changing societal, demographic and labour-market conditions. There is a necessity to ease the reconciliation of employment with family care. To accomplish this goal, the traditional standards in the world of work must be made more flexible, while outpatient and semi-inpatient services and facilities must also be expanded in order to support the family caregivers through professionals.

The current long-term care regime in Germany is decisively shaped by long-term care insurance. LTCI can be classified as the fifth pillar of the national statutory insurance system, with benefits based on insurance claims. It was introduced – after many years of discussion – only in 1995 (Naegele 2014). In previous years, the cost of inpatient and outpatient care had to be borne privately. Only in the case of lack of resources could means-tested social assistance (“help for care”) be claimed – whereby income and assets were taken into account, including the income and assets of the partner and children.

LTCI is characterised by similar structures as the health system and the Statutory Health Insurance (SHI) (Paquet and Jacobs 2015; Rothgang 2010):

- Membership of either statutory long-term care insurance or private long-term care insurance is compulsory for all citizens. All members of the SHI are automatically members of LTCI, and all members of Private Health Insurance (PHI) have private LTCI.
- Benefits provided under private long-term care insurance must be equivalent to those provided by statutory long-term care insurance. 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 when the contract is signed. The premiums are the same for men and women. Children receive free cover, as they do under statutory long-term care insurance. In 2014, 70.7 million citizens were covered by statutory LTCI and 9.5 million citizens by private LTCI.
- However, in contrast to the SHI, the amount of LTCI benefits is legally fixed. LTCI covers only part of the long-term care costs.
- The benefits of LTCI do not differ between regions and are not limited in time.
- All (insured) persons in need of care, irrespective of age or other criteria, are entitled to benefits.

- The expenditure on statutory LTCI is financed through contributions that are scaled according to income. As of 1 January 2015, the contribution rate is 2.35% of assessable income. The assessable income contribution is shared between employees and employers, so employers bear half of 2.35%. Contribution payers with no children – irrespective of the reason for their childlessness – are required to pay a supplement of 0.25%. The contribution assessment ceiling that applies to SHI also applies to statutory long-term health insurance (2016: EUR 4,238 per month). Dependent children, spouses and non-married partners are insured free of charge as family members under the family insurance provisions of the SHI, providing their regular monthly income does not exceed EUR 450. Pensioners' contributions have to be paid by the pensioners themselves.
- On the supply side, the long-term care market is dominated by private providers (for profit and non-profit). Nursing homes owned by municipalities are to be found only in the area of residential care. The long-term care insurance funds conclude contracts with the care providers at a regional or municipal level.

LTCI distinguishes between three levels of care, based on the severity of the health condition. In addition, a Care Level 0 also exists. If people require extreme care and fall under Care Level III, they may also qualify as a hardship case:

- Care Level 0: This includes people, no matter how old they are, who have a dementia-related incapacity, a mental disability or a physical disability, and whose everyday activities are severely restricted, even if their basic care and home-help needs do not qualify for Care Level I.
- Care Level I: Considerable need of care. A considerable need of care arises when people need help at least once every single day, for an average of at least 90 minutes.
- Care Level II: Severe need of care. A severe need of care arises when people need help at least three times a day and require an average of at least 180 minutes of help every day of the week.
- Care Level III: Extreme need of care. An extreme need of care arises when people are in need of care round-the-clock every day and an average of at least 300 minutes of (paid) care is required every day of the week.
- Hardship cases: If the need for care far exceeds Level III, people may qualify for additional care as a hardship case.

The expected time of care needed and the level of care are formally assessed by an independent Medical Review Board of the Statutory Health Insurance Funds (MDK). Long-term care benefits are granted on the basis of the care level and whether people need care at home or institutional care (for the amounts of the care benefits in 2016, see Table 1 in the Annex). Regardless of the level of care, assistance may be provided for prevention and rehabilitation (measures to overcome, reduce or prevent an increase in the need of long-term care). These measures are given priority over care. Home care is also given priority over institutional care.

In general, there are three different arrangements that a recipient can choose from: care allowance, home care (in kind) and residential care:

- Care allowance refers to so-called informal care, i.e. the person in need of care receives monetary support, typically lives at home and is looked after by close relatives.
- Home care (in kind) means that a professional care provider (such as a social services agency or home-care service) visits the recipient regularly at home. The provider is under contract to the LTCI fund and is paid directly by the LTCI.
- Residential care refers to a stay in a nursing home. The long-term care insurance will pay the costs of basic care, social support and treatment, according to the

care level. As with home nursing care, people in need of care are responsible for paying the costs of room and board.

LTCI pays the same fixed benefits according to the level of care, irrespective of the cost of the actual goods and services. Thus, the person in need of care has to make up the difference. In 2011, LTCI bore roughly 50% of residential and 54% of the cost of home care (in kind) (Statistisches Bundesamt 2013). Thus, LTCI is often referred to as a “part insurance cover” (Rothgang et al. 2012).

## 1.2 Description of carers' leave

The insight that there is an imperative need for legal measures to reconcile work and care obligations –not only in the case of rearing children, but also in the case of caring for older relatives –came to the fore in Germany only about 10 years ago.

In 2008, a legal entitlement to temporarily leave one's employment in order to care for a relative came into force for the first time (Home Care Leave Act: *Pflegezeitgesetz*):

(a) Temporary absence: introduction of an entitlement to 10 days off work to care for a close relative.

(b) Care leave: option of being released from work for a maximum period of six months.

The conditions of care leave were extended by the Family Care Leave Act (*Familienpflegezeitgesetz*) of 2011, which introduced part-time care leave:

(c) Part-time care leave: employees are entitled to reduce their weekly working hours to as little as 15 hours for a maximum period of two years.

As a third step, the Act for a Better Reconciliation of Family, Care and Work (*Gesetz zur besseren Vereinbarkeit von Familie, Pflege und Beruf*) came into force on 1 January 2015. Its intention was to improve the legal framework conditions of the temporary absence, the care leave and the part-time care leave. An entitlement to end-of-life care leave was also introduced.

(d) End-of-life care leave: leave to accompany a close relative in the final phase of life for up to three months.

Since 2015, the following regulations apply to carer's leave:

### (a) Temporary absence (short-term leave)

Short-term leave of up to 10 days a year provides an opportunity to organise assistance and support when an exceptional care situation affecting a close relative arises unexpectedly. Employees are thus given the opportunity to respond to an emergency situation, find out about the care services available, and make arrangements for their provision. The right to temporary absence from work also helps ensure that a person in need of care who cannot immediately be accommodated in a suitable nursing home after a stay in hospital can be looked after by relatives at home in the interim.

The right to temporary absence from work is unlimited; it applies to all employees regardless of the size of the regular workforce and the size of the enterprise.

### (b) Care leave

Employees who provide nursing care for a dependent relative at home have the right to leave from work for a maximum period of six months. This statutory right to the six months of care leave only applies to employees in companies with more than 15 staff.

### (c) Part-time care leave

Employees who take up this scheme can reduce their weekly working hours to just 15 hours for a maximum period of 24 months, with a guaranteed right of return from temporary part-time to full-time work. If working hours vary, they must reach an average of at least 15 hours a week over a period of up to one year. This statutory right

to a 24-month period of part-time work only applies to employees of companies with more than 25 staff.

Those entitled are spouses, partners in accordance with the cohabiting partnership law or equivalent partnerships, siblings, parents, step-parents, grandparents, parents-in-law, children, children-in-law, grandchildren, as well as brothers- and sisters-in-law.

*(d) End-of-life care leave*

Employees are entitled to take full-time or part-time leave of up to three months to accompany a close relative in the final phase of life and to be at her or his side to the end. It is not required for care to be provided at home. The entitlement can be exercised if the employer has a workforce of more than 15 employees.

*(e) Combination*

Care leave can be followed by part-time care leave and vice versa. The different types of leave must be taken without any gap between them. Leave to accompany a close relative in the final phase of life is the only type of leave that can be taken subsequent to one of the other forms, but after a gap. The total duration of all leave may not exceed 24 months.

An employer is not allowed to dismiss employees from the date when they give notice that they intend to take leave (a maximum of 12 weeks before the date on which the leave is due to commence) to the end of the temporary absence or to the end of the leave.

### **1.3 Description of carers' cash benefits**

#### **1.3.1 Benefits for dependent persons (and intended transfer to carers)**

According to the law, the recipients of benefits in cash (and also in kind) are those persons being cared for, not the carers. The recipient may freely dispose of the care allowance, but it is intended that he or she should transfer the amount to the family caregiver, as a kind of recognition. However, a precondition for the receipt of care allowance is that appropriate care is ensured. The law therefore prescribes periodic advice and inspection through a care provider that is authorised by the LTCl.

The care allowance can also be used to fund migrant carers (e.g. from Eastern EU countries); this applies especially to so-called 24-hour care. Legal recruitment occurs through agencies in Germany and in the posting country. Migrant 24-hour carers are the employees of a service agency, for example in Poland, and have to be paid privately; they are not under contract to the LTCl fund.

The amount of care allowance is staggered according to the level of care. The benefit currently amounts to EUR 123 per month (Care Level 0, sufferers from dementia), but may be as high as EUR 728 (Care Level III) (see Table 1 in the Annex).

Also to be mentioned are special allowances available to pay for the cost of modifying the home to accommodate the nursing care needs. A maximum of EUR 4,000 can be granted for each project, if there are no other means of financing it. People classified as Care Level 0 who face considerable restrictions in their everyday activities may also receive this allowance.

The long-term care allowance is not deemed to be "income". It is free of taxes and contributions, so that working carers (regularly part time) can simply add it to their net income. Care allowance is also not taken into account in the means test for social assistance.

### 1.3.2 Benefits for carers

Employees with care responsibilities who take up

- (a) care leave,
- (b) part-time care leave and
- (c) end-of-life care leave

can apply for a credit-financed benefit (interest-free loan) that must be paid back over time. This benefit is a net cash benefit, i.e. not a wage with social contributions and income tax.

Employees who take up

- (d) short-term leave

can apply for a "care support benefit" (*Pflegeunterstützungsgeld*). This benefit is an earnings-replacement benefit, with the amount being calculated as child sickness benefit. The gross amount of care support benefit is 90% of the pay forgone, net of deductions – minus employee contributions to the statutory pension, long-term care and unemployment insurance. The care support benefits are financed by LTCl.

Necessary statutory insurance cover is maintained during full-time care leave. Care leave is deemed as a qualifying period, and the long-term care insurance fund pays contributions to the unemployment insurance fund.

### 1.3.3 Statutory insurance for carers

Caregivers are covered by statutory pension insurance for the period during which they provide care, for a minimum of 14 hours a week in a person's home, and are not elsewhere employed or if they work for no more than 30 hours a week. The contributions are paid by the long-term care insurance fund. The contribution rate depends on the level of care provided and the amount of time which must consequently be spent providing that care. In holiday times (a break from providing nursing care), the pension contributions will be paid by the LTCl for the duration of the absence.

Carers also come under statutory accident insurance for the time during which they provide care.

## 1.4 Description of carers' benefits in-kind

As mentioned above, the amount of benefits in kind in the field of outpatient care depends on the level of care (see Table 1 in the Annex) and covers only part of the costs actually incurred. The purpose is to support the family caregivers through professionals. The current amounts vary between EUR 231 (Care Level 0, sufferers from dementia) and EUR 728 (Care Level III). The carer(s) or the person being cared for signs a contract with an outpatient care service, which in turn is under contract to the LTCl fund and is paid directly by LTCl. Home care under the non-cash benefits option can also be provided by an individual carer. Long-term care insurance funds are required to enter into a contract with individual carers, unless there is a specific reason not to do so.

In addition to the basic in-kind benefits, there are specific outpatient and semi-inpatient services and facilities provided under LTCl:

- Holiday stand-ins: If the person who provides the care at home goes on holiday or is otherwise unable to care, persons in need of care are entitled to a stand-in for a maximum of six weeks a year.
- Part-time institutional day and night care: Part-time institutional care refers to care in a facility that provides day or night care. The LTCl fund pays the costs of care, social support and medical treatment.

- Short-term care: Short-term care is provided in suitable 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).
- Nursing care courses for relatives and volunteer care givers.

## **1.5 Combination of benefits in kind and in cash**

It is possible (and common) to combine the receipt of care allowance with the claim of benefits in kind. The care allowance is accordingly reduced by the volume of benefits claimed in kind.

## **2 Analysis of the Effectiveness of Work-life Balance Measures for Working-age People with Dependent Relatives**

### **2.1 Assessment of individual measures**

#### **2.1.1 Carer's leave**

Unfortunately, representative and reliable data providing information on the take-up, structure and development of the outlined carer's leave schemes are not available, due to the absence of a reporting obligation. But a few research studies show that prior to 2015, the response to the care leave and part-time schemes then in existence was extremely poor (Reichert 2012; Deutscher Bundestag 2013). This was mainly due to the fact that at that time there were no legal entitlements to temporary part-time work and no reliable income compensation. Furthermore, research studies indicate that the information on the regulations and entitlements was very sparse and fragmentary—concerning both employees and employers.

The question is whether these sobering results will change in the coming years and whether the 2015 law (Act for a Better Reconciliation of Family, Care and Work) will contribute to a higher acceptance rate. Doubts are justified: the obligation to repay the loan is still a major barrier to reducing working hours or claiming care leave. And the restriction of the legal entitlement to employees of companies with more than 15 employees (or 25 in the case of part-time care leave) means that a great number of employees are not protected. In 2014, nearly 17% of all employees worked in companies with fewer than 20 staff, and 44% were in companies with fewer than 50 (Bechmann et al. 2013). This especially affects women, who often work in small and medium-sized businesses. Finally, it should be mentioned that the new law has attracted only little public attention, not least because it contains complex regulations and is difficult to understand.

#### **2.1.2 Carers' cash benefits**

##### **Benefits for carers**

The basic problem is that there are no wage-replacement benefits, such as parental allowance. To take out a loan and then to repay it is a strong barrier to reducing working hours or claiming care leave. Moreover, the procedure is complicated and time consuming. Only the "care support benefit", which is associated with short-term leave of up to 10 days, is a wage-replacement benefit. However, experts from the SHI and LTCI assume that recourse to this entitlement will remain limited, because it is easier for caring relatives to report in sick and to profit from their continued salary payment by their employer.

First statistical data show that the new care leave entitlements are scarcely known and hardly used: up to October 2015, only about 6,000 persons had made use of the short-term care leave, and only 313 (!) had claimed the credit-financed benefit (Schwesig 2016).

## Benefits for dependent persons

In 2014, about 1.25 million people in need of care received care allowance (see Figure 5 and Table 3 in the Annex). This corresponds to 45.1% of all recipients (including combined benefits: 61.9%), but to only 24.5% of all spending on LTCI (see Figure 6 in the Annex). Since 1998, the number of care allowance recipients has increased by about 33%, but the proportion of all LTCI recipients has declined. Benefits in kind – in particular outpatient and semi-inpatient services – have grown in significance. Recipients of care allowance are predominantly classified in Care Level I (see Table 2 in the Annex).

The benefit level of the care allowance has increased disproportionately in recent years, as home-care cash benefits are aimed at limiting the demand for professional services (benefits in kind). Conversely, inpatient care in nursing homes is the most expensive form of care, and comprises 47.4% of total costs. Care allowances – at an appropriate level – are therefore an important component in slowing down the cost increase of LTCI.

Yet there is the risk that these cash benefits may strengthen the traditional role of women and the male bread-winner model of gender relations. Amounts of up to EUR 728 may be an incentive to low-skilled and low-paid women to give up gainful employment or not to take up gainful employment.

Furthermore the question must be raised as to whether the quality of private/family care is sufficient, and for what purposes cash benefits are actually used by the benefit recipients. LTCI supervision bodies should check the quality (MDS 2012), but there is no evidence that an appropriate level of monitoring exists.

### 2.1.3 Carers' benefits in kind

The provision of quantitatively and qualitatively adequate outpatient and semi-inpatient services and facilities is a cornerstone of a better reconciliation of working life with care obligations. Supporting family caregivers through professionals in everyday care and in special situations (substitute care, short-term care, day-and-night care) can remove obstacles to carers entering or remaining in the labour market. A new task is the promotion of outpatient flat-sharing communities. Indeed, these services have been expanded considerably in recent years – in connection with rising expenditure (see Figure 6 in the Annex). The First Act on Strengthening Long-term Care (*Pflegestärkungsgesetz I*), which came into force in 2015, was primarily targeted at improving the conditions of home care.

But supply gaps have not yet been resolved. The care market is not transparent in terms of quantity, quality and performance. The expansion has not taken place in a planned and coordinated way. In many cities and neighbourhoods, and in particular in rural areas, there are still supply deficits with regard to people's needs (Hagen and Rothgang 2014).

The only partial coverage of costs by LTCI leads to enormous cost-pressure in the field of outpatient and inpatient care in Germany. Care service providers have to account for their time in minutes. The lack of time from which both the nursing staff and patients suffer is an essential characteristic of professional care. Often there is virtually no chance of personal attention – a prerequisite for humane and high-quality care (Kesselheim et al. 2013).

Long-term care is a personnel-intensive service. High-quality care requires adequate staff, in both quantitative and qualitative terms. But the worrying and chronic shortage of skilled staff in Germany has not been resolved; indeed the problem has even intensified (Nowossadeck 2012; Hämel 2013; Afentakis et al. 2013; Bogai 2014). This is a consequence of the high physical and mental strain involved, of difficult working conditions and of low pay in nursing jobs (Schulz 2012).

The number of employees in outpatient care increased significantly between 1999 and 2013 (see Figure 8 in the Annex). In home-care services, around 320,000 (mostly skilled) persons were employed in this sector in 2013, compared with 184,000 in 1999 – an increase of nearly 75% (!). This demonstrates that the long-term care field can be

classified as a greatly expanding employment sector – mostly for women, and concentrated on part-time and marginal jobs.

It is completely unknown how many migrant carers are working in the field of home care in Germany – illegally or legally (within the framework of the posting of workers directive). This “live-in arrangement” or “24-hour care” model means that the carers (up to now exclusively women from Eastern EU countries) live in the household of the person being cared for and – as already mentioned – have to be paid privately. As the German minimum wage applies to these workers, the costs are not negligible. Therefore only a small proportion of persons in need of care and their families can afford the legal version of this care model (Satola and Schywalski 2016).

## **2.2 Assessment of overall package of measures and interactions between measures**

The German long-term care regime faces major challenges in view of the foreseeable demographic and societal developments. The number of people in need of assistance and care will increase over the coming years and decades, and all sectors of the care regime will be affected. The maxim that home care must be given priority over institutional care in nursing homes is undisputed. But that does not mean that long-term care in nursing homes will become less important. On the contrary, there are some factors that could contribute to an increase in its importance (in absolute and relative terms). On the one hand, the demographic changes have to be taken into account: the percentage of women (and also men!) who remain without children for their entire lives is increasing. Calculations by the German Federal Statistical Office estimate the rate of childlessness at about 20% (birth cohort 1963–1967) (see Figure 9 in the Annex). At the same time, the number of siblings is decreasing. On the other hand, constantly growing spatial and occupational mobility leads to large distances between the places of residence of the elderly and of their children.

These trends have to be considered in view of the objective of easing the reconciliation of employment with family care. And we have to question what “family” means: what are the essential framework conditions in the families of the carer(s) and the cared for if assistance and care are to be possible and requested (Preuß 2014; Rothgang et al. 2015)? The willingness and possibility of home care and of reconciliation of employment with care depend on many factors, such as:

- The type, intensity, course of development and duration of the care needs of the dependant,
- The age, health and mental stability of the main caregiver,
- The emotional relations between caregiver and cared for,
- Support of the main caregiver by other members of the family or by neighbours,
- The housing conditions,
- Care inside or outside the household, distance between the places of residence of the caregiver and the cared for,
- The distance between domicile and workplace,
- The income and assets of the caregiver and the cared for, and
- The support by outpatient and semi-inpatient services.

If these factors prove hard or impossible to meet, then home care – and even more so the combination of home care and employment – can very quickly reach its limits. There is a great risk of a physical and mental overstraining of the caregiver (Backes et al. 2008). Unfavourable framework conditions can lead to a cessation or long-term interruption of gainful employment on the part of the main caregiver. As already discussed, this affects first and foremost the employment of women. But it must also be feared that persons in need of care will have to be admitted to a nursing home, even



though they could remain in their home if appropriate care were provided. Such a consequence would lead to a rising demand for institutional care and to an increased need for qualified staff and corresponding high employment effects – but also to considerable extra costs.

The task of fulfilling care obligations in parallel with work is therefore closely related to the living **and** working conditions. Decisive for the working conditions is first and foremost working time. A full-time job – which involves an absence from home of about nine hours (including break and travel time) – is not possible for the main caregiver (Bäcker 2003). What is required is a temporary reduction in working hours or leave/time off. But neither option is acceptable without an income replacement benefit – especially not for the main (male) earner. This is one of the reasons why women are (or feel) mainly responsible for the care of their relatives. The large majority of employed women aged 50+ work on a part-time basis (including marginal jobs) (see Figure 10 in the Annex).

Also necessary are reliable **and** flexible working hours. Location, duration and allocation of working hours must on the one hand be predictable, in order to allow the organisation of home care, and on the other hand be flexible, in order to enable a quick response to a sudden situation (for example, the absence of another caregiver or a health emergency). It is evident that these complex connections and interdependencies cannot be managed solely by statutory regulations. They must be complemented by collectively agreed and/or company regulations. Collective bargaining agreements referring to childcare are quite common, but are still rare in relation to the care of older dependants (Bäcker and Kümmerling 2012; Reuyß 2015).

### 2.3 Policy recommendations

Considering the complexity of the care regime, a wide range of policy recommendations should be listed. For this expert report, however, it seems more appropriate to concentrate on key points:

- Further extension of outpatient and semi-inpatient services and facilities,
- Increasing the attractiveness of the nursing and caring profession: better working conditions, high-quality training free of charge and adequate wages,
- Monitoring, controlling and interlinking of the private providers (for profit and non-profit) which are in competition with each other at the local/municipal level,
- Improvement of information and advice for caregivers,
- Introduction of an income replacement benefit for care leave schemes and extension of the legal entitlements to care leave in small companies.

Of particular significance is the question of the legal definition of the need for care: because the existing definition takes account only of remaining physical abilities (assessment in minutes per day), the care of dementia sufferers is insufficient. Experts have therefore for many years been demanding that assessment of the need for care should be completely changed (Rothgang and Jacobs 2013; BMG 2013). Instead of three levels, LTCI should distinguish between five different levels. These levels should be based on impairments, such as mobility, cognitive and communication skills, or coping with disease-related requirements. This requirement will now be fulfilled: in December 2015, the Federal Parliament passed the Act on Strengthening Long-term Care II (*Pflegestärkungsgesetz II*), which will come into force at the beginning of 2017. The previous definition of three care levels, based on physiological deficits, will be replaced by five care grades, based on physical, mental und psychological disabilities (Nakielski 2015). Relevant criteria are:

- Mobility,
- Cognitive and communicative abilities,

- Behaviour patterns and psychological problems,
- Level of Self-Sufficiency,
- Health restrictions, demands and stresses due to therapies, and
- Structure of everyday life and social contacts.

The five grades of “in need of care” are combined with new benefit amounts in cash and in kind (see Table 4 in the Annex). This reform will lead to increased spending on LTCI. The contribution rate will be raised by 0.2 percentage points to 2.55% (for people without children: 2.8%).

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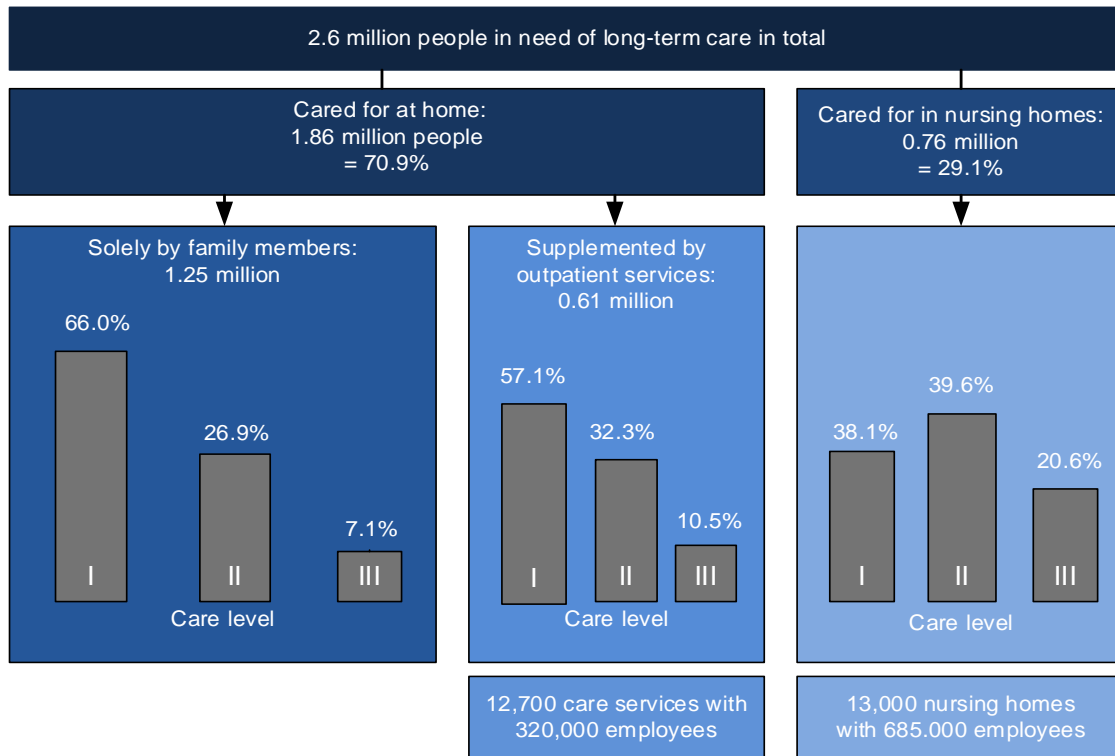
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## Annex

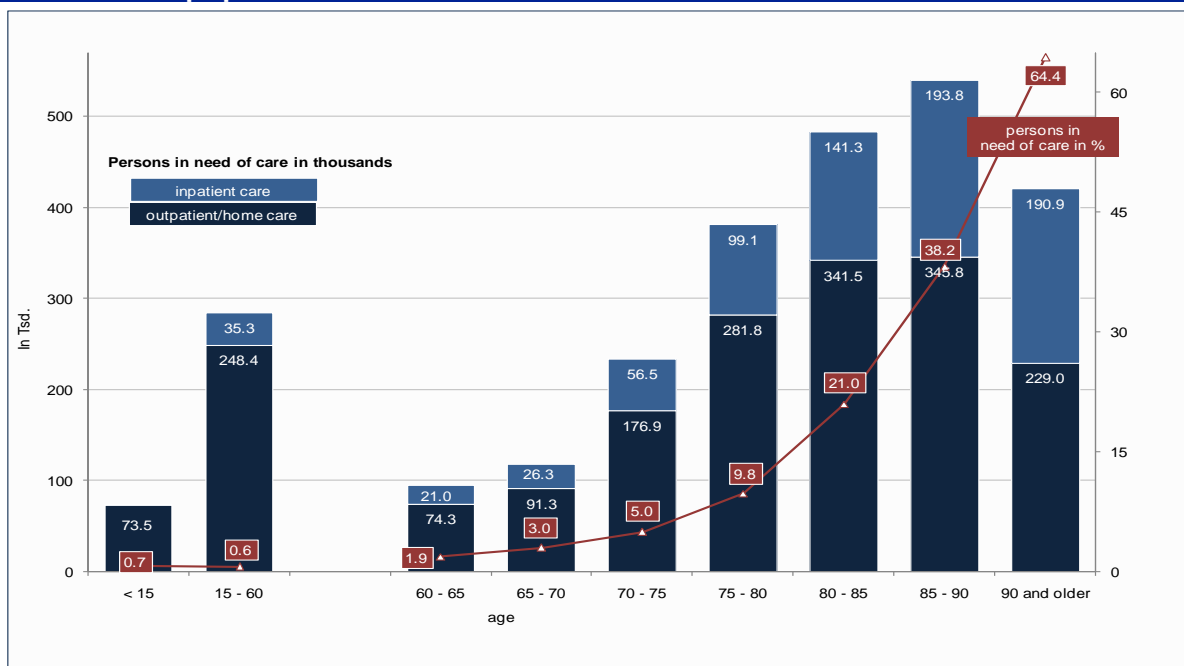
### Figures

**Figure 1: People in need of long-term care 2013: benefit types, care level and staff**



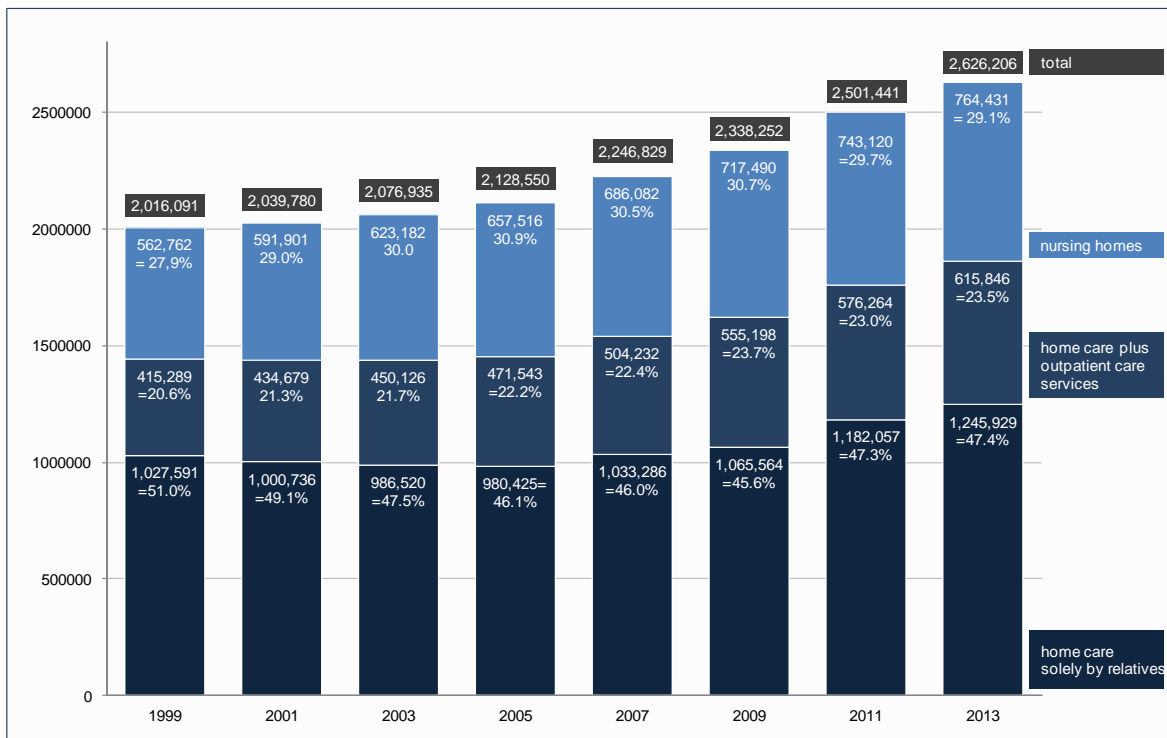
Source: Statistisches Bundesamt (2015): Pflegestatistik 2013.

**Figure 2: People in need of long-term care 2013 by age groups: in thousand and in % of population**



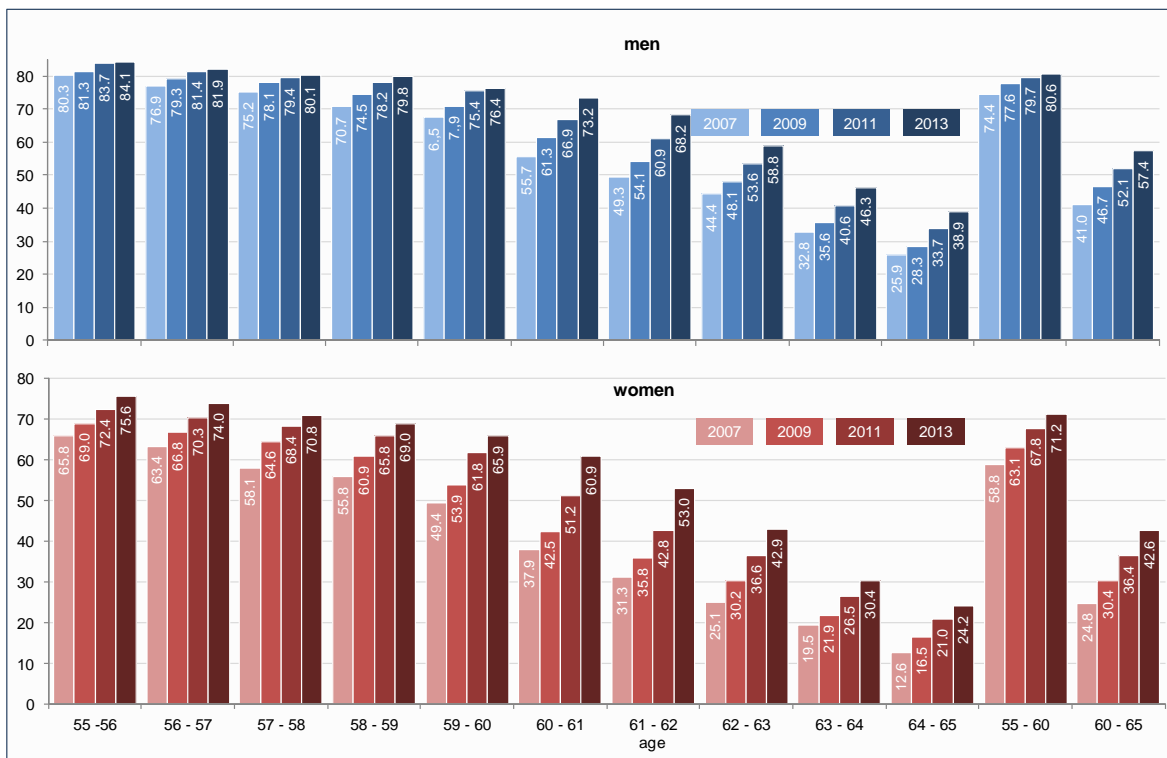
Source: Statistisches Bundesamt (2015): Pflegestatistik 2013.

**Figure 3: People in need of long-term care 1999–2013: by type of provision**



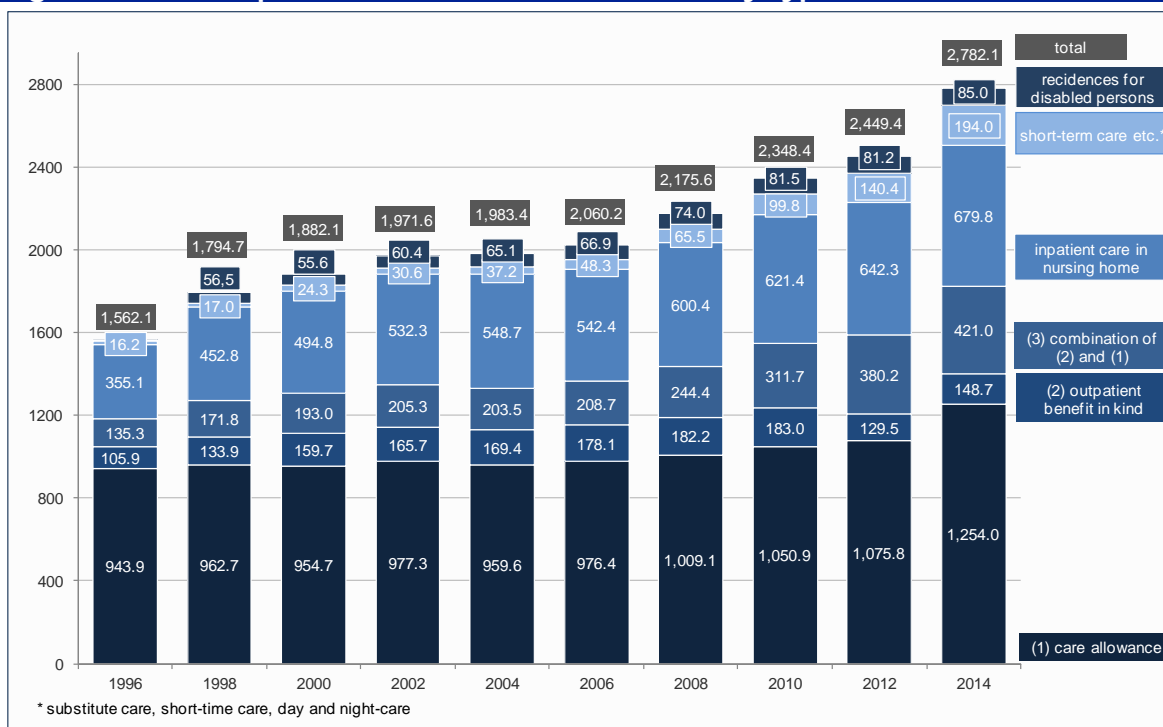
Source: Statistisches Bundesamt (2015): Pflegestatistik 2013.

**FIGURE 4: Employment rates 2007–2013: by gender and age groups**



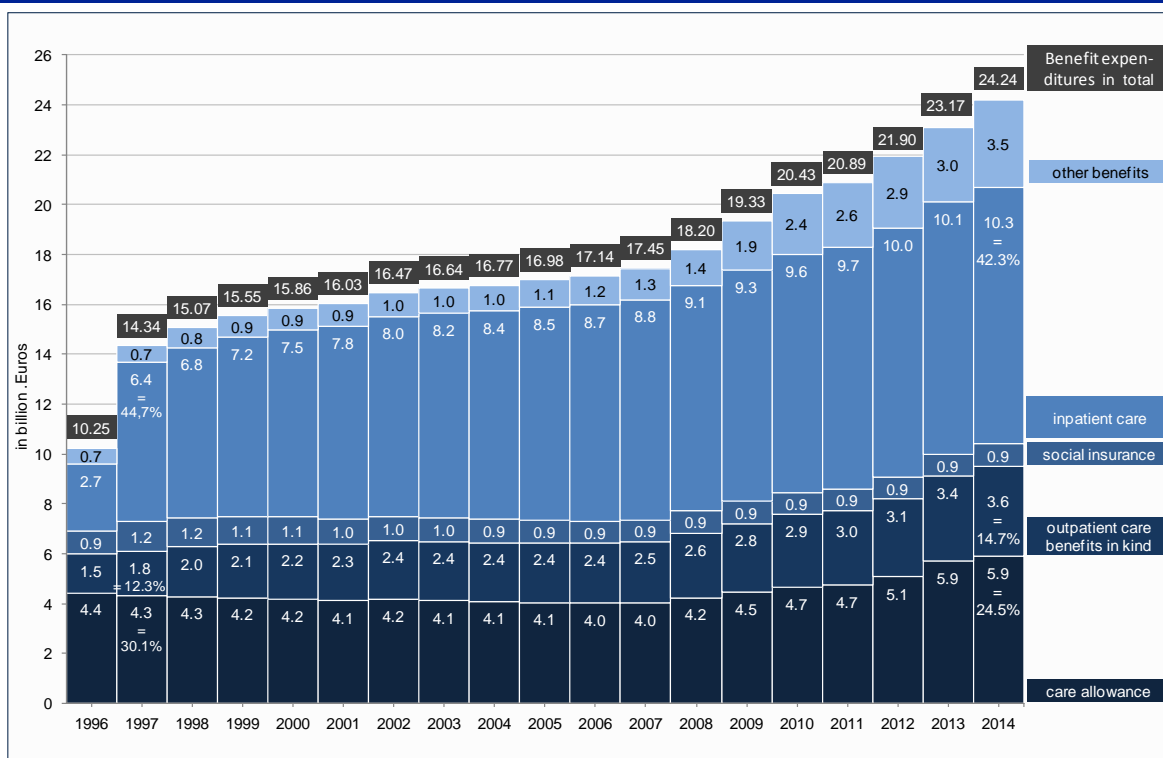
Source: Statistisches Bundesamt (2014), Mikrozensus, Arbeitstabellen (own calculations).

**Figure 5: Recipients of the LTCI 1996–2014: by type of benefit, in thousand**



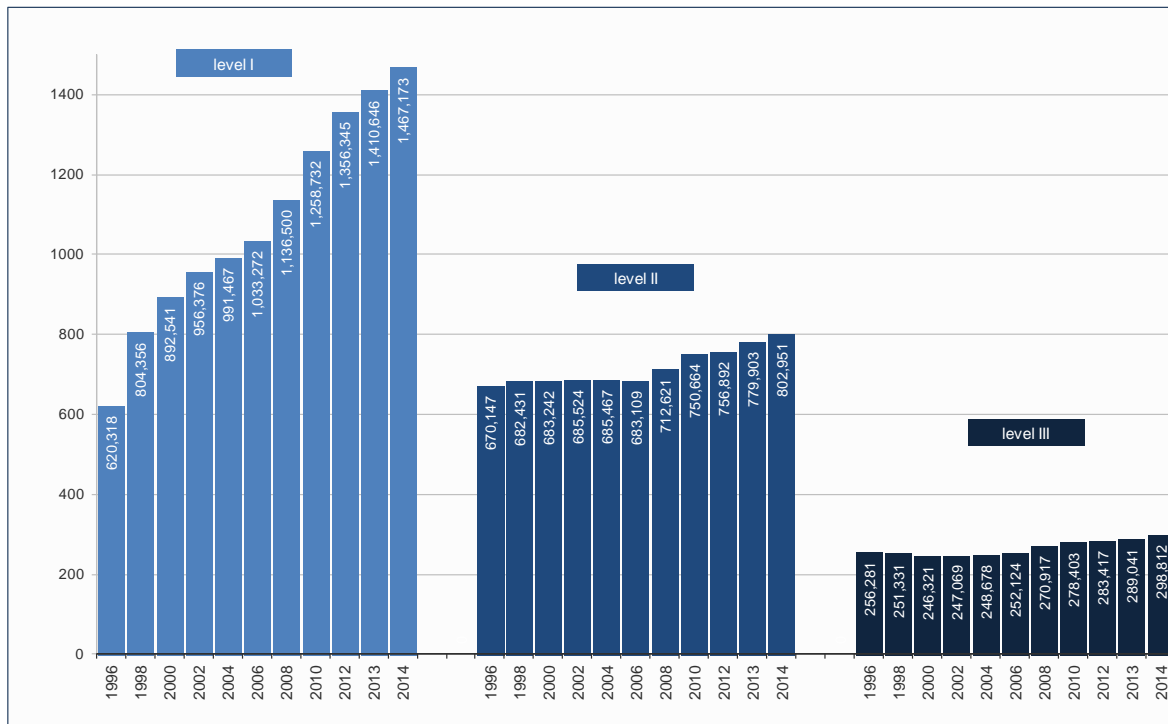
Source: Bundesministerium für Gesundheit (2015): Statistiken zur Pflegeversicherung.

**Figure 6: LTCI: expenditure development 1996–2014: by type of benefit in billion eur**



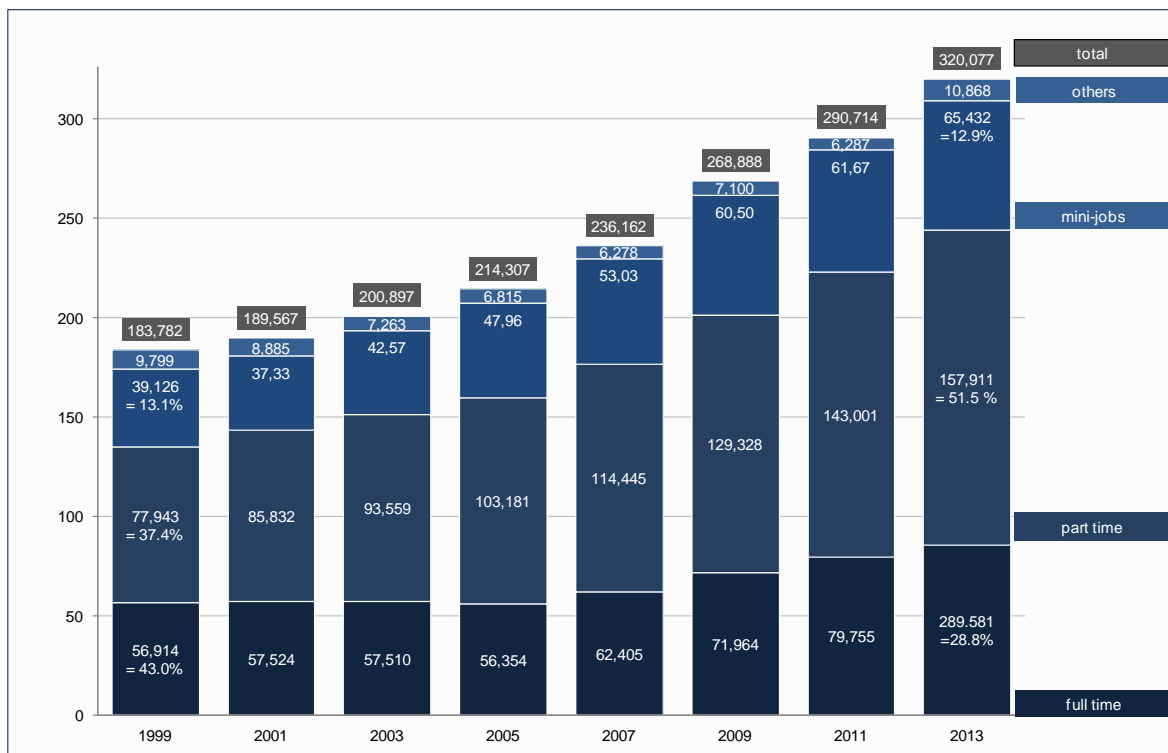
Source: Bundesministerium für Gesundheit (2015): Statistiken zur Pflegeversicherung.

**Figure 7: Recipients of the LTCI 1996–2014: by level of care**



Source: Bundesministerium für Gesundheit (2015): Statistiken zur Pflegeversicherung.

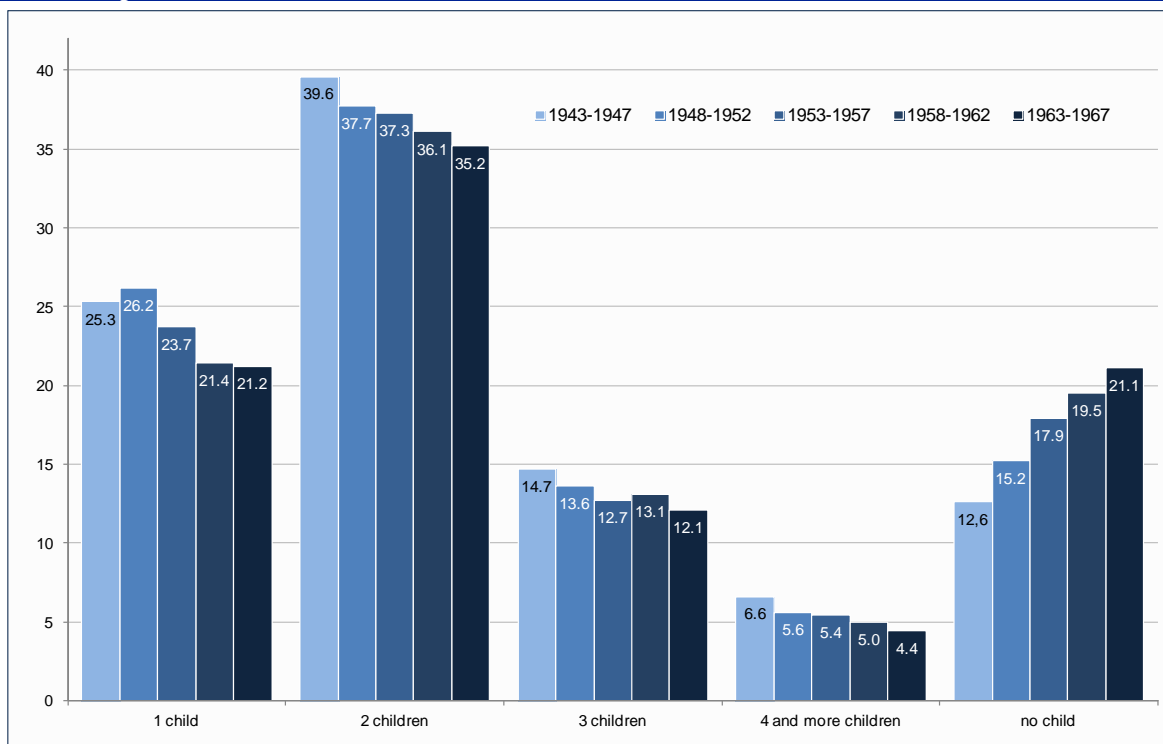
**Figure 8: Staff in outpatient care 1999–2013**



Source: Statistisches Bundesamt (2015), Pflegestatistik 2013.

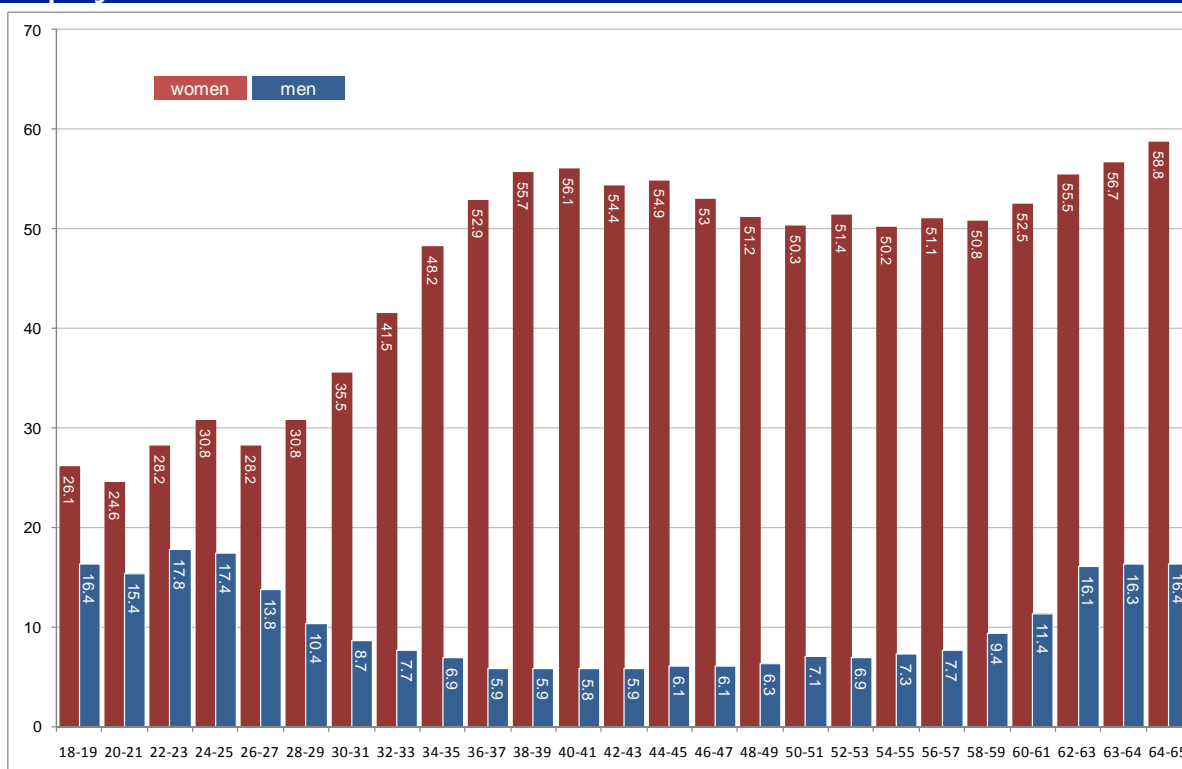


**FIGURE 9: Women and number of children: by birth cohorts 1943–1967, West Germany, in %**



Source: Statistisches Bundesamt (2015), Daten zu Geburten, Familien und Kinderlosigkeit.

**Figure 10: Part-time work of men and women 2013: by Age, in % of all employees**



Source: Statistisches Bundesamt (2014): Fachserie 1, Reihe 4.1.1, Stand und Entwicklung der Erwerbstätigkeit in Deutschland.

## Tables

**Table 1: monthly benefits of the LTCI, 2016, in eur**

Type of benefits		Care level 0	Care level I	Care level II	Care level III
<b>Dementia sufferers</b>	Care allowance	123	316	545	728
	Outpatient care benefits in kind	231	689	1,298	1,612
<b>All others</b>	Care allowance	-	244	458	728
	Outpatient care benefits in kind	-	468	1,144	1,612
<b>Substitute care per year</b>	Close relatives	184.50	474	817.50	1,092
	Other persons	1,612	1,612	1,612	1,612
<b>Short-term care</b>	Up to ... € per year	-	1,612	1,612	1,612
<b>Day-and-night care</b>	Up to ... € per year	-	468	1,144	1,612
<b>Inpatient care</b>	Standard amount	-	1,064	1,330	1,612

Source: Bundesministerium für Gesundheit 2015.

**Table 2: LTCI recipients and care levels 1996–2014**

	Total	Home care and day care								Nursing homes							
		Total		Care level						Total		Care level					
		absolute	in %	I		II		III		absolute	%	I		II		III	
				absolute	%	absolute	%	absolute	%			absolute	%	absolute	%	absolute	%
1996	1,546,746	1,162,184	75.1	508,462	43.8	507,329	43.7	146,393	12.6	384,562	24.9	111,856	29.1	162,818	42.3	109,888	28.6
1998	1,738,118	1,226,715	70.6	616,506	50.3	471,906	38.5	138,303	11.3	511,403	29.4	187,850	36.7	210,525	41.2	113,028	22.1
2000	1,822,169	1,260,760	69.2	681,658	54.1	448,406	35.6	130,696	10.4	561,344	30.8	210,883	37.6	234,836	41.8	115,625	20.6
2002	1,888,969	1,289,152	68.2	725,993	56.3	435,924	33.8	127,235	9.9	599,817	31.8	230,383	38.4	249,600	41.6	119,834	20.0
2004	1,925,703	1,296,811	67.3	746,140	57.5	426,632	32.9	124,039	9.6	628,892	32.7	245,327	39.0	258,926	41.2	124,639	19.8
2006	1,968,505	1,309,751	66.5	767,978	58.6	418,617	32.0	123,156	9.4	658,754	33.5	265,294	40.3	264,492	40.2	128,968	19.6
2008	2,113,485	1,432,534	67.8	861,575	60.1	439,605	30.7	131,354	9.2	680,951	32.2	274,925	40.4	273,016	40.1	133,010	19.5
2010	2,287,799	1,577,844	69.0	967,973	61.3	471,609	29.9	138,262	8.8	709,955	31.0	290,759	41.0	279,055	39.3	140,141	19.7
2012	2,396,654	1,667,108	69.1	1,043,065	62.6	483,159	29.0	140,884	8.5	729,546	30.9	313,280	42.9	273,733	37.5	142,533	19.5
2013	2,479,590	1,739,337	70.2	1,094,521	62.9	501,609	28.8	143,207	8.2	740,253	29.8	316,125	42.7	278,294	37.6	145,834	19.7
2014	2,568,936	1,818,052	70.8	1,145,958	63.0	522,218	28.7	149,876	8.2	750,884	29.2	321,215	42.8	280,733	37.4	148,936	19.8

Source: Bundesministerium für Gesundheit (2015): Statistiken zur Pflegeversicherung.

**Table 3: LTCI recipients and type of benefits 1996–2014**

	1996	1998	2000	2002	2004	2006	2008	2010	2011	2012	2014
<b>Recipients in millions</b>	1.56	1.79	1.88	1.97	1.98	2.06	2.18	2.35	2.39	2.45	2.78
<b>In% of recipients</b>											
<b>Care allowance</b>											
	60.4	53.6	50.7	49.6	48.4	47.4	46.4	44.8	44.2	43.9	45.1
<b>Outpatient care benefits in kind</b>											
	6.8	7.5	8.5	8.4	8.5	8.8	8.4	7.8	6.9	5.3	5.3
<b>Combined benefits</b>											
	8.7	9.6	10.3	10.4	10.3	10.1	11.2	13.3	14.1	15.5	15.1
<b>Substitute care</b>											
	0.4	0.2	0.3	0.4	0.6	0.9	1.4	2.0	2.5	3.0	3.8
<b>Day-and-night care</b>											
	0.2	0.4	0.5	0.7	0.8	0.8	0.9	1.5	1.8	1.9	2.4
<b>Short-term care</b>											
	0.4	0.3	0.4	0.4	0.5	0.6	0.7	0.7	0.7	0.8	0.7
<b>Inpatient care</b>											
	22.7	25.2	26.3	27.0	27.7	28.0	27.6	26.5	26.4	26.2	24.4
<b>Inpatient care in nursing homes for disabled</b>											
	0.4	3.2	3.0	3.1	3.3	3.3	3.4	3.5	3.4	3.3	3.1

Source: Bundesministerium für Gesundheit 2015.

**Table 4: Intended monthly benefits of the LTCI, in 2017, in EUR**

Type of benefits	Care grade 1	Care grade 2	Care grade 3	Care grade 4	Care grade 5
<b>Care allowance</b>	125	316	545	728	901
<b>Outpatient care benefits in kind</b>	-	689	1,298	1,612	1,995
<b>Inpatient care benefits in kind</b>	125	770	1,262	1,775	2,005

Source: Bundesministerium für Gesundheit 2016.



