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Assessing Needs of Care in European Nations

# THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN GERMANY

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## 1. The long-term care system

### 1.1 Overview

*Philosophy*

In general social care systems in European member states can be grouped into three categories:

- the state responsibility model,
- the family care model, and
- the subsidiary model.

The subsidiary model is common in Germany, but until 1994 long-term caregiving was predominately the task of the family and only those who could not cover the costs could apply for means-tested benefits from the social assistance scheme. After a long discussion driven by increasing social assistance expenditures, a mandatory and universal system of social long-term care insurance (LTCI) was introduced as a fifth pillar of the social security system in Germany in 1995 (Social Code Book, Part XI, Long-term care insurance).[1] The LTCI covers almost the entire population, according the principle that long-term care insurance follows health insurance. Members of the public health insurance system become members of the public LTCI scheme, and those who have private health insurance are obliged to buy private, mandatory LTCI providing the same benefit packages.

*Objectives*

The LTCI scheme has the following main objectives:

- providing social security against the risk of needing care in a similar way as insurance against illness, accidents and unemployment, and protecting income in old age;
- helping to mitigate the physical, mental and financial stresses resulting from the need for care and ensuring that the majority of individuals affected no longer depend on social assistance because of their need for care;
- enabling persons in need of care to stay in their familiar home and family environment for as long as possible. Long-term care insurance services are based on the principles of prevention and rehabilitation before care, outpatient care before inpatient care and short-stay care before full-time inpatient care;
- improving social security for carers who are not employed in order to promote willingness to provide care at home and to recognise the great commitment of carers who often give up their jobs fully or partially because of caring; and

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[1] The long-term care insurance system is the same across the country.

- helping to expand and consolidate the care infrastructure and encouraging competition among service providers.

The LTCI does not cover all expenses incurred by long-term caregiving. All insurance benefits are capped. The aim is to provide insurance covering basic long-term care needs, but not all of them.

*Eligibility criteria*

Benefits are available for all insured persons depending on the extent of the need for care, but irrespective of age, income or wealth. Since July 2008, the time to qualify for benefits has been two years (prior to 2008 it was five years). In legal terms, the 'need for long-term care' refers to those individuals who, owing to a physical, psychological or mental disease or handicap, require a significant or major amount of help to carry out the daily and recurring activities of everyday life over a prolonged period of time, most likely for a minimum period of six months. The entitlement to claim benefits is based on whether the individual needs help with carrying out at least two basic activities of daily living (ADL) and one additional instrumental activity of daily living (IADL). Three levels of dependency are distinguished by how often assistance is needed and how long it takes a non-professional caregiver to help the dependent person.

- Care level I: People who need assistance with personal hygiene, feeding or mobility for at least two activities from one or more areas at least once a day, and who additionally need help in the household several times a week for at least 90 minutes a day with 45 minutes attributable to basic care.
- Care level II: People who need assistance in at least two basic ADLs at least three times a day at various times and additional help in IADLs several times a week for at least three hours a day, with two hours attributable to basic care.
- Care level III: People who need assistance in at least two ADLs around the clock and additional help in an IADL several times a week for at least five hours per day, with four hours attributable to basic care.
- Hardship cases: People at care level III and in particular individuals who need assistance in ADLs for at least seven hours a day with at least two hours during the night, or who need basic care that can only be provided by several individuals together (at the same time).

*Available services*

The long-term care insurance predominantly provides assistance benefits for domiciliary care, in an effort to enable beneficiaries to remain in their home and their family context for as long as possible. Persons in need of care have been entitled to receive benefits from the insurance funds since April 1995 for caregiving at home and since July 1996 for caregiving in institutions as well if they need help in personal care and housekeeping to a substantial degree. The various forms of long-term care services offered under the German legislation include benefits for caregiving at home in cash and in kind, in day- or night-care institutions and in nursing homes (Table 1). Additional counselling for those in need of care and their relatives is provided as well as training courses for family caregivers. The benefits are set by law. Beneficiaries may choose among different benefits and services.

Individuals using home-based care can choose between in-kind benefits for community care and cash benefits. Cash benefits are given directly to the dependent person, who can choose to pass the cash on to a family (or other informal) carer, but the use of cash benefits is at the beneficiary's discretion – given that caregiving is guaranteed. To improve the quality of caregiving, recipients of cash benefits have to contact a professional caregiver twice a year for a

review. The result is reported to the LTCI funds. In cases of community care, the bills are covered by LTCI funds up to a fixed amount. Cash and in-kind benefits may be combined. If a family caregiver is on vacation, the LTCI will cover the expenses of a professional carer for a period of up to four weeks – up to a ceiling of €1,470. Additionally, LTCI funds pay pension contributions for informal carers who provide care 14 hours a week or more and are not employed or work less than 30 hours a week.

In general, all benefits are capped or given as lump sums. In nursing homes expenses are only co-financed. The LTCI funds reimburse caregiving costs up to a fixed amount; the so-called 'hotel costs' (board and lodging) are not covered. Uncovered costs have to be paid by the individuals in need of long-term care themselves. Co-payments may be quite substantial, particularly if an average monthly amount of about €376 for investment costs has to be added. This is the case if such costs are not covered by the provinces, the Länder.

*Funding*

Social long-term care insurance is funded by means of salary deductions of income-based insurance contributions. The contribution rate is set by law. Since July 2008 the contribution rate has been a uniform 1.95% of income subject to contributions. Additionally, members aged 23 and older without children have to pay a surcharge of 0.25% (since January 2005). Before July 2008 the contribution rate was 1.7%. Dependent children and spouses, whose monthly income does not exceed the contribution threshold, are insured without contributions as part of family insurance. There is comprehensive financial balancing among the long-term care insurance providers.

Private, mandatory long-term care insurance is financed within the context of the capital covering method. Fixed by law (Social Code Book XI, § 110), the services of private mandatory LTCI correspond to those of social LTCI, in particular there are no health checks and children must be insured without contributions. The premiums in private, mandatory LTCI are not based on the income of the insured person, but on the age of the person when the contract was taken out. Insurance companies have agreed on financial balancing among each other.

The costs for long-term caregiving that are not covered by the LTCI funds have to be paid by the care recipients themselves. Sometimes co-payments can be substantial and persons in need of care who are not able to cover these costs can apply for means-tested social assistance.

The Länder have the responsibility for financing investments in premises for long-term care services. Regulations vary greatly among the 16 provinces. Some Länder directly finance investments in nursing homes, while others only provide subsidies for dependent older persons living in nursing homes who currently rely or who would otherwise rely upon social assistance.

*Beneficiaries*

In 2007 around 2.25 million persons received benefits from the private and social long-term care insurance funds. This was 2.73% of the total population in Germany. Around 1.86 million recipients were aged 65 and older. Thus, 11.3% of the elderly population received benefits for long-term care.

The need for care is strongly related to age. While only 2.6% of persons aged 65 to 70 received benefits, the share increases sharply with age: 4.9% at age 70-75, 10% at age 75-80, 20% at age 80-85, 37% at age 85-90 and 62% at age 90 and older. The share of those in need of highly intensive care (care level III) is highest in the younger age groups, but the share rises again in the very old ages. Two out of three beneficiaries are women. Owing to the higher life expectancy of women, their share of beneficiaries, at 80%, was the highest in the oldest age group.

Additionally, some 3 million persons are estimated to need help mostly with housework, but as not fulfilling the eligibility criteria to receive benefits from the LTCI funds.

## 1.2 Assessment of needs

The Medical Advisory Service of the Statutory Health Insurance Funds undertakes the assessment to determine whether an individual is entitled to benefits. For private LTCI, the private company Mediproof carries out this task.

Fifteen Medical Boards nationwide conduct in-home assessments for the statutory LTCI funds (at home or in nursing homes). These assessments are done primarily by geriatric-trained nurses and physicians, who observe both the home and social environments of the person in need of care and assess the individual's health and functional status on the basis of national standards. The detailed guidelines for assessment procedures and standards are specified and drawn up by the Medical Boards and these rules, which are agreed by all the parties involved, are the same nationwide and binding (MDS, 2006).

Individuals are assessed for limitations in ADLs, such as bathing and dressing, and IADLs, such as shopping and cooking, as well as hours of care needed per day. These assessments have focused largely on physical needs for personal care, nutrition and mobility rather than on needs for supervision or prompting, which persons with dementia or learning disabilities often need.[2] The new LTCI reform changed this situation. Individuals whose competence in coping with everyday life is considerably impaired will be assessed on the basis of a catalogue of special criteria. If applicants fulfil the criteria they can receive additional benefits, and even those who do not fulfil the criteria for care level I are entitled to receive benefits (MDS, 2008).

The assessment does not focus on income or assets, but on the family situation and the home environment. Therefore, the 'stresses in caring and the stress-bearing capacity' of informal caregivers are assessed and, if possible, help is offered to them as well, such as measures to improve the home environment. In accordance with the principle that rehabilitation services should be available before LTC services, the assessment also encompasses options for rehabilitation, including the need for medical equipment and technical aides.

The result of the assessment will be reported to the LTCI fund and the applicant will receive a written report from his/her insurance fund. In the report the care services needed and the intensity of care (classification of care level) will be stated as well as the option of caregiving at home or the requirement of caregiving in institutions. The applicant can reapply to the medical unit for a reassessment of the reported disability level. This is also the case if their functional status changes. In general, the assessment will be repeated at the required time intervals specified in the assessment notification.

[2] The assessment process currently focuses on the level of limitations in the following areas: *personal care* (washing, taking a shower, bathing, dental care, combing, shaving, defecation, urination); in *nutrition* (bite-sized preparation of nutrition, ingestion); *mobility* (moving in and out of bed, dressing, moving, standing, climbing stairs, leaving and returning to the home); and *IADLs* (shopping, cooking, cleaning the dwelling, washing the dishes, washing, cleaning and ironing the clothes, heating) (MDS, 2006).

## 1.3 Available long-term care services

*General*

The available benefits from the long-term care insurance funds are fixed by law (Social Code Book XI). The benefits are the same for the private long-term care insurance funds as for the social long-term care insurance funds. They include benefits for home care, institutional care and for informal caregivers.

*Which services?*

Outpatient care benefits have been in place since 1 April 1995; the benefits provided in full-time inpatient care settings entered into effect on 1 July 1996. Currently the following services are available:

- benefits in kind for community care (§ 36 scb xi),
- benefits in cash for informal care (§ 37),
- a combination of benefits in cash and in kind (§ 38),
- respite care at home during a vacation or the illness of informal carers (§ 39),
- medical equipment and technical aides (§ 40),
- day care and night care (§ 41),
- short-stay institutional care (§ 42),
- full-time inpatient care (§ 43),
- long-term caregiving in institutions for the disabled (§ 43a),
- social security benefits for informal carers (§ 44),
- benefits for carers who take long-term care leave (§ 44a),
- training courses for family carers and voluntary carers (§ 45),
- additional benefits for individuals whose competence in coping with everyday life is considerably impaired (§ 45b), and
- benefits for a personal budget (§ 17 scb ix).

Additionally, insured persons are entitled to claim individual care counselling provided by the LTCI funds (§ 7a). Disabled persons can apply for benefits from the LTCI funds alongside benefits for the disabled (Social Code Book IX).

The amount of benefits provided depends on the care level needed. As of 1 July 2008, benefits in cash for informal caregiving are up to €215 per month for care level I, up to €420 for care level II and up to €675 for care level III. Benefits for professional home-care services are in general higher than for informal caregiving. The LTCI funds reimburse the costs of home-care services up to €420 per month for care level I, up to €980 for care level II, up to €1,470 for care level III and up to €1,918 for hardship cases. The same amounts are available for part-time institutional care. For full-time institutional care, a lump sum will be provided: for care level I €1,023 per month, for care level II €1,279, for care level III €1,470 and for hardship cases €1,750 (see in detail Table 1).

*Who is eligible?*

All insured persons are eligible for benefits, irrespective of age, income or wealth. The period to qualify for benefits is two years (before July 2008 it was five years). Insured persons living in

Germany are entitled to all services, while individuals who are insured in Germany yet living in another EU country are entitled to cash benefits alone. Beneficiaries receive their benefits during vacations outside Germany for up to four weeks.

In 2007 around 70 million persons were insured in the statutory health and long-term care insurance system and some 9.4 million persons had a long-term care insurance contract with a private LTCI fund. Therefore, a small proportion of the population was not insured and consequently was not eligible to receive benefits from the LTCI system. The reform of the social health insurance system from 2008 (Social Code Book V) will lead to greater coverage of the total population in Germany. As of 1 January 2009 all citizens must have health insurance and hence long-term care insurance.[3] Individuals not covered by the social health insurance funds have to undertake a contract with a private insurer at a basic tariff.

Insured persons can apply for benefits from the social or private LTCI funds, if they meet the criteria for being 'in need of care'.

## 1.4 Management and organisation

In Germany the organisation of health care and therefore long-term care is based on self-administration. Each health insurance fund has an affiliated care insurance fund. In 2009 seven types of statutory health insurance funds and thus long-term care insurance funds existed, with around 200 single funds.[4] They are self-administrating corporations under public law. That means they carry out the legally mandated tasks under government supervision but are organisationally and financially independent. In additional, around 40 private LTCI funds exist. The seven statutory health insurance types are organised under the Central Association of Health Insurance Funds (GKV-Spitzenverband). This central organisation also administers the tasks of the Federal Association of Long-term Care Insurance Funds (Spitzenverband Bund der Pflegekassen). Together with the Federal Working Group of Supra-regional Social Welfare Agencies (Bundesarbeitsgemeinschaft der überörtlichen Träger der Sozialhilfe), the Confederation of Municipal Authorities' Associations (Bundesvereinigung der kommunalen Spitzenverbände), the Federal Association of Long-term Care Providers and the participation of the Association of Private Insurance Funds, they manage the organisation of long-term care tasks based on self-government. The LTCI funds are mainly responsible for capacity planning, monitoring, the organisation of care provision and the assessment of long-term care, but also for quality control. The contract parties within the framework of providing long-term care (*Pflegeselbstverwaltung*) must ensure that national quality standards (expert standards) are developed and continually updated.

The LTCI funds have to negotiate the services to be provided and the prices with the care provider. Each care facility is supposed to negotiate its per diem rates for care individually with

[3] There are exceptions for special groups of beneficiaries of social assistance (disabled persons, those receiving 'help with care', 'help for subsistence' or basic social care for the elderly).

[4] The seven types are the following: 1) general, local insurance funds organised under the Federal Association of Local Health Insurance Funds (AOK); 2) alternative health insurance funds organised under the Federation of Alternative Health Insurance Funds (vdek); 3) company insurance funds organised under the Federal Association of Company Health Insurance Funds (BKK); 4) guild insurance funds organised under the Federal Association of Guild Health Insurance Funds (IKK); 5) agricultural insurance funds organised under the Central Agricultural Social Insurance Fund (LSV); and finally, 6) and 7) refer to the Sickness Fund for Miners and Seamen (Knappschaft, since 1 January 2008, including the See-Krankenkasse).

the LTCI funds, and each facility has its own individual benefit and price structures. The LTCI funds operate collectively, potentially raising buying power.

For home care, provider associations have developed about 20 bundles of care services (e.g. brief morning and evening visits to help with dressing and personal hygiene) that are assigned weights and form the basis for payment for most providers.

The Medical Advisory Service of the Health Insurance Funds will set up guidelines for quality control in institutions and for home-care services together with the above-mentioned associations. The Medical Advisory Service will be responsible for conducting quality audits. These include reviews and assessments, but also recommendations for improving quality. Nursing homes will be required to post the last audit at a highly visible location (for example, at the entrance of a nursing home).

## 1.5 Integration of long-term care

Long-term care stands beside health care and is almost separate. In the latest reform of the LTCI, more integration and better coordination among long-term care, medical and social assistance is intended (see also section 3.2). As of 1 January 2009, under the system an individual and comprehensive claim to care counselling (case management) will be established. Long-term care support bases are to be set up to provide persons requiring long-term care and their relatives with central, local portals through which they can access services (§ 92c Social Code Book XI). The support base will be a place where referrals can be made and coordinated for measures to provide long-term care along with medical and social assistance and support. LTCI funds can conclude contracts with long-term care providers and other partners for integrated care (§ 92b, Social Code Book XI). The new reform supports better discharge management from hospitals to nursing homes, rehabilitation or home care.

# 2. Funding

Germany has a mixed public–private system of financing. The public LTCI system is financed through a nationally uniform payroll tax of currently 1.95% of wages shared equally by employers and employees (0.975%), subject to a wage ceiling of €3,600 per month in 2008. Dependents (spouse and children) with incomes below a certain threshold are covered without any additional worker contributions. Retirees have to pay the full contribution rate themselves (from the beginning of 2006). As of January 2005, childless employees aged 23 or older began paying an additional 0.25% of their income, raising their contribution rate to 1.225%. The rationale was that child rearing is “one of the pillars of the viability of social insurance systems, which is being financed as a pay-as-you-go system” (Schwanenflügel, 2006).

Employees who have earned more than €4,012.50 on average per month in the last three years can opt for private health and long-term care insurance. The private mandatory LTCI funds must offer at least the same level of benefits as the public mandatory LTCI. Premiums are established primarily on the basis of the age at which the individual becomes insured and are the same for men and women (which are different from the calculation of the health insurance premiums and fixed by law). Premiums may not exceed the contribution levels for the public LTCI. Children have to be covered without additional contributions.

As the benefits of the LTCI are capped, co-payments for institutional care in particular are high. Beneficiaries in nursing homes have to pay the ‘hotel costs’, room and board, themselves. The charges vary substantially, averaging about €580 in 2007 (Federal Ministry of Health, 2008). Furthermore, in some Länder the beneficiaries in nursing homes have to pay the investment costs of building and modernising care facilities. While these capital investments are considered the responsibility of the Länder, regulations about the amount of subsidies for such costs differ

greatly among the Länder. In practice, these costs have often been passed on to residents, at an estimated average monthly amount of €347 in 2007 (Federal Ministry of Health, 2008).

According to the System of Health Accounts from Eurostat (2008), in total 1.28% of GDP was spent on long-term care in 2005, while public expenditure amounted to 0.93% of GDP and private expenditure to 0.35%. The statistics of the social LTCI funds provide information about the expenditure on long-term care subdivided by kind of benefit. The expenditure of the social LTCI funds amounted to €18.34 billion in total in 2007. The highest amount was spent on full-time institutional care (€8.83 billion) together with full-time institutional care for the disabled (€0.24 billion). Benefits in cash for persons needing care who received informal care was €4 billion and the benefits for professional home-care services was €2.47 billion (Table 2).

While the benefits for home-care services cover the costs of personal care and help with practical tasks according to the level care needed as assessed by the Medical Board, the benefits for institutional care cover only part of the total costs of nursing homes. The average costs of nursing homes per month were €1,889 for care level I, €2,322 for care level II and €2,756 for care level III in 2007. The lump sums provided for caregiving in nursing homes were lower than the average costs. The LTCI funds cover on average around half the costs (investment costs not included): 54% at care level I, 55% at care level II and 52% at care level III.

Beneficiaries who are not able to cover the additional costs are entitled to means-tested social assistance. During 2007, 218,000 persons received social benefits for long-term care in addition to the benefits from the LTCI funds, most of whom – 209,000 – were residents in nursing homes. In total some €3.2 billion was spent on social assistance pertaining to ‘help with care’ in 2007.

## 3. Demand and supply of LTC

### 3.1 Need for long-term care

In 2007 around 82.2 million persons lived in Germany, among whom 16.5 million were aged 65 and older. Thus, every fifth person was at retirement age. In particular the older age groups have shown a reduction in mortality rates compared with the past, leading to a growing number of very old persons. In 2007 around 3.9 million persons were aged 80 and older – 1.2 million men and 2.7 million women. According to the Eurostat population forecast, the population in Germany will decrease to 74.5 million in 2050, while the share of the elderly (65) will increase from 19.8% to 31.7%, and the share of the oldest old from 4.6% to 14%.

The number of persons in need of care is hard to quantify. The number of individuals receiving benefits from the LTCI funds is well known. But the benefits from the LTCI funds are restricted to persons with substantial impairments in the activities of daily living (ADLs and IADLs). Therefore, the demand for long-term caregiving is greater than the number of recipients of private and social LTCI funds. Official statistics rely solely on the data concerning the beneficiaries of the LTCI funds (social and private). The need for care among individuals not fulfilling the eligibility criteria can only be estimated.

The Federal Ministry of Family Affairs, Senior Citizens, Women and Youth initiated a research programme entitled “Prospects and constraints of self-contained living of people in need of help and care”. The programme conducted surveys (in private households and in institutions) to estimate the total number of persons needing care, including those who did not receive benefits from the LTCI funds. In 2002 the figure for those needing care who did not receive benefits from the LTCI funds and who were living in private households was estimated at about 3 million (Schneekloth, 2005), and in institutions at about 45,000 in 2005 (Schneekloth and von Törne, 2007).

In 2007 some 2.2 million persons received benefits in cash or in kind from the social and private LTCI funds (Table 3).[5] The number in need of care can be calculated to amount to 5.1 million persons, taking the estimation of Schneekloth et al. and the official number of beneficiaries of the LTCI funds into account.

More than two-thirds of the beneficiaries (68%) received benefits for care at home by informal caregivers or professional home-care services (or both), and 32% lived in nursing homes (Figure 1).

Most of the persons in need of care were aged 65 and older. In total, around 4 million persons aged 65 and older – 24% of the elderly – needed help with household chores or personal care in 2007, among whom 1.9 million were beneficiaries and 2.1 million were 'non-beneficiaries' (Table 4).

The Ageing Working Group (AWG) carried out a new estimation of the future development of long-term care expenditure (European Commission/EPC, 2009). In gathering basic information they also estimated the number of dependent persons using the data from the SHARE project and/or EU SILC (statistics on income and living conditions). According to this estimation, the number of dependent individuals amounted to 3.2 million in 2007, and was forecast to rise to 5.954 million by 2050. The number of dependent persons receiving formal care was estimated at 1.589 million in 2007, with an expected increase to 3.483 million in 2050. The number of dependent individuals receiving only informal care or no care was estimated at 1.612 million, and was expected to grow to 2.471 million by 2050. Thus, the estimation of the AWG was lower than the number of persons needing care as estimated by Schneekloth et al. The difference can be traced back to the number of individuals who assessed themselves as needing help with practical tasks, but who are not classified as dependent according the definition used by the AWG.

We have only some information about the characteristics of the individuals in need of care. Detailed information is only available for the beneficiaries of the statutory and private LTCI funds. For this group we can show certain additional characteristics, such as the age profile and the intensity of caregiving.

*Beneficiaries by gender, age group and care level*

The need for care is strongly related to age. The share of long-term care recipients among the population accounts for less than 1% in the younger and middle-aged groups (up to age 55), for 1% among those aged 55 to 60, 1.6% for those aged 60 to 65 and 2.6% for those aged 65 to 70. Thereafter the share of persons in need of care increases sharply, accounting for around 5% of

[5] In Germany there are two kinds of statistics concerning the number of persons in need of care. The Federal Statistical Office provides the long-term care statistics based on data provided by the long-term care institutions (nursing homes) and the providers of home-care services, as well as on data from the LTCI funds on recipients of benefits in cash. These statistics do not include individuals in special homes for the disabled, receiving additional benefits in kind from the LTCI funds. But individuals simultaneously receiving benefits in cash and in kind may be counted twice. The second kind of statistics pertains to beneficiaries of the social LTCI funds and beneficiaries of the private LTCI funds. These two sets of statistics together provide the number of beneficiaries of the private and social LTCI funds. These statistics include persons living in special homes for the disabled if they receive additional benefits from the LTCI funds. The statistics from the Federal Statistical Office and from the LTCI funds differ a little in the total number of persons in need of care, but in the individual age groups the differences are much greater. The divergences depend on the double counting and the persons living in special homes for the disabled. For our report we have used the statistics of the Federal Statistical Office.

those aged 70 to 75, 10% of those aged 75 to 80, 20% of those aged 80 to 85, 37% of those aged 85 to 90 and 62% of those aged 90 and older (Table 4). The number of beneficiaries grew by 230,000 individuals between 1999 and 2007. This can be traced to a large extent to the ageing of the population. Thus, the share of beneficiaries in the population was nearly the same within the age groups throughout this period (Figure 2).

Women make up a higher share of beneficiaries than men, particularly in the oldest age groups. Women have a higher life expectancy, but often the additional years are years in bad health. For example, men make up 28% of beneficiaries in the age group 85 to 90 and 39% in the age group 90 and older, while the shares of women were 41% (85-90) and 69% (90+) in 2007.

More than half (52%) of the elderly in need of care had substantial impairments in ADLs and IADLs (care level I), around one-third (35%) had severe impairments and 12% had very severe impairments in 2007 (Table 6). While in 2007 the share of those with very severe impairments was a little lower among the elderly than among the beneficiaries in total, the development showed a higher dynamic among the elderly compared with the past. The number of elderly beneficiaries increased in total by 16%, while the number of elderly persons with substantial impairments rose by 29%, with severe impairments by 4% and with very severe impairments by 5% between 1999 and 2007. The increases in total beneficiaries, at 11% (at all care levels), 25% (care level I), 0.3% (care level II) and 3% (care level III) were lower.

Individuals in need of care want to live for as long as possible in their own homes; therefore, a large share of beneficiaries received benefits for caregiving at home. In 2007 some 46% received cash benefits and another 22% benefits in kind for home-care services. At around 65% (40% in cash and 25% in kind), the share of beneficiaries at home among the elderly was a little lower compared with the beneficiaries in total, and hence the share of beneficiaries in institutions a bit higher (Table 7). In the past (between 1999 and 2007), the shift from home care to institutional care took place among the elderly.
Individuals in need of care at home can receive benefits (solely) in cash for informal carers at home or benefits in kind for professional home-care services, or a combination of both. Those exclusively receiving benefits in cash were counted as receiving informal caregiving. Individuals receiving benefits in kind or a combination of benefits in cash and in kind were counted as receiving ambulant care.

Since July 2008, individuals whose competence in coping with everyday life is considerably impaired (mostly persons with dementia) have also been able to apply for benefits from the LTCI funds, even if they do not fulfil the eligibility criteria of care level I. Therefore, the number of long-term care recipients will be higher in the future. The very first results for the second half of 2008 show that an additional 20,000 persons received such benefits for the demented, at ‘care level 0’ (Wagner et al., 2009).

## 3.2 Role of informal and formal care in the LTC system

Germany’s LTCI is based on the principle of ‘rehabilitation before caregiving, caregiving at home before institutional care, and short-stay institutional caregiving before full-time institutional care’. Caregiving by informal caregivers has the priority. Informal carers will be supported by benefits from the LTCI funds. These benefits include respite care, contributions to social security insurance for informal carers who provide care at least 14 hours a week and are not employed or work less than 30 hours a week, training courses and counselling.

## 3.3 Demand and supply of informal care

### *3.3.1 Demand*

*Beneficiaries*

In 2007, around 1 million persons received benefits solely in cash – 0.4 million men and 0.6 million women. Three out of four beneficiaries were aged 65 and older. Recipients of informal care without the help of professional care services were to a large extent those with (only) substantial impairments in ADLs. Two-thirds of the elderly receiving informal care had substantial impairments (care level I), 28% severe impairments (care level II) and 6% very severe impairments (care level III) in 2007 (Table 8). The number of elderly persons receiving solely cash benefits rose by 32,000 between 1999 and 2007. This increase was accompanied by a shift to a lower level of care on average, because only the number of elderly persons with substantial impairments rose (75,000) while the number of elderly persons with severe (-36,000) and very severe impairments (-7,000) declined.

While the prevalence rates of the need for care in total were nearly constant over the period 1999 to 2007, the prevalence rates for informal caregiving (exclusively) decreased, especially among the oldest ages (Figure 3). That indicates that the share of older persons needing care and relying on professional home care or institutional care increased.

The proportion of those receiving caregiving at home depends on the living arrangements of the elderly and the availability of informal caregivers. The German microcensus, a representative survey covering 1% of all private households, provides information about the family status of individuals receiving long-term care benefits from the private or social insurance funds (Federal Statistical Office of Germany, 2003). Great differences concerning the marital status existed between men and women receiving long-term care at home. Among the beneficiaries, most of the men were married (55%), while a quarter had never married and only 17% were widowed. Among the women beneficiaries (as among the overall female population) widowhood was common: 58% were widowed, while only 23% were married (Table 9). This is the result of the differences in life expectancy between men and women and the fact that in a partnership women tend to be around three years younger than men.

Widowed persons often live alone. Among the 530,000 widowed women, around 470,000 lived as single persons and around 10% in other households. In total more than half of women lived in a one-person household, and among women aged 85 to 90 the highest share of women living alone can be observed – 68% (Table 10). The proportion of women living in households of three or more was higher in the age group of 90 and older than in the age group 85 to 90. This can be attributed to the relocation of women – no longer able to live alone – into the households of their children. In total, only 22% of female beneficiaries lived in households of three or more in 2006, while male beneficiaries more often lived in a two-person household (53%) or in households of three or more (26%). Thus, changes in the living arrangements of those needing care may also be a driver of the shift towards professional caregiving at home or, in the past, towards institutional care.

*Estimated persons in need of care without LTCI benefits*

Family care is also required for persons in need of care at care level 0. Schneekloth and Leven (2003) provide some information about the characteristics of individuals at care level 0. Persons needing care but not receiving benefits from the long-term care insurance funds accounted for

some 3 million in 2006.[6] They were on average younger than beneficiaries of the LTCI funds. The share of elderly persons amounted to 68% (75% of the beneficiaries) and the share of the oldest old (aged 80 and older) amounted to 30% (see also Table 4).

A high percentage of those in need of help were married (42%), but widowhood was also common (36%); 41% lived alone, another 40% in a two-person household and 11% in a three-person household. Two-thirds were women.

*Average hours of care*

The individuals needing help and personal care were asked how many hours of care they received per week (Schneekloth and Leven, 2003). Beneficiaries who had at least substantial impairments in ADLs received on average 36.7 hours of care and help per week (Table 11), and those who needed help and personal care to a lower degree (care level 0) received on average 14.7 hours of care and help per week. The average hours of care depended on the level of dependency. Individuals at care level I received on average 29.4 hours, those at care level II 42.2 hours and those at care level III 54.2 hours. Notably the supervision of persons with dementia requires more time than help and personal care of the elderly without mental illnesses. On average demented persons at care level III received 61.9 hours of help and care in 2002.

### 3.3.2 Supply

*Estimated number of informal caregivers*

In Germany informal caregiving plays a significant role, but the number of informal caregivers can only be estimated. Information about the situation of informal care provision and the characteristics of informal caregivers was the focus of a survey on caregiving at home carried out by Infratest in 2002 (Schneekloth and Leven, 2003). The study showed that informal caregiving activities were often shared among members of the family. On average, beneficiaries received help from two informal caregivers, and those at care level 0 by 1.7 persons. Only a third of individuals needing care received help from one person (36%), but 29% had two and 27% had three or more family carers. In view of the number of persons needing care at home (around 1 million without the help of professional caregivers and 230,000 receiving benefits in kind and in cash) and additionally considering those needing help with practical tasks (3 million), the number of family members providing any kind of help or personal care can be estimated at 5 to 7 million persons. According the European Community Household Panel (ECHP), on average 5% of the population provided help and care to elderly persons in Germany in 2001 (Schulz, 2004). That is more consistent with the lower estimation.

*Characteristics of the main informal caregivers*

In most cases the spouse, daughters or daughters-in-law are responsible for personal care, but also the sons provide help (mostly with financial tasks): in terms of the main caregivers, 28% receive help from a partner, 32% from a daughter or daughter-in-law and 10% from a son. As caregiving occurs at later ages, and the partners rank first as caregivers, to a significant extent the informal caregivers are also elderly persons. Around a third of informal carers are at retirement age, another quarter is aged between 55 and 65, and a further quarter between 40 and 55 (Table 18).

Caregiving in the majority of cases is a full-time job and a heavy burden for informal carers. The reconciliation of caregiving and work is often hard. Therefore, informal caregivers aged 15

[6] Estimation by DIW based on the information of Schneekloth and Leven for 2002.

to 64 are largely not employed (among those providing care to beneficiaries the figure was 60%, and among those providing care to persons at care level 0 the figure was 50%), with a smaller proportion being employed full-time (19% and 32%, respectively). This picture prompts the question of whether caregivers changed their employment status at the beginning of caregiving. Around half of informal carers were not employed when caregiving occurred, some 10% (caregiving to beneficiaries) and 4% (caregiving to persons in need of help) gave up their job, while 11% and 5% respectively reduced their working time, but 26% and 40% respectively continued to work in 2002 (Table 19).

The reconciliation of caregiving and employment is a little easier if the persons in need of care live in the same household, in the same house structure or a short distance from the carer. Whereas beneficiaries on average live a short distance from their informal caregivers (70% in the same house and another 14% at a distance of less than 10 minutes), those in need of care living alone are not in such a comfortable situation. Only 57% live a short distance from their informal carer (Table 20).

*Available support for informal caregivers*

Informal caregiving is supported by the LTCI funds with several measures: 1) If an informal carer is ill or on vacation the LTCI funds will cover the expenses of a professional caregiver or of another family carer up to four weeks per year (up to a ceiling of €1,470). 2) LTCI funds pay pension contributions of informal carers who provide care 14 hours a week or more and who are not employed or work less than 30 hours a week. 3) As of 1 July 2008, relatives of persons requiring long-term care are also entitled to claim long-term care leave and related benefits. People employed in companies with at least 15 employees can take leave for a period of up to six months. During this period they will not receive any pay, but they will continue to be covered by social insurance. 4) In the event that a relative suddenly requires long-term care, help must be organised quickly. In addition to a claim for long-term care leave, employees are also entitled to be away from work for a period of up to ten working days. 5) Informal carers can receive counselling using the support base or an individual contact person of the LTCI funds. Furthermore, they are entitled to receive training courses free of charge.

Informal caregiving is a hard burden for family carers, especially if they are employed. Thus, a growing share of recipients of informal care engage additional, privately financed home-helpers to relieve the burdens of a family carer. The number of privately financed home-helpers was estimated at 100,000 persons in 2008. In particular persons aged 80 and older with substantial impairments in ADLs who lived alone engaged additional home-helpers. Often home-helpers from Eastern and Central European countries were preferred, because their wages were lower (Neuhaus et al., 2009). On average they earned between €800 and €1,200 and received free lodging and board. The share of illegal employment cannot be estimated.

Additional home-helpers are mostly engaged for beneficiaries who need supervision around the clock due to mental illnesses. Such arrangements for assistance are seen as an alternative to institutional care.

## 3.4 Demand and supply of formal care

### *3.4.1 Demand*

***Recipients of formal home-care services***

Around 0.5 million beneficiaries at home (0.15 million men and 0.35 million women) received benefits in kind or a combination of benefits in cash and in kind in 2007. Nearly all persons (90%) receiving benefits in kind were aged 65 and older and therefore on average older than beneficiaries of cash benefits, while 60% of the beneficiaries were aged 80 and older. This may

indicate that informal caregiving for the oldest old is a hard job and informal carers, who are often older themselves, need the additional help of professional home-care services.

Figure 4 shows the share of the dependent elderly by age group. While in total the prevalence rates remained nearly constant between 1999 and 2007, the proportion of beneficiaries receiving formal home care increased in particular among the older age groups.

Recipients of formal home care are on average more dependent than those receiving only informal care. The share of the elderly at care level I was therefore lower than that of the elderly receiving informal care alone (54% compared with 66%) and the proportion of the elderly with severe impairments (36%) and very severe impairments (11%) analogically higher (Table 12). Unlike the development of the elderly receiving benefits in cash, those receiving benefits in kind increased at all care levels. The number of elderly persons receiving formal home care rose by 82,000 in total, with an increase of 68,000 at care level I, 12,000 at care level II and 1,000 at care level III between 1999 and 2007.

The number of beneficiaries receiving formal home care can be subdivided into recipients of solely benefits in kind and recipients of a combination of benefits in kind and in cash. The latter may be an indicator of the need for additional help by professional home-care services owing to the burden for informal carers. In 2007 around 234,000 persons received a combination of benefits in kind and in cash (Table 13). Thus, nearly half the beneficiaries of ambulant care received a combination of benefits in kind and in cash. This share increased between 1999 and 2007 from 37% to 46%.

Concerning the burden of caregiving for informal carers (who are mainly the spouses), the share of recipients of a combination of benefits in kind and in cash among all recipients of cash benefits (including those with a combination of benefits) is of interest. The figures show that 1) the share of beneficiaries who receive additional help from professional home-care services increases with age; 2) the share increased between 1999 and 2007 in all age groups; but 3) it particularly did so among the oldest ages. From age 80 upwards the share of recipients of a combination of benefits was higher among men than women (see Table 13).

***Individuals receiving care in institutions***

*Beneficiaries*

In 2007 around 710,000 persons received benefits for institutional care, among whom 670,000 received them for full-time institutional care, 15,000 for short-term institutional care and 23,000 for day care. The number of persons receiving night care, at 33, was negligible (Table 14). Thus, nearly all beneficiaries of institutional care were living in nursing homes in 2007 (95%). Most of those receiving institutional care were aged 65 and older (93%), while 69% were aged 80 and older. In view of the longer life expectancy of women, their share among beneficiaries in institutions amounted to 80%, while among the elderly it was 85% of the oldest old (80+).

As persons in need of care prefer to live in their family environment and in their own home for as long as possible, moving into a nursing home is the last step. Relocation to a nursing home is necessary if the beneficiary needs care around the clock, if there is no family carer or the caregiving to the required degree is not possible. The availability of informal carers is the key to staying at home. A higher percentage of individuals receiving care at home are married compared with those living in a nursing home. Thus, never-married or widowed persons have a higher possibility of being institutionalised than married persons. Around two out of three men and 90% of women living in a nursing home are widowed or were never married (Table 14).

The absence of informal carers at home is one factor leading to institutionalisation; another is the dependency and the level of care needed. As individuals grow older and the severity of impairments increases, the caregiving burden rises. At the end of such a process, relocation to a

nursing home may be necessary. Around 20% of residents in nursing homes have very severe impairments in activities of daily living, which means they need care around the clock (Table 15). The share of hardship cases amounts to 0.5%. Only a third of beneficiaries in nursing homes have substantial impairments. The number of elderly persons living in nursing homes increased to a higher degree than the number of those receiving caregiving at home. In total the number of elderly residents in nursing homes grew by some 137,000, that is to say 26%, among whom 78,000 had substantial impairments (a 49% increase), 50,000 had severe impairments (a 21% increase), 16,000 had very severe impairments (a 14% increase) and around 2,000 were hardship cases (a 110% increase) between 1999 and 2007.

Relocation to a nursing home takes place mostly in the higher ages, and as mentioned above it is the last alternative. The average age at the time of moving to a nursing home was 81 in 2007. Therefore, it is not astonishing that a third of institutionalised persons (31%) died within the first year of living in a nursing home, and one out of five in the first six months. On average, the length of stay was 3.4 years – 3.9 years for women and 2.2 years for men (Table 17).

Between 1999 and 2007 the proportion of beneficiaries living in nursing homes among the total population increased, especially among the older ages (Figure 5). The average age of moving to a nursing home has risen, as well as the share of persons receiving around the clock care, but the length of stay has declined. The tendency is that residents in nursing homes to an increasing degree suffer from dementia, with very severe impairments in ADLs and are very old. This trend has mainly been driven by the above-mentioned determinants.

*Persons in need of care not receiving LTC benefits*

Infratest carried out a survey in homes for the elderly in 1994 and 2005 (Schneekloth and von Törne, 2007). In 2005 nearly all homes for the elderly (97%) were nursing homes with a contract for LTCI funds according to the Social Code Book XI. Thus, a high percentage of residents in such institutions were beneficiaries of the LTCI funds (86%). Some 6% were persons in need of care and help, but not fulfilling the eligibility criteria of the LTCI (45,000 persons at care level 0). But the survey does not provide the characteristics of residents in nursing homes subdivided by care level.

### 3.4.2 Supply

*Home-care services*

Since the introduction of the LTCI in Germany, the amount of professional home-care services has expanded, especially in the area of private home-care services. Between 1999 and 2007 the number of home-care services grew in total by 700, whereas the number of private companies rose by 1,400 (Table 21). In 2007 around 11,530 companies provided home-care services for 504,230 persons in need of care. The average number of individuals cared for was 44 per company. Between 1999 and 2007 the average number of persons cared for increased, thus reflecting a tendency towards greater service provision by companies.

In total around 236,160 persons were employed in home-care services in 2007. Most of the employees were nurses, followed by home-helpers. More than 80% were women (Table 22). The home-care services provide not only personal care and home help, but also nursing care. Besides state-approved nurses for the elderly and state-approved geriatric nurses, they also employ registered nurses and auxiliary nurses, orthopaedists and occupational therapists.

Between 1999 and 2007 the number of employees increased by some 52,000 – that is to say nearly 30% (Table 23). The highest increase can be seen for part-time employees and especially those working more than 50% of the normal working time (a 58% rise).

Home-care services provide the agreed service bundle to the persons in need of care at home and they will be reimbursed by the LTCI funds up to a fixed ceiling depending on the dependency of the persons in need of care and the required services. For an example of the service bundle, see Table 24. It is common for all services to provide brief and intensive morning/evening toilet assistance, help with eating, getting in and out of bed, departing or returning to the dwelling, but also cleaning the dwelling, washing and ironing clothes, and preparing the meals. The bundles and the prices are agreed between the LTCI funds and the service providers, often with duration of more than one year.

*New kinds of living arrangements*

Persons in need of care will be supported in their desire to continue to live self-determined lives and also in new living arrangements, such as residential groups. Since July 2008, individuals sharing the same residence have been allowed to pool their claims to benefits in kind and to jointly claim benefits for basic care and housekeeping (Federal Government of Germany, 2008). By pooling claims to benefits in new residential arrangements, efficiencies arise and reserves are created, of which it is possible to make use. The time that is freed up as a result is to be used for outpatient care services, exclusively in the interest of caring for those persons in need of care who participate in the pool. But currently such residential groups are not widespread.

*Nursing homes*

In 2007 11,029 nursing homes existed in Germany with a total of 799,059 places. The average number of places per institution amounted to 72.5 (Table 25). Between 1999 and 2007 the number of nursing homes increased by nearly a quarter. While the number of public nursing homes fell by 15%, the number of private nursing homes grew by 40%. Thus, the structure of nursing-home providers changed markedly in this period.

In 2007, 573,545 persons were employed in nursing homes, among whom 202,764 were in full-time jobs (Table 26). Traditionally most of the employees have been women, particularly among nurses, social workers and home-helpers. In total 68% were nurses and some 17% were home-helpers. Nursing homes do not employ doctors. The medical care is provided by doctors and specialists of the ambulatory health-care system.

Between 1999 and 2007 the number of persons employed in nursing homes expanded by some 133,000 – that is to say 30% (Table 22). While the number of full-time employees decreased by 4%, notably the number of part-time employees working more than 50% of the normal working time increased markedly (by 83%).

On average the expenditure for full-time institutional care including board and lodging ranged from €63 (care level I) to €91 (care level III) per day in 2007 (Table 28). Within these costs, the investment costs are not included. As the LTCI funds only reimburse the costs of a lump sum that is less than the average costs, persons in need of care have to pay high co-payments. But those who are not able to pay these co-payments can apply for means-tested social assistance. In general a new trend towards high-quality accommodation can be seen with high monthly prices. These homes compete for the growing number of elderly persons with middle and high incomes.

## 4. LTC policy

Germany has succeeded in creating a comprehensive social network in the area of tension between public welfare, on the one hand, and personal responsibility on the other. This process has its origins in the 19th century, when Reich Chancellor Otto von Bismarck organised the first large-scale provision of security against life's major crises with the introduction of his social legislation. The health insurance law of 1883, the accident insurance laws of 1884 and those on

invalidity and old age provision of 1889 were the beginnings of state social policy (Schwanenflügel, 2006). On 1 January 1995 long-term care insurance was introduced as the fifth pillar of the social security system. It ensures that the risk of being in need of care is also covered by its mandatory insurance system, according to the principle that long-term care insurance follows health insurance. The individual branches of the social insurance system are not subsidiaries of the state, but self-administrated institutions. They organise self-help in a large, solidarity-based risk community complementing the solidarity of families by assuming the tasks that are too great for the individual or his/her family to cope with.

## 4.1 Policy goals

The main goal of long-term care insurance is to provide coverage for the risk of dependency – helping people to mitigate the physical, mental and financial burdens resulting from frailty and dependency. It is supposed to only secure basic provision, which usually suffices to cover the expenses of nursing care, and hence ensure that, in the majority of cases, those affected no longer depend on social assistance as a result of their need for care. The goal is to provide benefits predominantly for caregiving at home to enable beneficiaries to remain at home and with their families for as long as possible. The principles are 'rehabilitation care before long-term care, home care before institutional care, short-term care before full-time inpatient care'. Informal caregiving will be supported by the provision of respite care, contributions towards the social security benefits of those not employed or working less than 30 hours a week, training courses or counselling.

## 4.2 Integration policy

In general, long-term care insurance is separate from other social security laws and benefits, like health insurance benefits or social assistance. Before the introduction of the new LTCI reform on 1 July 2008, the various social security systems did not sufficiently network or coordinate with each other. Hence, one aim of the reform has been to improve the networking, integration and coordination of the relevant systems. Long-term care and health insurance funds will establish long-term care support bases when the Federal Land in question opts for them. The long-term care support bases will combine care counselling with efforts to integrate various benefits for care, medical assistance and social welfare under one roof. All of the services related to long-term care are to be included, i.e. social assistance for the elderly and aid for long-term care according to the laws on social assistance. In order to promote the establishment of long-term care support bases throughout the country as rapidly as possible, the long-term care insurance equalisation fund has provided initial funding of €45,000 per support base and an additional €5,000 when volunteers and self-help groups are sustainable and integrated into the work. In total, the long-term care insurance funds will make €60 million in funding available nationwide by the end of June 2011.

As of 1 January 2009, every person in need of care has a legal claim to help and support through a long-term care counsellor. Counselling for persons in need of care and their relatives is provided by case managers employed by long-term care insurance funds at a long-term care support base or through qualified experts. Suitably qualified personnel with professional training and work experience are essential in the complex field of long-term care counselling. Therefore, training courses (in the fields of social law, nursing science and social work) are also offered. The Federal Association of Long-term Care Insurance Funds has submitted the corresponding recommendations pertaining to both the number and the qualifications of care counsellors.

Furthermore, better discharge management ensures the seamless transition of patients into outpatient care, rehabilitation programmes or nursing homes. Counselling already begins in the

hospital. Specially trained employees of the discharging hospital, for example, address the problems the person requiring long-term care faces and begin planning further steps with the person affected, the relatives and the case manager.

Another step towards more integration is the new § 92b Social Code Book XI: Integrated Care. Long-term care insurance funds and care providers (together with other partners) can enter into contracts dealing with integrated care.

## 4.3 Recent reforms and the current policy debate

The LTCI reform, which entered into force on 1 July 2008, provides tangible and concrete improvements for individuals requiring long-term care, their relatives and caregivers. The benefits will be gradually increased by 2012, and the circle of those entitled to benefits will be widened. Informal caregivers will be entitled to claim leave benefits related to providing long-term care. As mentioned above, an individual and comprehensive claim to care counselling (case management) will be established and long-term care support bases will be created. A series of measures will contribute to improvements in the quality of long-term care in institutions and at home. To finance the current steps of the reform, the contribution rate was increased on 1 July 2008 by 0.25%, i.e. from the previous level of 1.7% (which has been unchanged since the introduction of the LTCI system in 1995) to the current level of 1.95% (2.2% for the insured aged 23 and older without children).

*More financial support*

The benefit payments for home care as well as for institutional care will be increased (see Table 1). Benefits in cash for home care will rise from €215 to €235 in 2012 (care level I), from €420 to €440 (care level II) and from €665 to €700 (care level III). Benefits for professional home-care services will increase from €420 to €450 (care level I), €980 to €1,100 (care level II) and €1,470 to €1,550 (care level III), but will remain stable for hardship cases (€1,918). The benefits for full-time institutional care will only increase for those at care level III and hardship cases: from €1,470 to €1,550 (care level III) and from €1,750 to €1,918 (hardship cases). The government will review the level of benefits every three years starting from 2014. The reviews will prove whether a further increase is required (Social Code Book XI, § 30).

*Benefits for persons with limited competence in everyday life tasks*

Individuals whose competence in coping with everyday life is considerably impaired require more extensive assistance and support than is normally required. Since 1 January 2002 such individuals – mostly those with dementia, who are cared for on an outpatient basis – have been able to apply for additional benefits for caregiving, but until July 2008 the amount was limited to €460 per year. This money is intended as compensation for expenditures required for day or night care, short-term care, care provided by an approved long-term care service or care through approved offers of low-threshold support. As of 1 July 2008, the amount has increased: those affected will receive up to €100 per month (basic benefit) or up to €200 (augmented benefit). Individuals who require a comparatively low degree of general support receive the basic benefit, those with a high requirement for support the augmented benefit. The criteria for being accorded one of these benefits is determined by guidelines developed by the Federal Association of the LTCI funds. An additional and new aspect is that those suffering from dementia but not fulfilling the criteria for care level I can also apply for these benefits.

Nursing homes will be supported if they want to provide additional supervision and activities to stimulate dementia sufferers. They can apply for benefits to employ extra nurses and nurse assistants for these activities.

*Long-term care leave*

With the reform of long-term care insurance in 2008, the reconciliation of family care and work has improved (through the law on nursing-care time). People employed in companies with at least 15 employees can take leave for a period of up to six months. During this period they will receive no pay, but they will continue to be covered by social insurance. Throughout the care leave, contributions to pension insurance will be paid by the LTCI fund, as long as the caregiver provides care for at least 14 hours per week. Health insurance and long-term care insurance will be covered through the family insurance. If this is not the case, the caregivers must voluntarily continue their health insurance coverage by paying the minimum contribution. Upon request, the LTCI fund can reimburse the caregivers up to the minimum contribution. In cases of the unexpected occurrence of a special care situation, employees are entitled to be away from work for a period of up to ten working days in order to make provisions for the care of a close relative.

*New ways of living*

The long-term care reform supports individuals requiring long-term care in their desire to continue to live self-determined lives and it also supports new living arrangements, such as residential groups. The latter allows persons sharing the same residence to pool their claims to benefits in kind and to jointly claim benefits for basic care and housekeeping. By pooling claims to benefits in new residential arrangements, efficiencies arise that it will be possible to make use of as reserves. The time that becomes free as a result is to be used by outpatient care services exclusively in the interest of caring for those persons requiring long-term care who participate in the pool (Social Code Book XI, § 89). Benefits can also be pooled among individuals who do not live at the same location.

The Federal Ministry of Family Affairs, Senior Citizens, Women and Youth supports innovative living arrangements, for example the so-called ‘more generation houses’. The Ministry provides €3 million for 30 projects in this field.

*Long-term care support bases and counselling*

The long-term care support bases will serve as an initial portal for individuals seeking help and as a place where referrals can be made and coordinated with measures to provide long-term care along with medical and social assistance and support. The LTCI funds will establish such support bases when the Federal Land in question opts for them. Since 1 January 2009, LTCI funds have been required to provide comprehensive counselling and support through qualified experts in a support base or elsewhere.

*Improving the quality of care*

The long-term care reform takes steps to improve both the quality and the quality control of long-term care in institutions and in outpatient care. The reform includes the development of expert standards, which have to be continually updated. The standards are expected to concretely define what is generally recognised as the current state-of-the-art in terms of medical and nursing care in a variety of areas and to provide support, certainty and practical expertise for professional caregivers when performing everyday tasks.

The frequency of quality assurance audits of outpatient and inpatient care will be increased. As of 2011, audits will be carried out each year. In the meantime every facility will be inspected once until the end of 2010. The audits are to take place without prior notice. The inspections will be carried out by the Medical Advisory Service of the Health Insurance Funds. The inspections focus on the physical state of the person in need of care and the effectiveness of the care and support measures. The underlying guidelines have to be regularly adapted to the latest

innovations in medical and nursing care so that the most recent scientific findings in terms of appropriate patient care play a role in the inspection.

The results of the audits must be published in a manner that is easily understandable and consumer-friendly. Nursing homes will be required to post the last audit results in a highly visible location. An easily understandable assessment system will be developed, so that the public can recognise 'at a glance' whether or not a facility provides good quality care. It was decided to introduce an assessment system according to school grades, i.e. with ratings from 'very good' to 'poor'.

Recipients of benefits in cash have to contact a professional carer to review the activities relating to personal care and the situation at home: beneficiaries at care levels I and II have to initiate a review twice a year, while beneficiaries at care level III must do so every quarter. The aims of the review are to ensure that the counselling and informal caregiving at home are of good quality and to support informal carer. The costs will be covered by the LTCI funds. If a recipient does not call for a review, the level of benefits can be reduced or as a last step suspended.

*Increasing voluntary activity and civic engagement*

Self-help groups and volunteers make an important contribution towards caring for persons needing help. By promoting the involvement of civil society with regard to care, a 'new culture of helping' is to be fostered. Volunteerism will thus be enhanced to an even greater extent than in the measures already anchored in the law. The long-term care reform will increase the support for offers of low-threshold support up to €25 million per year. Low-threshold support offers include those by groups that provide supervision, day care and helper's circles, which offer relief for hours at a time to relatives who provide care. Together with co-financing provided by the Länder and municipal governments, this results in a total of €50 million per year now being made available. In addition, the expenses incurred by volunteers can also be taken into consideration in remuneration for long-term care facilities.

*Prospects for the future: New definition of the concept of being in need of care*

Deficits in the provision of long-term care are often related to the definition of being in 'need of care'. More specifically, in view of the situation of individuals with cognitive impairments, who often need special advice and support, the definition of the need for care is to be changed. Thus, a new assessment procedure was tested and the first results were published in January 2009 (Federal Ministry of Health, 2009). It is planned that the criterion for assessing the need for care will not be the time needed to provide care, but rather the degree of independence in performing activities, coming to terms with aspects of everyday life or in individual settings. The new assessment method includes six modules. Each module includes several items:

- mobility, i.e. locomotion for short distances and ambulation of the body;
- cognitive and communicative abilities;
- modes of behaviour and psychological problem areas;
- ability to care for oneself;
- dealing with the demands of illness and therapy; and
- performing activities of daily living and maintaining social contacts.

The result of each of the six modules will be consolidated into a point score. The resulting value will lead to one of the new five care levels (low, considerable, severe, very severe and hardship cases). A study on the impact of the new assessment system on the structure of care provided to

recipients in nursing homes shows that the new assessment process will lead to a shift towards higher care levels (Rothgang et al., 2009). But these are only the first results.

## 4.4 Critical appraisal of the LTC system

The long-term care reform has been a step forward, but this step is not enough to ensure the financial sustainability of the system in the long run. In view of the increasing number of the elderly, particularly the oldest old who often experience multi-morbidity and mental illnesses, new methods of long-term care provision are required. Among other things these include more flexible living arrangements. As the experience in Denmark shows, preventive home visits may reduce the probability that elderly persons at home receive no help or the needed help is provided to late. Thus, preventive home visits can help to reduce the share of individuals with severe or very severe disabilities and may save money.

Additionally, the link between home care and caregiving in institutions has to strengthen as well as the connection between the acute care sector and the long-term care sector. Notably the transition from a hospital into caregiving at home or caregiving in institutions has to be improved. The family doctor must be involved in this system.

Furthermore, the new definition of the concept of being in need of care should be implemented as soon as possible.

Another problem is the expected shortage of nurses, especially qualified nurses, but also other caregiving staff. To meet the increasing demand for nursing staff the standing of this profession and the salaries paid must rise to make it more attractive.

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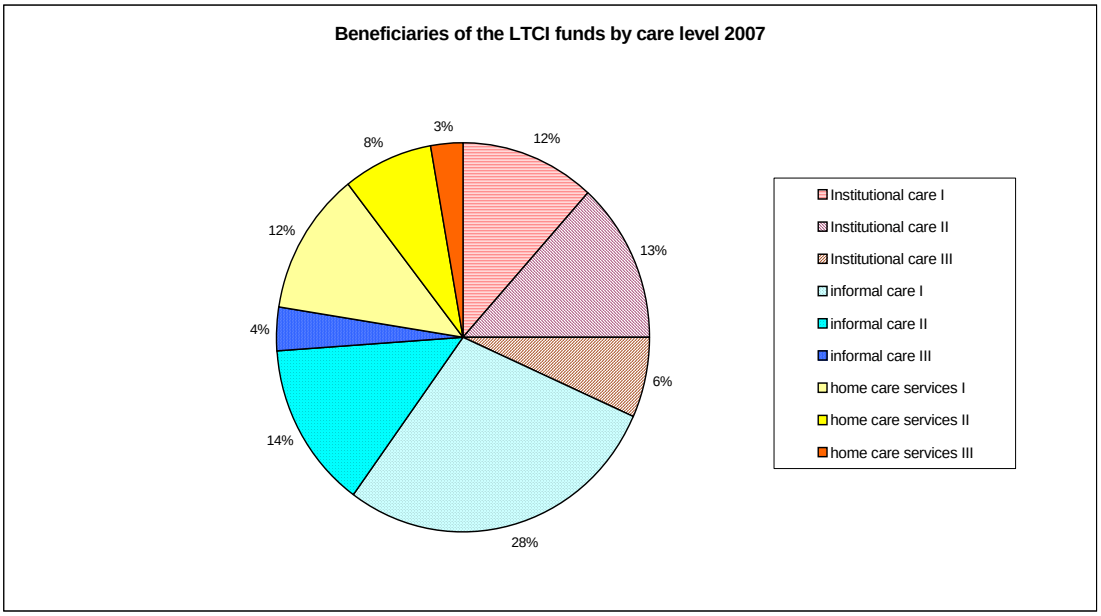
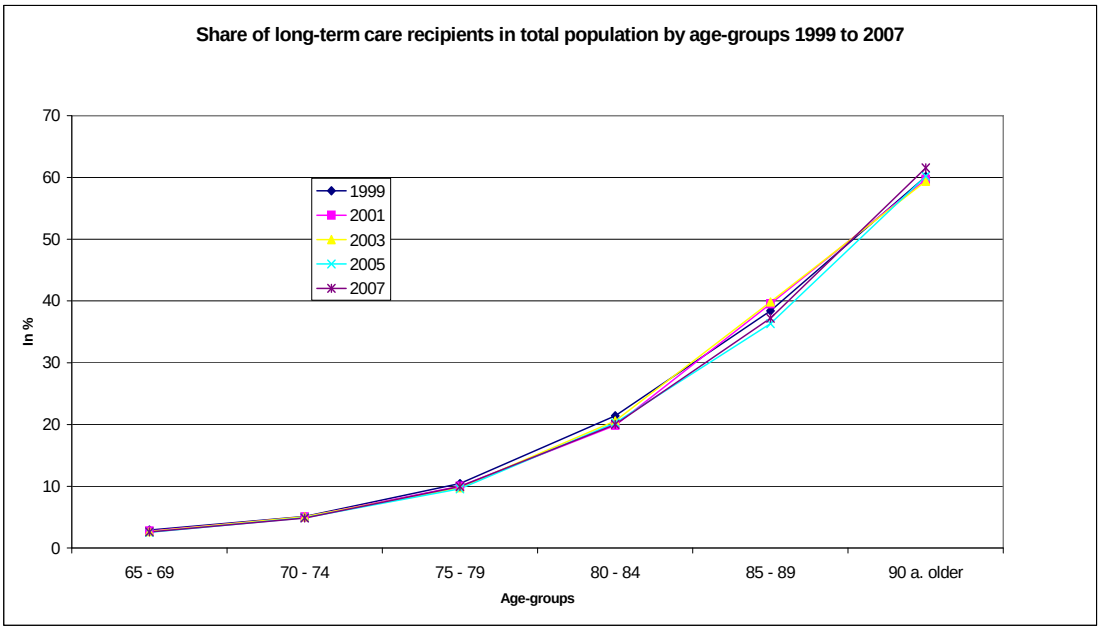
*Figure 1. Beneficiaries of the LTCI funds by care level in 2007*



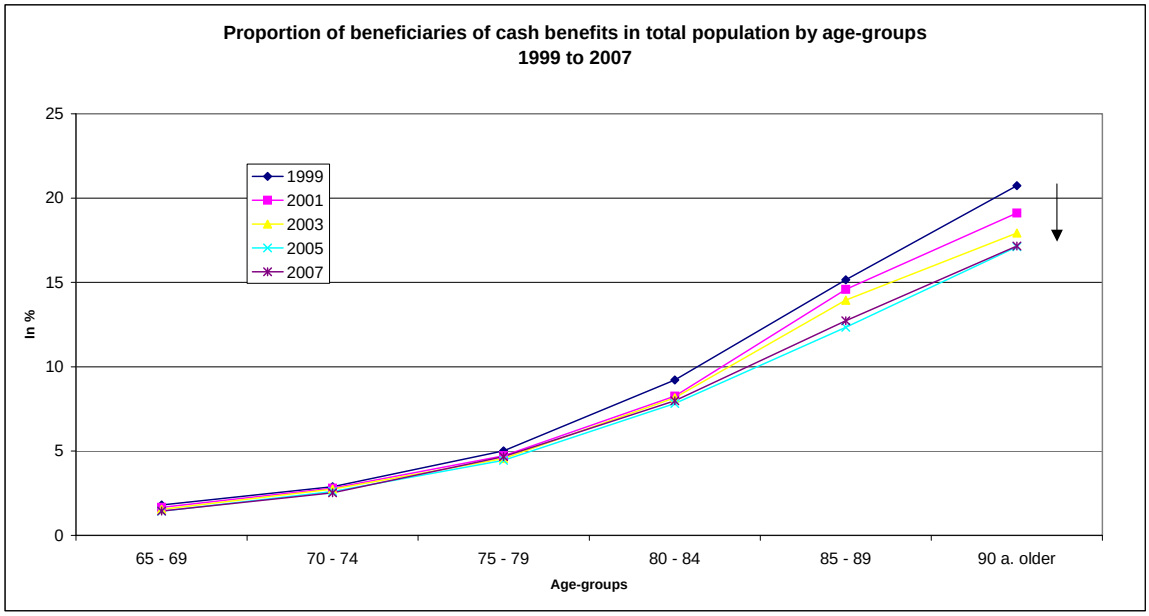

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Figure 2. Share of long-term care recipients among the total population by age group in Germany (1999 to 2007)*



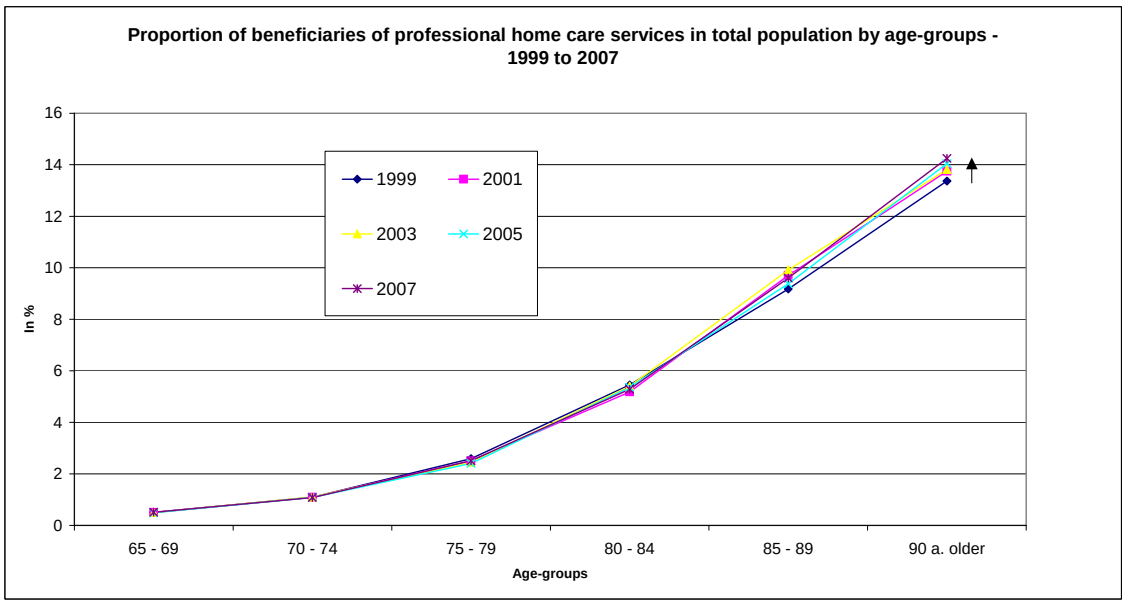

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Figure 3. Share of recipients of benefits in cash among the total population by age group (1999 to 2007)*



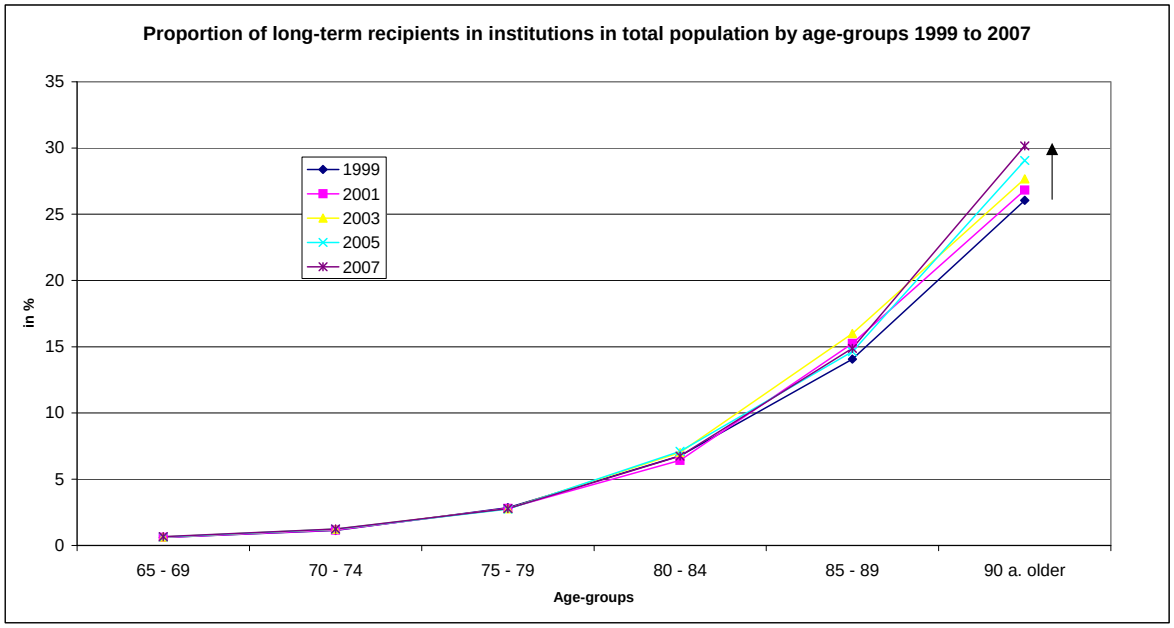

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Figure 4. Share of beneficiaries of professional home-care services among the total population by age group (1999 to 2007)*




*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Figure 5. Share of beneficiaries in institutions among the total population by age group (1999 to 2007)*




*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 1. Benefits provided by the LTCI scheme*

| | | previously | As of 1.7.2008 | 2010 | 2012 |
|---|---|---|---|---|---|
| **Home care** | *Care allowance* | up to per month in Euro | | | |
| Benefits in cash | Care level I | 205 | 215 | 225 | 235 |
| | Care level II | 410 | 420 | 430 | 440 |
| | Care level III | 665 | 675 | 685 | 700 |
| | *Care Assistance* | up to per month | | | |
| Benefits in kind | Care level I | 384 | 420 | 440 | 450 |
| | Care level II | 921 | 980 | 1040 | 1100 |
| | Care level III | 1432 | 1470 | 1510 | 1550 |
| | hardship cases | 1918 | 1918 | 1918 | 1918 |
| **Respite Care** | up to four weeks per year up to ... | | | | |
| by near relatives 1) | Care level I | 205 | 215 | 225 | 235 |
| | Care level II | 410 | 420 | 430 | 440 |
| | Care level III | 665 | 675 | 685 | 700 |
| by other persons | Care level I to III | 1432 | 1470 | 1510 | 1550 |
| **Short-time care** | up to four weeks per year up to ... | | | | |
| | Care level I to III | 1432 | 1470 | 1510 | 1550 |
| **Part-time institutional care** | up to ... per month | | | | |
| | Care level I | 384 | 420 | 440 | 450 |
| | Care level II | 921 | 980 | 1040 | 1100 |
| | Care level III | 1432 | 1470 | 1510 | 1550 |
| **Supplementary benefits for people with consi-derable genral need for care** | up to per year | | | | |
| | Care level I to III | 460 | 1200 | 1200 | 1200 |
| | | | 2400 | 2400 | 2400 |
| **Full-time institutional care** | lump sum per month | | | | |
| | Care level I | 1023 | 1023 | 1023 | 1023 |
| | Care level II | 1279 | 1279 | 1279 | 1279 |
| | Care level III | 1432 | 1470 | 1510 | 1550 |
| | Hardship cases | 1688 | 1750 | 1825 | 1918 |
| **Care provided in full-time institutions for the disabled** | long-term care expenses amounting to | 10% of the fee for the institutional care, but not more than 256 Euro per month | | | |
| **Consumable aids** | up to per month | 31 Euro | | | |
| **Technical aids** | | mostly provided by a loan basis, otherwise cost coverage 90%, 10% co-payment up to 25 Euro per item | | | |
| **Measures to improve the living invironment** | up to per measure | 2557 Euro, considering a reasonable co-payment | | | |

*Table 2. Development of the long-term care expenditure of the social LTCI funds (2001 to 2007) (€ billion)*

| Revenues/Expenses | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|
| **Revenues** | | | | | | | |
| Contributions | 16,56 | 16,76 | 16,61 | 16,64 | 17,38 | 18,36 | 17,86 |
| thereof | | | | | | | |
| Contributions to LTCI | 13,66 | 13,57 | 13,30 | 13,28 | 13,98 | 14,94 | 14,44 |
| Contributions to equalisation funds | 2,90 | 3,19 | 3,31 | 3,36 | 3,40 | 3,42 | 3,42 |
| other revenues | 0,25 | 0,22 | 0,25 | 0,23 | 0,12 | 0,13 | 0,16 |
| **Total** | **16,81** | **16,98** | **16,86** | **16,87** | **17,49** | **18,49** | **18,02** |
| **Expenses** | | | | | | | |
| Expenditure for benefits | 16,03 | 16,47 | 16,64 | 16,77 | 16,98 | 17,14 | 17,45 |
| thereof | | | | | | | |
| benefits in cash | 4,11 | 4,18 | 4,11 | 4,08 | 4,05 | 4,02 | 4,03 |
| benefits in kind | 2,29 | 2,37 | 2,38 | 2,37 | 2,40 | 2,42 | 2,47 |
| respite care | 0,11 | 0,13 | 0,16 | 0,17 | 0,19 | 0,21 | 0,24 |
| day/night care | 0,07 | 0,08 | 0,08 | 0,08 | 0,08 | 0,09 | 0,09 |
| additional benefits for mentally ill | | 0,00 | 0,01 | 0,02 | 0,02 | 0,03 | 0,03 |
| short time institutional care | 0,15 | 0,16 | 0,16 | 0,20 | 0,21 | 0,23 | 0,24 |
| Contributions to social security of informal carers | 0,98 | 0,96 | 0,95 | 0,93 | 0,90 | 0,86 | 0,86 |
| Medical equipment and technical aids | 0,35 | 0,38 | 0,36 | 0,34 | 0,38 | 0,38 | 0,41 |
| Full-time institutional care | 7,75 | 8,00 | 8,20 | 8,35 | 8,52 | 8,67 | 8,83 |
| Full-time institutional in homes for the disabled | 0,21 | 0,21 | 0,23 | 0,23 | 0,23 | 0,24 | 0,24 |
| Half of the costs for the services of the Medical Board | 0,25 | 0,26 | 0,26 | 0,27 | 0,28 | 0,27 | 0,27 |
| Administration expenses | 0,57 | 0,58 | 0,59 | 0,58 | 0,59 | 0,62 | 0,62 |
| Other expenses | 0,02 | 0,01 | 0,06 | 0,07 | 0,00 | 0,00 | 0,00 |
| **Total** | **16,87** | **17,36** | **17,56** | **17,69** | **17,86** | **18,03** | **18,34** |

*Source*: Federal Ministry of Health.

*Table 3. Beneficiaries of the social and private LTCI funds (1999 to 2007)*

| Year | Total | Men | Women |
|---|---|---|---|
| | All ages | | |
| 1999 | 2.016.091 | 631.822 | 1.384.269 |
| 2001 | 2.039.780 | 641.881 | 1.397.899 |
| 2003 | 2.076.935 | 662.893 | 1.414.042 |
| 2005 | 2.128.550 | 690.272 | 1.438.278 |
| 2007 | 2.246.829 | 728.946 | 1.517.883 |
| | 65 years and older | | |
| 1999 | 1.610.643 | 412.390 | 1.198.253 |
| 2001 | 1.645.951 | 428.445 | 1.217.506 |
| 2003 | 1.689.687 | 452.455 | 1.237.232 |
| 2005 | 1.751.243 | 485.274 | 1.265.969 |
| 2007 | 1.861.304 | 528.406 | 1.332.898 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 4. Characteristics of persons in need of care at care level 0 at home in Germany (2002)*

| | in % | | in % |
|---|---|---|---|
| **Gender** | | **Family status** | |
| male | 34 | married | 42 |
| female | 64 | widowed | 36 |
| | | divorced | 5 |
| **Age-groups** | | single | 17 |
| under 40 | 10 | | |
| 40-64 | 23 | **Household Size** | |
| 65-74 | 26 | 1 Person | 41 |
| 75-85 | 26 | 2 Persons | 40 |
| 85 and older | 16 | 3 Persons | 11 |
| | | 4 + Persons | 8 |
| Source: Schneekloth and Leven 2003. | | | |

*Table 5. Proportion of persons in need of care by age group in 2007 (%)*

| Age from ... up to under ... years | Total | Men | Women |
|---|---|---|---|
| Under 5 | 0,34 | 0,34 | 0,33 |
| 5 - 10 | 0,67 | 0,71 | 0,62 |
| 10 - 15 | 0,65 | 0,69 | 0,62 |
| 15 - 20 | 0,53 | 0,55 | 0,50 |
| 20 - 25 | 0,40 | 0,42 | 0,37 |
| 25 - 30 | 0,33 | 0,35 | 0,31 |
| 30 - 35 | 0,32 | 0,33 | 0,30 |
| 35 - 40 | 0,33 | 0,34 | 0,32 |
| 40 - 45 | 0,39 | 0,39 | 0,39 |
| 45 - 50 | 0,51 | 0,51 | 0,52 |
| 50 - 55 | 0,70 | 0,70 | 0,70 |
| 55 - 60 | 1,04 | 1,06 | 1,02 |
| 60 - 65 | 1,64 | 1,72 | 1,56 |
| 65 - 70 | 2,62 | 2,76 | 2,48 |
| 70 - 75 | 4,85 | 4,80 | 4,89 |
| 75 - 80 | 9,95 | 8,85 | 10,75 |
| 80 - 85 | 20,01 | 15,58 | 22,23 |
| 85 - 90 | 37,21 | 27,55 | 40,71 |
| 90 and older | 61,56 | 38,93 | 68,76 |
| Total | 2,73 | 1,81 | 3,62 |
| 65 and older | 11,27 | 7,61 | 13,92 |
| 80 and older | 30,92 | 21,37 | 35,01 |
| *) Beneficiaries of the social and private LTCI funds. | | | |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 6. Beneficiaries of the LTCI funds by care level (1999 to 2007)*

| Year | Total | Care level I | Care level II | Care level III | Hardship-cases | Not jet classified |
|---|---|---|---|---|---|---|
| | | | Number of beneficiaries - all ages | | | |
| 1999 | 2.016.091 | 926.476 | 784.824 | 285.264 | 4.254 | 19.527 |
| 2001 | 2.039.780 | 980.621 | 772.397 | 276.420 | 4.407 | 10.342 |
| 2003 | 2.076.935 | 1.029.078 | 764.077 | 276.126 | 4.755 | 7.654 |
| 2005 | 2.128.550 | 1.068.943 | 768.093 | 280.693 | 5.551 | 10.821 |
| 2007 | 2.246.829 | 1.156.779 | 787.465 | 291.752 | 6.556 | 10.833 |
| | | | Changes between 1999 and 2007 | | | |
| Number | 230.738 | 230.303 | 2.641 | 6.488 | 2.302 | -8.694 |
| % | 11,44 | 24,86 | 0,34 | 2,27 | 54,11 | -44,52 |
| | | | Share of beneficiaries (all ages) by care level | | | |
| 1999 | 100,00 | 45,95 | 38,93 | 14,15 | 0,21 | 0,97 |
| 2001 | 100,00 | 48,07 | 37,87 | 13,55 | 0,22 | 0,51 |
| 2003 | 100,00 | 49,55 | 36,79 | 13,29 | 0,23 | 0,37 |
| 2005 | 100,00 | 50,22 | 36,09 | 13,19 | 0,26 | 0,51 |
| 2007 | 100,00 | 51,48 | 35,05 | 12,99 | 0,29 | 0,48 |
| | | | Number of beneficiaries 65 years old and older | | | |
| 1999 | 1.610.643 | 749.379 | 631.478 | 213.241 | 2.117 | 16.545 |
| 2001 | 1.645.951 | 801.805 | 628.536 | 206.815 | 2.092 | 8.795 |
| 2003 | 1.689.687 | 847.931 | 627.896 | 207.387 | 2.388 | 6.473 |
| 2005 | 1.751.243 | 889.077 | 638.728 | 214.105 | 3.134 | 9.333 |
| 2007 | 1.861.304 | 970.367 | 657.942 | 223.668 | 4.056 | 9.327 |
| | | | Changes between 1999 and 2007 | | | |
| Number | 250.661 | 220.988 | 26.464 | 10.427 | 1.939 | -7.218 |
| % | 15,56 | 29,49 | 4,19 | 4,89 | 91,59 | -43,63 |
| | | | Share of elderly beneficiaries by care level | | | |
| 1999 | 100,00 | 46,53 | 39,21 | 13,24 | 0,13 | 1,03 |
| 2001 | 100,00 | 48,71 | 38,19 | 12,57 | 0,13 | 0,53 |
| 2003 | 100,00 | 50,18 | 37,16 | 12,27 | 0,14 | 0,38 |
| 2005 | 100,00 | 50,77 | 36,47 | 12,23 | 0,18 | 0,53 |
| 2007 | 100,00 | 52,13 | 35,35 | 12,02 | 0,22 | 0,50 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 7. Beneficiaries of the LTCI funds by kind of benefit (1999 to 2007)*

| Year | Total | cash benefits | home care services 1) | in institutions |
|---|---|---|---|---|
| | Number of beneficiaries all ages | | | |
| 1999 | 2.016.091 | 1.027.591 | 415.289 | 573.211 |
| 2001 | 2.039.780 | 1.000.736 | 434.679 | 604.365 |
| 2003 | 2.076.935 | 986.520 | 450.126 | 640.289 |
| 2005 | 2.128.550 | 980.425 | 471.543 | 676.582 |
| 2007 | 2.246.829 | 1.033.286 | 504.232 | 709.311 |
| | Share of beneficiaries by kind of benefits | | | |
| 1999 | 100,00 | 50,97 | 20,60 | 28,43 |
| 2001 | 100,00 | 49,06 | 21,31 | 29,63 |
| 2003 | 100,00 | 47,50 | 21,67 | 30,83 |
| 2005 | 100,00 | 46,06 | 22,15 | 31,79 |
| 2007 | 100,00 | 45,99 | 22,44 | 31,57 |
| | Number of beneficiaries under 65 years old | | | |
| 1999 | 405.448 | 314.642 | 40.760 | 50.046 |
| 2001 | 393.829 | 302.901 | 42.156 | 48.772 |
| 2003 | 387.248 | 294.936 | 43.308 | 49.004 |
| 2005 | 377.307 | 284.041 | 44.508 | 48.758 |
| 2007 | 385.525 | 288.062 | 47.917 | 49.546 |
| | Share of 'young' beneficiaries by kind of benefits | | | |
| 1999 | 100,00 | 77,60 | 10,05 | 12,34 |
| 2001 | 100,00 | 76,91 | 10,70 | 12,38 |
| 2003 | 100,00 | 76,16 | 11,18 | 12,65 |
| 2005 | 100,00 | 75,28 | 11,80 | 12,92 |
| 2007 | 100,00 | 74,72 | 12,43 | 12,85 |
| | Number of beneficiaries 65 years old and older | | | |
| 1999 | 1.610.643 | 712.949 | 374.529 | 523.165 |
| 2001 | 1.645.951 | 697.835 | 392.523 | 555.593 |
| 2003 | 1.689.687 | 691.584 | 406.818 | 591.285 |
| 2005 | 1.751.243 | 696.384 | 427.035 | 627.824 |
| 2007 | 1.861.304 | 745.224 | 456.315 | 659.765 |
| | Share of elderly beneficiaries by kind of benefits | | | |
| 1999 | 100,00 | 44,26 | 23,25 | 32,48 |
| 2001 | 100,00 | 42,40 | 23,85 | 33,76 |
| 2003 | 100,00 | 40,93 | 24,08 | 34,99 |
| 2005 | 100,00 | 39,77 | 24,38 | 35,85 |
| 2007 | 100,00 | 40,04 | 24,52 | 35,45 |

1) Including beneficiaries at home receiving a combination of benefits in cash and in kind.

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 8. Recipients of benefits (solely) in cash by care level (1999 to 2007)*

| Year | Total | Care level I | Care level II | Care level III |
|---|---|---|---|---|
| | Number of recipients - all ages | | | |
| 1999 | 1.027.591 | 559.603 | 370.517 | 97.471 |
| 2001 | 1.000.736 | 574.455 | 336.529 | 89.752 |
| 2003 | 986.520 | 588.039 | 313.820 | 84.661 |
| 2005 | 980.425 | 597.751 | 301.605 | 81.069 |
| 2007 | 1.033.286 | 638.846 | 308.997 | 85.443 |
| | Changes between 1999 and 2007 | | | |
| Number | 5.695 | 79.243 | -61.520 | -12.028 |
| % | 0,55 | 14,16 | -16,60 | -12,34 |
| | Share of recipients by care level | | | |
| 1999 | 100,00 | 54,46 | 36,06 | 9,49 |
| 2001 | 100,00 | 57,40 | 33,63 | 8,97 |
| 2003 | 100,00 | 59,61 | 31,81 | 8,58 |
| 2005 | 100,00 | 60,97 | 30,76 | 8,27 |
| 2007 | 100,00 | 61,83 | 29,90 | 8,27 |
| | Number of recipients 65 years old and older | | | |
| 1999 | 712.949 | 415.099 | 247.157 | 50.693 |
| 2001 | 697.835 | 429.359 | 222.989 | 45.487 |
| 2003 | 691.584 | 441.360 | 208.393 | 41.831 |
| 2005 | 696.384 | 452.903 | 203.056 | 40.425 |
| 2007 | 745.224 | 490.012 | 211.279 | 43.933 |
| | Changes between 1999 and 2007 | | | |
| Number | 32.275 | 74.913 | -35.878 | -6.760 |
| % | 4,53 | 18,05 | -14,52 | -13,34 |
| | Share of elderly recipients by care level | | | |
| 1999 | 100,00 | 58,22 | 34,67 | 7,11 |
| 2001 | 100,00 | 61,53 | 31,95 | 6,52 |
| 2003 | 100,00 | 63,82 | 30,13 | 6,05 |
| 2005 | 100,00 | 65,04 | 29,16 | 5,80 |
| 2007 | 100,00 | 65,75 | 28,35 | 5,90 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 9. Long-term care recipients at home by family status (2003)*

| Age-groups | Family status | | | | | |
|---|---|---|---|---|---|---|
| | Total | | Never married | Married | Widowed | Divorced |
| | in 1000 | in % | | | | |
| | | | | Men | | |
| under 25 | 57 | 100 | 100 | 0 | 0 | 0 |
| 25-60 | 91 | 100 | 55,3 | 34,2 | 1,1 | 9,4 |
| 60-70 | 85 | 100 | 9,7 | 78,9 | 5,6 | / |
| 70-75 | 64 | 100 | / | 79,7 | 11,5 | / |
| 75-80 | 68 | 100 | / | 74,3 | 18,4 | / |
| 80-85 | 61 | 100 | / | 71,4 | 25,1 | / |
| 85-90 | 52 | 100 | / | 48,9 | 45,4 | / |
| 90 and older | 34 | 100 | / | 38,1 | 60,6 | / |
| total | 513 | 100 | 24,7 | 55 | 16,6 | 3,6 |
| | | | | Women | | |
| under 25 | 46 | 100 | 100 | 0 | 0 | 0 |
| 25-60 | 80 | 100 | 44,9 | 42 | 3,7 | 9,4 |
| 60-70 | 80 | 100 | 12,5 | 54,9 | 24 | / |
| 70-75 | 76 | 100 | / | 43,2 | 40,7 | / |
| 75-80 | 137 | 100 | 7,5 | 32,9 | 55,5 | / |
| 80-85 | 168 | 100 | 4,6 | 20,7 | 70,2 | 4,5 |
| 85-90 | 188 | 100 | 5 | 9,1 | 82,6 | / |
| 90 and older | 147 | 100 | / | 5 | 87,4 | / |
| total | 922 | 100 | 14,2 | 23,3 | 57,6 | 4,9 |

Source: Micro-census 2003; calculation by DIW Berlin..

*Table 10. Long-term care recipients at home by size of household (2003)*

| Age-groups | Number of persons in the household | | | | |
|---|---|---|---|---|---|
| | Total | | 1 | 2 | 3 + |
| | in 1000 | in % | | | |
| | | | Men | | |
| under 25 | 57 | 100 | / | / | 90,3 |
| 25-60 | 91 | 100 | 22,4 | 31,6 | 46 |
| 60-70 | 85 | 100 | 16,4 | 67,6 | 16 |
| 70-75 | 64 | 100 | 15,7 | 76,4 | / |
| 75-80 | 68 | 100 | 19,8 | 71,8 | / |
| 80-85 | 61 | 100 | 23,7 | 67,1 | / |
| 85-90 | 52 | 100 | 34,6 | 50,9 | 14,5 |
| 90 and older | 34 | 100 | 49 | 40,1 | / |
| total | 513 | 100 | 21 | 52,7 | 26,3 |
| | | | Women | | |
| under 25 | 46 | 100 | 0 | / | 93,6 |
| 25-60 | 80 | 100 | 16,2 | 39,5 | 44,3 |
| 60-70 | 80 | 100 | 32,3 | 54,1 | 13,6 |
| 70-75 | 76 | 100 | 44,8 | 46,4 | / |
| 75-80 | 137 | 100 | 52,5 | 36,6 | 10,8 |
| 80-85 | 168 | 100 | 61,4 | 26,4 | 12,2 |
| 85-90 | 188 | 100 | 68,1 | 13,9 | 18 |
| 90 and older | 147 | 100 | 65,2 | 11,7 | 23,1 |
| total | 922 | 100 | 51,2 | 27,2 | 21,6 |

Source: Micro-census 2003; calculation by DIW Berlin.

*Table 11. Average hours of personal care and help with practical tasks per week for persons in need of care at home in 2002*

| Average hours per week 1) | Total | With mental illnesses | Without mental illnesses |
|---|---|---|---|
| *Beneficiaries of LTCI funds* | | | |
| Care level I | 29,4 | 31,4 | 28,1 |
| Care level II | 42,2 | 43,7 | 40 |
| Care level III | 54,2 | 61,9 | 46,6 |
| Total | 36,7 | 39,7 | 33,7 |
| *People in need of help* | | | |
| Care level 0 total | 14,7 | 19,3 | 13,2 |

1) From the household self assessed time of care and help.

Source: Schneekloth and Leven 2003: Infratest-Survey 2002.

*Table 12. Recipients of benefits in kind at home by care level (1999 to 2007)*

| Year | Total | Care level I | Care level II | Care level III | Hardship cases |
|---|---|---|---|---|---|
| | | | Number of recipients - all ages | | |
| 1999 | 415.289 | 190.300 | 165.368 | 59.621 | 1.343 |
| 2001 | 434.679 | 209.613 | 166.717 | 58.349 | 1.396 |
| 2003 | 450.126 | 224.732 | 167.558 | 57.836 | 1.376 |
| 2005 | 471.543 | 240.086 | 172.937 | 58.520 | 1.411 |
| 2007 | 504.232 | 264.527 | 178.532 | 61.173 | 1.603 |
| | | | Changes between 1999 and 2007 | | |
| Number | 88.943 | 74.227 | 13.164 | 1.552 | 260 |
| % | 21,42 | 39,01 | 7,96 | 2,60 | 19,36 |
| | | | Share of recipients by care level | | |
| 1999 | 100,00 | 45,82 | 39,82 | 14,36 | 0,32 |
| 2001 | 100,00 | 48,22 | 38,35 | 13,42 | 0,32 |
| 2003 | 100,00 | 49,93 | 37,22 | 12,85 | 0,31 |
| 2005 | 100,00 | 50,91 | 36,67 | 12,41 | 0,30 |
| 2007 | 100,00 | 52,46 | 35,41 | 12,13 | 0,32 |
| | | | Number of recipients 65 years old and older | | |
| 1999 | 374.529 | 175.563 | 150.905 | 48.061 | 497 |
| 2001 | 392.523 | 193.390 | 152.268 | 46.865 | 488 |
| 2003 | 406.818 | 207.512 | 153.105 | 46.201 | 471 |
| 2005 | 427.035 | 221.834 | 158.310 | 46.891 | 532 |
| 2007 | 456.315 | 244.051 | 163.178 | 49.086 | 640 |
| | | | Changes between 1999 and 2007 | | |
| Number | 81.786 | 68.488 | 12.273 | 1.025 | 143 |
| % | 21,84 | 39,01 | 8,13 | 2,13 | 28,77 |
| | | | Share of elderly recipients by care level | | |
| 1999 | 100,00 | 46,88 | 40,29 | 12,83 | 0,13 |
| 2001 | 100,00 | 49,27 | 38,79 | 11,94 | 0,12 |
| 2003 | 100,00 | 51,01 | 37,63 | 11,36 | 0,12 |
| 2005 | 100,00 | 51,95 | 37,07 | 10,98 | 0,12 |
| 2007 | 100,00 | 53,48 | 35,76 | 10,76 | 0,14 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 13. Recipients of a combination of benefits in kind and in cash at home in 1999 and 2007*

| | 1999 | | | 2007 | | |
|---|---|---|---|---|---|---|
| | Total | Men | Women | Total | Men | Women |
| *Number of people* | 153.828 | 48.194 | 105.634 | 234.140 | 78.714 | 155.426 |
| under 65 years old | 14.583 | 7.058 | 7.525 | 22.893 | 10.696 | 12.197 |
| 65 years old and older | 139.245 | 41.136 | 98.109 | 211.247 | 68.018 | 143.229 |
| 80 years old and older | 88.959 | 22.252 | 66.707 | 139.836 | 37.468 | 102.368 |
| 90 years old and older | 23.929 | 5.149 | 18.780 | 33.499 | 7.234 | 26.265 |
| *Share in beneficiaries of ambulant care* | 37,04 | 41,06 | 35,46 | 46,43 | 49,98 | 44,82 |
| under 65 years old | 35,78 | 36,60 | 35,04 | 47,78 | 44,79 | 50,74 |
| 65 years old and older | 37,18 | 41,94 | 35,49 | 46,29 | 50,91 | 44,38 |
| 80 years old and older | 36,80 | 40,99 | 35,58 | 45,53 | 51,19 | 43,76 |
| 90 years old and older | 35,99 | 38,95 | 35,25 | 44,12 | 48,66 | 43,02 |
| *Share in beneficiaries of benefits in cash solely and of both, in cash and in kind* | 13,02 | 10,91 | 14,28 | 18,47 | 16,45 | 19,70 |
| under 65 years old | 4,43 | 3,95 | 5,00 | 7,36 | 6,75 | 8,00 |
| 65 years old and older | 16,34 | 15,64 | 16,65 | 22,09 | 21,25 | 22,51 |
| 80 years old and older | 18,37 | 20,19 | 17,83 | 25,01 | 26,52 | 24,49 |
| 90 years old and older | 18,83 | 21,88 | 18,14 | 26,82 | 30,13 | 26,03 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 14. Beneficiaries by kind of institutional care in 2007*

| Age-groups | Total | Full-time institutional care | Short-time | Day care | Night care |
|---|---|---|---|---|---|
| Total | 709.311 | 671.080 | 15.002 | 23.196 | 33 |
| Men | 171.624 | 159.462 | 4.439 | 7.706 | 17 |
| Women | 537.687 | 511.618 | 10.563 | 15.490 | 16 |
| Aged 65 and older | 659.765 | 624.085 | 14.102 | 21.547 | 31 |
| Men | 142.756 | 131.862 | 3.967 | 6.912 | 15 |
| Women | 517.009 | 492.223 | 10.135 | 14.635 | 16 |
| Aged 80 and older | 487.600 | 464.951 | 10.009 | 12.624 | 16 |
| Men | 74.789 | 69.637 | 2.260 | 2.885 | 7 |
| Women | 412.811 | 395.314 | 7.749 | 9.739 | 9 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 15. Long-term care recipients in institutions by family status (2003)*

| | Family status | | | | | |
|---|---|---|---|---|---|---|
| Age-groups | Total | | Never married | Married | Widowed | Divorced |
| | in 1000 | in % | | | | |
| | | | | Men | | |
| under 25 | / | 100 | / | 0 | 0 | 0 |
| 25-60 | 15 | 100 | 81,2 | / | / | / |
| 60-70 | 24 | 100 | 41,3 | / | / | 30,8 |
| 70-80 | 32 | 100 | 26,4 | 29,3 | 36,1 | / |
| 80-90 | 37 | 100 | / | 31,5 | 54,1 | / |
| 90 and older | 17 | 100 | / | / | 62 | 0 |
| total | 126 | 100 | 28,9 | 22,1 | 37,8 | 11,2 |
| | | | | Women | | |
| under 25 | / | 100 | / | 0 | 0 | 0 |
| 25-60 | 11 | 100 | / | / | / | / |
| 60-70 | 22 | 100 | 38,5 | / | 38,8 | / |
| 70-80 | 86 | 100 | 19 | 11,3 | 63,5 | / |
| 80-90 | 219 | 100 | 13,1 | 4,1 | 78,9 | 4 |
| 90 and older | 130 | 100 | 12,4 | / | 82,1 | / |
| total | 469 | 100 | 16,2 | 5,1 | 73,1 | 5,4 |

Source: Micro-census 2003; calculation by DIW Berlin.

*Table 16. Long-term care recipients in institutions by care level (1999 to 2007)*

| Year | Total | Care level I | Care level II | Care level III | Hardship cases | Not jet classified |
|---|---|---|---|---|---|---|
| | | | Number of recipients - all ages | | | |
| 1999 | 573.211 | 176.573 | 248.939 | 128.172 | 2.911 | 19.527 |
| 2001 | 604.365 | 196.553 | 269.151 | 128.319 | 3.011 | 10.342 |
| 2003 | 640.289 | 216.307 | 282.699 | 133.629 | 3.379 | 7.654 |
| 2005 | 676.582 | 231.106 | 293.551 | 141.104 | 4.140 | 10.821 |
| 2007 | 709.311 | 253.406 | 299.936 | 145.136 | 4.953 | 10.833 |
| | | | Changes betweeen 1999 and 2007 | | | |
| Number | 136.100 | 76.833 | 50.997 | 16.964 | 2.042 | -8.694 |
| % | 23,74 | 43,51 | 20,49 | 13,24 | 70,15 | -44,52 |
| | | | Share of recipients (all ages) by care level | | | |
| 1999 | 100,00 | 30,80 | 43,43 | 22,36 | 0,51 | 3,41 |
| 2001 | 100,00 | 32,52 | 44,53 | 21,23 | 0,50 | 1,71 |
| 2003 | 100,00 | 33,78 | 44,15 | 20,87 | 0,53 | 1,20 |
| 2005 | 100,00 | 34,16 | 43,39 | 20,86 | 0,61 | 1,60 |
| 2007 | 100,00 | 35,73 | 42,29 | 20,46 | 0,70 | 1,53 |
| | | | Number of recipients 65 years old and older | | | |
| 1999 | 523.165 | 158.717 | 233.416 | 114.487 | 1620 | 16545 |
| 2001 | 555.593 | 179.056 | 253.279 | 114.463 | 1604 | 8795 |
| 2003 | 591.285 | 199.059 | 266.398 | 119.355 | 1917 | 6473 |
| 2005 | 627.824 | 214.340 | 277.362 | 126.789 | 2602 | 9333 |
| 2007 | 659.765 | 236.304 | 283.485 | 130.649 | 3416 | 9327 |
| | | | Changes betweeen 1999 and 2007 | | | |
| Number | 136.600 | 77.587 | 50.069 | 16.162 | 1.796 | -7.218 |
| % | 26,11 | 48,88 | 21,45 | 14,12 | 110,86 | -43,63 |
| | | | Share of elderly recipients by care level | | | |
| 1999 | 100,00 | 30,34 | 44,62 | 21,88 | 0,31 | 3,16 |
| 2001 | 100,00 | 32,23 | 45,59 | 20,60 | 0,29 | 1,58 |
| 2003 | 100,00 | 33,67 | 45,05 | 20,19 | 0,32 | 1,09 |
| 2005 | 100,00 | 34,14 | 44,18 | 20,19 | 0,41 | 1,49 |
| 2007 | 100,00 | 35,82 | 42,97 | 19,80 | 0,52 | 1,41 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 17. Length of stay of persons living in nursing homes in 1994 and 2005 (%)*

| Length of stay | 1994 | | | 2005 | | |
|---|---|---|---|---|---|---|
| | Total | Men | Women | Total | Men | Women |
| up to 6 month | 18 | 18 | 20 | 22 | 17 | 29 |
| 6 to 12 month | 11 | 9 | 12 | 9 | 8 | 17 |
| 1 to 2 years | 10 | 12 | 7 | 15 | 14 | 16 |
| 2 to 3 years | 11 | 10 | 13 | 10 | 10 | 9 |
| 3 to 4 years | 12 | 8 | 24 | 11 | 11 | 9 |
| 4 to 5 years | 10 | 10 | 9 | 10 | 11 | 6 |
| 5 to 10 years | 14 | 15 | 12 | 16 | 19 | 7 |
| 10 years and more | 14 | 18 | 3 | 6 | 9 | 4 |
| no answer | | | | 1 | 1 | 2 |
| Average in years | 4.7 | 5.2 | 2.9 | 3.4 | 3.9 | 2.2 |
| Sources: Infratest-Nursing Home Survey 1994 and 2005. | | | | | | |

*Source*: Schneekloth and von Törne (2007).

*Table 18. Characteristics of informal caregivers at home in Germany (2002)*

| | Care giving to people with care level | | | Care giving to people with care level | |
|---|---|---|---|---|---|
| | I-III | 0 | | I-III | 0 |
| **Gender** | | | **Family status** | | |
| male | 27 | 30 | married | 69 | 78 |
| female | 73 | 70 | widowed | 12 | 8 |
| | | | divorced | 5 | 4 |
| **Age-groups** | | | single | 12 | 10 |
| under 40 | 11 | 13 | | | |
| 40-54 | 27 | 26 | **Activity status** | | |
| 55-64 | 27 | 23 | Full time employed | 19 | 32 |
| 65-79 | 26 | 28 | Part time employed | 15 | 15 |
| 80 and older | 7 | 4 | Marginally employed | 6 | 3 |
| NA | 3 | 6 | Not employed | 60 | 50 |
| Source: Schneekloth and Leven 2003. | | | | | |

*Table 19. Impact of caregiving on the employment status of informal carers (2002) (%)*

| Changes in employment status | Beneficiaries on LTCI funds | | People in need of help (care level 0) | |
|---|---|---|---|---|
| | 1991 | 2002 | 1991 | 2002 |
| At the beginning of care giving ... | | | | |
| not employed | 52 | 51 | 45 | 48 |
| employed and carer | | | | |
| give up the job | 14 | 10 | 5 | 4 |
| reduced working time | 12 | 11 | 5 | 5 |
| continue to work | 21 | 26 | 44 | 40 |
| No answer | 1 | 2 | 2 | 3 |

Source: Schneekloth and Leven 2003: Infratest-Survey 2002.

*Table 20. Living place of the main informal carer in 2002*

| People in need of care live in .... | Distance to people in need of care | |
|---|---|---|
| | total | living alone |
| Same household | 62 | 0 |
| Same house | 8 | 20 |
| a distance up to 10 minutes | 14 | 37 |
| a distance up to 30 minutes | 5 | 14 |
| a longer distance | 3 | 7 |
| no private helper | 8 | 21 |

*Source*: Schneekloth and Leven (2003).

*Table 21. Professional home-care services and number of persons cared for*

| | 1999 | 2001 | 2003 | 2005 | 2007 |
|---|---|---|---|---|---|
| | Number of home care services | | | | |
| Private | 5.504 | 5.493 | 5.849 | 6.327 | 6.903 |
| Charitable | 5.103 | 4.897 | 4.587 | 4.457 | 4.435 |
| Public | 213 | 204 | 183 | 193 | 191 |
| Total | 10.820 | 10.594 | 10.619 | 10.977 | 11.529 |
| | Number of people cared for | | | | |
| Private | 147.804 | 164.747 | 184.754 | 203.142 | 228.988 |
| Charitable | 259.648 | 261.365 | 257.564 | 259.703 | 265.296 |
| Public | 7.837 | 8.567 | 7.808 | 8.698 | 9.948 |
| Total | 415.289 | 434.679 | 450.126 | 471.543 | 504.232 |
| | Number of people cared for per care service | | | | |
| Private | 26,9 | 30 | 31,6 | 32,1 | 33,2 |
| Charitable | 50,9 | 53,4 | 56,2 | 58,3 | 59,8 |
| Public | 36,8 | 42 | 42,7 | 45,1 | 52,1 |
| Total | 38,4 | 41 | 42,4 | 43 | 43,7 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 22. Staff in home-care services (1999 to 2007)*

| Years/Employees | Total | Men | Women |
|---|---|---|---|
| 1999 | 183.782 | 27.377 | 156.405 |
| 2001 | 189.567 | 26.579 | 162.988 |
| 2003 | 200.897 | 26.295 | 174.602 |
| 2005 | 214.307 | 26.429 | 187.878 |
| 2007 | 236.162 | 29.330 | 206.832 |
| | | 2007 | |
| Management | 14.859 | 2.494 | 12.365 |
| Nurses | 163.580 | 17.011 | 146.569 |
| Home helpers | 33.140 | 3.195 | 29.945 |
| Administration | 12.349 | 2.834 | 9.515 |
| Other | 12.234 | 3.796 | 8.438 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 23. Staff in home-care services by working time (1999 to 2007)*

| Year | Total | Full-time | Part-time | more than 50% | less than 50% | marginal | Other |
|---|---|---|---|---|---|---|---|
| 2007 | 236.162 | 62.405 | 167.479 | 77.762 | 36.683 | 53.034 | 6.278 |
| 2005 | 214.307 | 56.354 | 151.138 | 68.141 | 35.040 | 47.957 | 6.815 |
| 2003 | 200.897 | 57.510 | 136.124 | 60.762 | 32.797 | 42.565 | 7.263 |
| 2001 | 189.567 | 57.524 | 123.158 | 55.008 | 30.824 | 37.326 | 8.885 |
| 1999 | 183.782 | 56.914 | 117.069 | 49.149 | 28.794 | 39.126 | 9.799 |
| | Changes between 1999 and 2007 | | | | | | |
| Number | 52.380 | 5.491 | 50.410 | 28.613 | 7.889 | 13.908 | -3.521 |
| % | 28,50 | 9,65 | 43,06 | 58,22 | 27,40 | 35,55 | -35,93 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 24. Service bundles of home-care services – Example of selected services in Rheinland-Pfalz in 2007*

| Service bundles (selected services) | Category | Price (Euro) |
|---|---|---|
| Brief morning/evening toilet | Personal care | 11.5 |
| Intensive morning/evening toilet | Personal care | 16.11 |
| intensive morning/evening toilet with bathing | Personal care | 20.71 |
| Bathing | Personal care | 13.41 |
| Help with eating | Personal care | 11.5 |
| Mobilisation | Personal care | 7.14 |
| Help with leaving the dwelling | Personal care | 2.66 |
| Heating the dwelling | help with housework | 2.58 |
| Cleaning the dwelling (usually daily work) | help with housework | 5.21 |
| Ironing | help with housework | 7.79 |
| Shopping | help with housework | 6.49 |
| Preparing the meals (without meals on wheals) | help with housework | 11.70 |
| First visit | help with housework | 26.82 |

*Source*: Federal Ministry of Health (2008).

*Table 25. Nursing homes and places in nursing homes (1999 to 2007)*

| Kind of provider | 1999 | 2001 | 2003 | 2005 | 2007 |
|---|---|---|---|---|---|
| | | | Number of nursing homes | | |
| Private | 3.092 | 3.286 | 3.610 | 3.974 | 4.322 |
| Charitable | 5.017 | 5.130 | 5.405 | 5.748 | 6.072 |
| Public | 750 | 749 | 728 | 702 | 635 |
| Total | 8.859 | 9.165 | 9.743 | 10.424 | 11.029 |
| | | | Places in nursing homes | | |
| Private | 166.637 | 188.025 | 215.901 | 245.972 | 275.257 |
| Charitable | 406.705 | 415.725 | 431.743 | 448.888 | 469.574 |
| Public | 72.114 | 70.542 | 65.551 | 62.326 | 54.228 |
| Total | 645.456 | 674.292 | 713.195 | 757.186 | 799.059 |
| | | | Places per home | | |
| Private | 53,9 | 57,2 | 59,8 | 61,9 | 63,7 |
| Charitable | 81,1 | 81,0 | 79,9 | 78,1 | 77,3 |
| Public | 96,2 | 94,2 | 90,0 | 88,8 | 85,4 |
| Total | 72,9 | 73,6 | 73,2 | 72,6 | 72,5 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 26. Employees in nursing homes in 2007*

| | Total | Men | Women |
|---|---|---|---|
| Employees in total | | | |
| Total | 573.545 | 87.551 | 485.994 |
| Nurses | 393.772 | 51.834 | 341.938 |
| Social workers | 22.405 | 3.600 | 18.805 |
| Home helpers | 102.547 | 8.331 | 94.216 |
| Utilities management | 15.057 | 13.847 | 1.210 |
| Management, administration | 31.754 | 7.448 | 24.306 |
| Other | 8.010 | 2.491 | 5.519 |
| Thereof: Full-time employees | | | |
| Total | 202.764 | 44.196 | 158.568 |
| Nurses | 148.190 | 25.527 | 122.663 |
| Social workers | 5.370 | 1.162 | 4.208 |
| Home helpers | 25.053 | 4.485 | 20.568 |
| Utilities management | 7.461 | 7.174 | 287 |
| Management, administration | 14.859 | 5.190 | 9.669 |
| Other | 1.831 | 658 | 1.173 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 27. Employees in nursing homes by working time (1999 to 2007)*

| Year | Total | Full-time | Part-time | more than 50% | less than 50% | marginal | other |
|---|---|---|---|---|---|---|---|
| 2007 | 573.545 | 202.764 | 327.992 | 184.596 | 84.666 | 58.730 | 42.789 |
| 2005 | 546.397 | 208.201 | 296.108 | 162.385 | 78.485 | 55.238 | 42.088 |
| 2003 | 510.857 | 216.510 | 260.733 | 140.488 | 71.066 | 49.179 | 33.614 |
| 2001 | 475.368 | 218.898 | 226.432 | 120.218 | 61.843 | 44.371 | 30.038 |
| 1999 | 440.940 | 211.544 | 198.441 | 100.897 | 54.749 | 42.795 | 30.955 |
| | Changes between 1999 and 2007 | | | | | | |
| Number | 132.605 | -8.780 | 129.551 | 83.699 | 29.917 | 15.935 | 11.834 |
| % | 30,07 | -4,15 | 65,28 | 82,95 | 54,64 | 37,24 | 38,23 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

*Table 28. Average per diem rates for long-term care in nursing homes in 2007*

| Institutional Care | Kind of provider | | | |
|---|---|---|---|---|
| | Private | Charitable non-profit | Public | Total |
| Full-time institutional care | Euros per person per day | | | |
| Care level I | 41 | 43 | 46 | 43 |
| Care level II | 54 | 58 | 60 | 57 |
| Care level III | 67 | 73 | 74 | 71 |
| Board and lodging | 19 | 20 | 19 | 20 |
| Short-time institutional care | | | | |
| Care level I | 45 | 50 | 50 | 48 |
| Care level II | 56 | 63 | 60 | 60 |
| Care level III | 68 | 76 | 72 | 73 |
| Board and lodging | 19 | 21 | 19 | 20 |

*Sources*: Federal Statistical Office of Germany, statistics on long-term care, calculations by DIW Berlin.

# About DIW – Deutsches Institut für Wirtschaftsforschung

The German Institute for Economic Research (a registered association) in Berlin was originally founded in 1925 as the “Institute for Business Cycle Research”. It is now one if the leading economic think tanks in Germany. As an independent non-profit organisation, the DIW is exclusively committed to academic pursuits in the public interest. The DIW’s main task is to investigate economic processes in Germany and abroad and to support decision-making in politics, the economy and administration. The analytical tools are theoretical assessment, empirical testing, economic and econometric modelling. The wide range or research covers anything from short-term analysis of economic developments, searching for answers to current economic and fiscal affairs, to the long-term projection and evaluation of developments in the global economy and individual sectors alike. Social changes are recorded by the German Socio-Economic Panel (SOEP), which compiles a periodical representative longitudinal survey of German private households.

The unifying research theme of the Public Economics Department is how the various policy instruments of the welfare state, such as taxes, transfers, the provision of public services, and government regulations, affect the allocation of resources and the distribution of incomes. Our trademark of research is the strong empirical microeconomic foundation based on new methodological developments, in particular micro-econometrics and micro-simulation models. One focus lies on health and long-term care provision and demand. The department participated in several projects financed by the European Commission under FP5 and FP6, namely the AGIR and AHEAD projects.

# ANCIEN

**Assessing Needs of Care in European Nations**


***FP7 HEALTH-2007-3.2-2***

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

***For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).***