Summary Table of Peer Country Comments

	Situation in the peer country relative to the host country	Assessment of the policy measure	Assessment of success factors and transferability	Questions to the host country
Austria	▪ Tax funded LTC, no LTCI ▪ Already long and positive experience with seven care levels ▪ Explicit inclusion of dementia as needs-criterion since 2009 ▪ Gradual increase of support measures for family carers over last decade similar to Germany, partly more generous (leave arrangements, short-term residential care) ▪ Mixed experience with semi-residential care forms, low take-up, but gradual increase in use, most pronounced with day-care	▪ Many similar developments as in Austria, e.g. kinds of care leave arrangements ▪ Lack of data on 'real' evaluation in Austria, therefore true assessment of measures not yet feasible (even new database - since 2011 - is of limited quality) ▪ In contrast to Austria, care grades were developed based on research and hopefully provide a good basis for evaluations to improve further development	▪ Implementing dementia as an eligibility criterion for certain LTC benefits seems highly necessary, especially for countries that strive at raising labour market participation of persons during the last years before reaching retirement age. ▪ Timely and low-threshold counselling on availability of practical and financial support as well as on medical matters arising from care needs therefore can be beneficial. ▪ A strong and promising feature of day and night care is, that under certain conditions a right to receive this type of care has been established, and that costs up to a care-grade dependent maximum are to be covered by LTCI, including costs of transport.	▪ Availability of numbers on use? ▪ Evaluation results? ▪ What happens if there is a lack of cooperation from beneficiaries? ▪ Operationalisation of the measure related to help avoiding relocation to a nursing home? ▪ For which kind of services the EUR 125 in grade 1 are actually used?
Czech Republic	▪ In the Czech Republic, there still exists a division in the responsibilities for the LTC – between the social care system and the health care system. ▪ There is no special LTC legislation in the Czech Republic, the system of social care services and the provision of care allowance are regulated by Act No. 108/2006 Coll., on	▪ There is no system in the Czech Republic similar to LTCI in Germany; both the care allowance and funding of social care services are tax-based, additionally, the LTC care provided within health care system is covered by the health insurance. ▪ A similar feature in the Czech Republic is that the dependency on the care of persons entitled to the care allowance is assessed by a medical doctor of the Medical	▪ One success factor of Germany's LTC system is that it has been developed systematically over more than 20 years and the reforms were prepared over many years of discussions with and consideration by experts and scientists. ▪ The integration of social and health care within the framework of the LTC system contributes to the effectiveness and long-term	▪ Regarding the new assessment instrument, how is it assured that the doctors and nurses of the Medical Service of the Health Insurance Funds would use it in the same way? Was there any training in using the new assessment tool? ▪ As the assessment of individual care needs is carried out by doctors and nurses, is there any rule as to what kinds of

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	Social Services. ▪ The care allowance is a tax-based in-cash benefit for people in need of care to enable them to buy social care services or to "hire" a family/informal carer. ▪ There is a variety of social care services typically providing LTC: care homes and special care homes intended for people with dementia, day- and week-care centres as a kind of respite care, community-based services like home care services and personal assistance. ▪ Lately, there has been relatively large growth in the number of non-registered for-profit care and nursing homes (as well as community care providers), as a result of insufficient capacity of registered services.	Assessment Service; the areas of assessed ability to perform the activities of daily living are more or less the same too. ▪ The subject of assessment is not primarily "the need of care" as for Germany, but "the dependency on care caused by a decline in the functional abilities of the person due to their long-term health conditions", which favours medical perspective within the assessment procedure. ▪ The support by counselling or care management to the people in need of care and their family members when they are arranging for care has not been recognized as vital in the Czech environment yet. ▪ Policy measures improving situation of family carers, similar to that of Germany: the state covers the contributions to social (pension) and health insurance for family caregivers who are caring for a family member with the II level of care allowance or higher, provided they are living with them in a shared household; in 2017, a long-term care leave was introduced.	sustainability of the system. ▪ Recognition of the necessity to support the family care-givers and the home-based services seems to be reasonable and natural if we take into account the fact that approximately 70 % of all LTC insurance beneficiaries in Germany are receiving care at home, most of them by informal family care-givers. ▪ Strengthening the ability of doctors of the Medical Assessment Service to assess the claimants with mental or psychological disorders correctly is one of the crucial prerequisites of functional LTC system. ▪ The support of family/informal caregivers by easily accessible advice services and care management could be carried out by the Czech municipal social workers, alternatively by the social workers of the Labour Office.	applications for the assessment process the doctors and nurses must undergo? ▪ What is the first experience with the newly established advisory service for people in need of care and their families? Is there already any evidence about its usage rate and evaluations by its users? ▪ How is the care management at the regional or municipal level organized/provided where the new advisory centres are not available (e.g. in Saxony)? ▪ In general, what is the spatial and financial availability of the community-based social care services, on the one hand, and of the care homes, on the other?
France	▪ 24.5% of the population in France aged 60 or over, slightly below the European average (25%) and Germany (27.4%)	▪ APA allowance in place since 2002, means-tested benefits ▪ Assessment of the level of dependency made though the	▪ In France in 2002 the creation of APA resulted in 642,000 additional beneficiaries, to be compared to the about 500,000 additional	▪ What types of semi-residential services and facilities have been put in place in Germany? ▪ What are the most innovative

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	▪ 1.3 million older people in need of long-term care (LTC) benefiting from the APA (Personal Autonomy Allowance) in 2014 (compared to 3.3 million people receiving care allowances in Germany) (administrative figure) ▪ Estimated 3.3 million persons in need of care (epidemiological figure) ▪ Cost of dependency in France represented € 34.2 billion in 2014, 70% of which is public expenditure and 30% is private expenditure	"AGGIR" grid, 6-level scale (levels 1-4 giving entitlement to APA) ▪ Maximum amount (ceiling) of APA from € 662 per month (lowest level of dependency) to € 1,713 (highest level of dependency) ▪ Free choice model ▪ 2015 law into force in order to reduce user fees ▪ A small majority of people with LTC needs live at home (670,000 persons, 51% of beneficiaries of APA) ▪ 590,000 people living in residential care homes (42% of APA beneficiaries), and 102,000 in service housing (7.5%).	beneficiaries expected to get first-time access to LTCI benefits in Germany ▪ Central role of the assessment grid (AGGIR) ▪ This grid may underestimate some types of care needs and not enough take into consideration the influence of the person's environment (social isolation, death of the spouse, removal of children, etc.) ▪ Importance of constantly reassess the needs of the person, but a rather exceptional practice ▪ Social issue of the non take-up of APA (estimated 20-28% of potential beneficiaries) ▪ Importance of coordination between nursing and care services, role of "one-stop shops" and new methods recently developed ▪ Constant development of halfway offer between home care and accommodation (semi-residential facilities) and innovative forms of housings ▪ Development of a quality private housing offer for highest-income persons ▪ Recent creation of a (modest) right to respite for family caregivers	forms of residential care or alternative forms of housing for people in need of LTC? ▪ What elements characterise working conditions in community care and residential facilities in Germany? ▪ Regarding the coordination of care, what is the role of municipalities in the German model? Are there any difficulties to coordinate social care and health care (home nursing) services in community care?

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			▪ Issue of difficult working conditions of professional carers, particularly home workers	
Spain	▪ In Spain, the life expectancy at 65 years is 20.8 years and the life expectancy of women in 2016 was 85.7 years; those over 65 years old are 8.7 million people and represent 18.7% of the population (21.1% in Germany, 19.2% in EU-28). In 2012, 38% of people aged over 65 years were disabled (34% in Germany, 36% in EU-27). ▪ This Dependency Act was a change in the previous Spanish legal conception of the provision of social services, setting protection to dependence as a subject to the right, that can be claimed to the powers of the State; in contrast, Germany provides long-term care by a compulsory long-term care Insurance (LTCI), where LTCI comprises of two independent parts, the social (public, non-profit) and the private long-term care insurance. ▪ In Germany, in 2017 about 3.3 million people have been (re-)grouped or (re-)assessed and	Highlight positively: ▪ The promotion of personal autonomy and empowerment of people and their caregivers. ▪ Recognition of universal access to dependence care for all dependent people; commitment to organize services to allow beneficiaries to remain in their community/environment of reference. ▪ Assurance of services' quality, sustainability with public funded provisions and accessibility. ▪ Despite the difficulties, the stability of the system has made possible to respond to the needs of people with a complexity and social needs that are very important, and has given greater visibility to the carer environment. ▪ Improve the visibility of unknown cases to the system and improve the access and the coverage of the people with severe and higher complex needs. ▪ Contribution to the professionalization of the staff of the residential and home care centres. ▪ The impact of the economic crisis has	▪ Implication of government authorities and broad support from parliament in passing the law. ▪ Alignment with policies focused on the person, and empowerment of citizens. The preferences of the people are honoured more. ▪ A unique information system with interoperability systems ▪ Existence of a single rating scale for the person and their environment. ▪ Participation of those involved in the design, monitoring and evaluation of the system.	▪ How do you tackle the impact of existing regulations on data protection and the social and health integration of people who require long term care? ▪ How to achieve the best balance between the individual protection systems and the community approach? ▪ How can a long term care system be made more flexible when it is associated with the recognition of a right and benefits from the application of a structured scale of assessment? ▪ What are the main achievements in integrated information systems at the level of Health and social services in home care?

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	are therefore receiving benefits; it represents 4,0% of the population of Germany vs 3,7% in Spain. ▪ Another difference is that in Germany 80% of all beneficiaries are choosing cash benefits, whilst Spain 67.2% is receiving service benefits (in kind). The last evaluation of the Dependency Act, identifies that it is necessary to focus in services, with a gender perspective. ▪ With relation to the family care givers, their role is recognized in Spain by the Dependency Act (Art.18 referring to informal care givers which can be family members or not). In Germany, as of 1 January 2017, family care givers have received noticeably more support, in particular, having their benefits expanded. ▪ Germany provides long-term care by a compulsory stand-alone long-term care Insurance (LTCI) in addition to the social insurances covering sickness, accident, unemployment and old age provision. Germany's LTCI mainly covers the costs of care-related expenses. LTCI	generated delays in the expected deployment and coverage, as well as an increase in the waiting list and maintenance of the same financing system practically in the last 5 years. ▪ Challenge to tackle this issue with 3 levels of governance at Macro (central administration), regional (Autonomous Government) and local level with different regulations, criteria, sources, needs, costs, … ▪ The individual care plan that covers social and health needs has been promoted, but mechanisms for adequate updating, consultation and follow-up of the plan in real time have not always been available. The impact of the applicable regulations on data protection has slowed down and truncated existing initiatives in terms of the social and health integration of the teams. ▪ The assessment system is quite static, and the needs of people are changing over time either because they need a greater intensity of services or because the conditions of the person and their caregiving environment have improved. ▪ Assessment and recognition of the dependence benefit do not always work with the speed necessary for people who are in a situation of		

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	comprises of two independent parts, the social (public, non-profit) and the private long-term care insurance. In Spain, the long-term care insurance is not independent but included in the only social protection system; and private insurances are optional and independent of the system.	advanced disease and end of life. ▪ The deployment of the Spanish dependency law generated the creation of new assessment teams, sometimes duplicating existing structures. ▪ The deployment of the Spanish dependency law focuses on personal needs sometimes leaving out the community vision and caregiver environment of the person that may vary over time.		