interlinks

Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Governance and financing of long-term care

German National report

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Berlin | Frankfurt a.M. | April 2010

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SEVENTH FRAMEWORK PROGRAMME

Funded by the European Commission
under the Seventh Framework Programme
Grant agreement no. 223037

Contents

1 Key contextual factors

The German long-term care system is based on three institutional levels of governance and financing and is imbedded in the fundamental state principles of federalism and subsidiarity. The different political administrative levels take responsibility for different legislative and executive duties. According to the federal construction of the German Constitution, the governmental administrations act at a federal, a state (Länder) and at a local level. The Federal Government and the Governments of the States have a legislative function while the local authorities are responsible primarily for executive implementation. Local authorities in particular have a duty to avoid disparities in support and to ensure a regular supply of long-term care in every region of Germany. This takes into account the contribution of all local, state-owned, and non-profit-making care institutions and private enterprises. Statutory long-term care insurance (LTC) (Soziale Pflegeversicherung, SGB XI) is the most important programme in long-term care and constitutes the 'fifth column' of the social insurance system as implemented in 1995, along with statutory health, accident, unemployment and pension insurance schemes. All of these are organized within a 'Bismarck type' welfare system (Esping-Andersen, 1990). The foundations of such central institutions as Social Health Insurance (Krankenversicherung) date back to the 19th century. The remit of the long-term care insurance scheme is to ensure the provision of care for the insured and the quality control of care delivered. Nevertheless, the scheme's ability to ensure the supply of care is limited by the fact that it has no appropriate bearing on the creation, promotion or maintenance of an LTC infrastructure. This task is assigned to the federal states and municipalities and is decreed in special acts and regulations, e.g. the (Retirement) Home Act (Heimgesetz) or the Assistance Act for Senior Citizens (Altenhilfe, § 71 SGB XII). Indeed, the concept of a corporate model in terms of "managed care" or "integrated care network" is lacking. A move towards a "competitive market" was promoted by recent reforms in favour of more market-oriented mechanisms. Thus, health and long-term care systems are still characterized by a mix of autonomy and interdependence regarding the different professional interest groups, featuring competitive negotiation processes between them. However, these diagnostic findings are only true for the Western federal states, the former German Federal Republic. After World War II, the East German health care system underwent radical changes, which cannot be described here in detail, but still affect present health policies in the reunified health care system after 1989. Since care for older people is regarded as an upcoming social challenge, the issue of long-term care currently receives considerable attention in the context of concerns about the affordability and sustainability of care in an ageing society. There is a societal and political consensus regarding the need for quality care of older people, protecting their dignity, coupled with recognition that great efforts will be required to uphold these values.

To sum up, the following contextual factors influence the governance and financing of LTC in Germany:

- *Focus on coverage and accessibility*: LTC Insurance is the most important instrument for managing and financing LTC in home care and residential care. As a compulsory insurance LTCI is linked to the Social Health Insurance and is compulsory for all employees below a certain income – in all other cases, private health and long-term care insurance are available. This leads to coverage by the social

health and long-term care insurance of about 99.7% of the German population and good access population-wide to care services (Gesundheitsberichterstattung des Bundes)[1]

- *Focus on the "benefits of LTC Insurance":* The main difference between LTC Insurance and other statutory insurance schemes is the degree of cost coverage. SHI is conceived as full coverage for all health costs without limits, except for some additional payments. LTCI affords partial insurance cover related to the degree of care, including aspects of social care. Therefore LTCI partly covers the real expenses people with care needs have to pay.
- *Focus on "home care instead of residential care"*: The main intention of LTC Insurance is to postpone residential care as long as possible and facilitate living at home. The basic strategies to achieve this aims are:
  - support of the person in need of care in the form of a cash benefit (care attendance allowance = Pflegegeldleistung) depending on the degree of care needs
  - meeting the costs of professional care services (care allowance in kind = Pflegesachleistung), depending on the degree of care needs
  - support of informal carers: trainings in home care and contributions in pension insurance
  - relieving informal carers by having the needy person taken into short-time or intermediate residential care, maximum 28 days p.a. (respite care = Kurzzeit-, resp. Verhinderungspflege)
  - adapting housing environments to barrier-free standards, by a maximum benefit of 2.557 Euro. (housing adaption = Wohnungsanpassung)

- *Focus on "cure instead of care":* The principle "cure instead of care" in LTCI guidelines should be decisive in any medical and care action. However, the interplay between the different insurance systems and care sectors is shaped by a relatively strong focus on acute medical care and sophisticated downstream interventions. For many years, comprehensive care concepts including preventative and rehabilitative approaches, or integration of different sectors such as health and social care or the different professions, have been underdeveloped – and have only recently been accorded some attention in German health policies. Since the last LTCI Reform in 2008, geriatric rehabilitative care has been classed as standard insurance benefit (not a matter of discretion). Every (old) patient is eligible by law.[2] (For current trends towards prevention and rehabilitation in LTC see National Report for Germany, WP3)
- *Focus on coordination between care sectors and professions:* Different factors contribute to the fragmented delivery of health and long-term care in Germany . In contrast to many other countries, free access to specialists is guaranteed for the majority of the population, and the general practitioner's role as gatekeeper is weak. Different sectors (e.g. in-patient and out-patient care) are divided, as different financing and regulation rules create barriers. Regulation initiatives by authorities or bottom-up coordination of catchment areas are in the offing, especially at the local level, most of which are not connected to profit or non-profit, private enterprises. A steering authority for LTC coordination is virtually absent at the local level. Care or Case Management

1 Statistisches Bundesamt: http://www1.bpb.de/wissen/S4VGR2,0,Krankenversicherungsschutz_der_Bevölkerung.html

2 At present it is not clear whether the law "works" as intended or not. Problem is: The payers of the geriatric rehabilitative care are the health insurance funds and not the long-term nursing care funds.

approaches are neither implemented in LTCI nor are they the task of local authorities. For LTC these circumstances often lead to unclear patient pathways and intransparent choice options. Cultures of inter-professional and inter-organisational cooperation and intermediate re integrated care forms remain underdeveloped.

- *Focus on Volunteers in LTC*: actors in informal care are mainly family members but also friends and neighbours who participate in informal care arrangements. Organised volunteer commitment in LTC has been supported by welfare organisations and parishes for years. LTC Insurance envisages the extension of volunteering in care arrangements. Since the first reform of LTCI in 2002 the legislator has allocated a marginal budget (460 euros p.a.) for trainings and coordination of volunteer support for people with mental disorder and their family carers. Within the latest LTCI Reform in 2008, the investments in low-threshold services and the development of volunteer work increased to maximum 2.400 euros p.a. 20 million euros plus the same amount again as co-financing by the federal states or municipalities mobilised in LTC.

2 The governance and financing of long-term care services for older people

Long-term care delivery in Germany includes services supplied through the long-term care system itself and, in addition, services administered by the health care system as well as social and informal care efforts. This diversity is caused by the fact that finance and delivery of these services are regulated by different insurance schemes and at various governmental levels.

The statutory long-term care insurance scheme is organized in a similar manner to other social insurance systems in Germany (pension, employment and health insurance). However, coverage by the long-term care insurance is limited regarding actual care needs and is understood as complementary (partial coverage). The aim is to support informal care rather than to replace it. If beneficiaries with low income cannot afford additional private spending for services, they can apply for a public long-term care assistance allowance on a welfare base, which is intended to bridge the gap in statutory long-term care insurance. These benefits are means-tested according to family income. Eligibility to LTC services depends on the level of (nursing) care required as assessed and certified by the Medical Review Board of the Statutory Health Insurance Funds, categorized in 3 care levels. Fixed amounts are granted accordingly to the beneficiaries. The final financial decision is made by the long-term care insurance. Statutory health care for older people with medical care needs and some kinds of nursing support (e.g. short-term nursing care up to 6 months) are covered by the SHI and mostly delivered as a benefit in kind. In contrast to the long term care insurance, the health insurance system aims to be fully comprehensive with some additional payments for dental facilities and medical care.

The financing of social insurance benefits is based on the principle of the shared payment of contributions: by all employees covered by the social security system on the one hand, and their employers on the other. Membership within this system is obligatory for all employees up to a certain earnings ceiling. Contributions are calculated on the basis of gross income and are fixed every year. Employees who are not covered by the social insurance system (i.e. civil-servants, self-employed etc.) are usually members of a private health and pension insurance scheme (around 9%). Based on the

solidarity principle, people on higher incomes contribute more to the social insurance schemes (for more details see Arntz et al., 2007). The expenditures of LTC Insurance are statutorily fixed at the level of monthly revenues. If costs for LTC increase, the contributions for LTCI have to be adapted. This expenditure control mechanism does not apply to SHI because any strong up and downturns are compensated for by government subventions.

Although the Assistance Act for Senior Citizens is legally binding, municipalities decide in practice about its application. This means that local authorities are not obliged to offer social care in the form of additional services, e.g. volunteer visiting schemes or volunteer companion services for elderly or participative efforts. Municipalities allocate social care unequally, in response to the financial situation and political priorities. Thus, the variations in benefits arising out of the Assistance Act for Senior Citizens are not income-related.

Given the different insurance schemes and the above mentioned multiplicity of organized professional interest groups, which exert considerable influence, the governance of LTC services is a complex task, shaped e.g. by the following institutional circumstances:

- Governance challenges caused by fragmentation of care provision: Health-, long-term- and social care are delivered by a mixture of non-profit and private providers in an increasingly competitive market. However, the implementation of an assessed care level and the resulting individual care arrangements are supposed to be organized by GPs, discharge staff (physicians, nurses, social worker) at the hospital, community care staff or informal carers/relatives. In many cases, patient pathways are unclear and there is no accountability for case management. Frequently, individual professionals try to compensate for this lack and act as case managers, because 'otherwise no one else would do it…'
- Limited access to LTC services: Eligibility to LTC services depends on the level of (nursing) care required as assessed and certified by the Medical Review Board of the Statutory Health Insurance Funds. Fixed amounts are granted to the beneficiaries according to 3 grades of need. The final financial decision is made by the long-term care insurance according to the recommendations of the Medical Review Beard. However the criticism has been made that in times of scarce resources access to services tends to be restricted and therefore functions as an instrument of cost control (e.g. grades of care need have ignored the special demands of dementia patients for a long time and have only recently been adjusted).
- Income disparities result in heterogeneous care quality: Overall, families' engagement remains crucial to organizing and insuring good service quality, continuity and adequate services for the person in need of care. Differences in patients'/families' financial resources in fact do matter: Higher income helps to compensate insufficient home care services by making affordable additional services like night care etc.
- Governance problems caused by underdeveloped local regulation: As mentioned before, local authorities play a weak role in the coordination and commissioning of LTC, especially in the broader sense of the coordinated and need-oriented provision of nursing, social, medical and informal community-based care. Fragmentation between care sectors (e.g. ambulatory and institutional care) and professions tends to be an obstacle to effective cooperation, especially within competitive local environments. Unfortunately, the steering competencies of regulating authorities which might

potentially adopt a community-oriented and population-based approach, such as local government, often do not have sufficient institutional powers to promote care integration.

- Limited scope of current reforms: Within the recent LTC reform, care support centres (Pflegestützpunkte) for comprehensive advice and coordination of neighbourhood located services in terms of case management (Federal Ministry of Health, 2009) have to be set up as independent neutral agencies, under the auspices of local authorities and the main health insurance companies, but nonetheless dependent on the decision of the federal states. The intended service provided by the new agencies should offer information on care questions from one source. Additionally, recent reforms of the health care system have addressed the coordination deficits between sectors and promoted care integration by introducing several laws for new contracting options. However, these reforms still fail to enhance inter-professional collaboration, as they are limited to the level of interdisciplinary medical care (nursing or social organisations are hardly involved in new integrated care contracts).
- Demographic developments are expected to result in a reduction of resources and the numbers of informal as well as professional carers. There is a significant trend over the next 30 years towards a decreasing capacity of family and professional carers to keep pace with the continuously rising rate of people in need of care. The governance challenge is to establish a comprehensively and individualy adapted support system for informal carers. Legislation is needed to promote informal care by creating opportunities for short-term leave and long-term nursing care time as an important incentive. To avert a dramatic shortage of professional care-givers, steering strategies are needed in the field of vocational education and further education as well as to improve the working conditions and salary of professional nursing stuff.
- Legalizing the ”grey market” of unprofessional care-givers: An unpredictable number of illegal working carers, mostly from Eastern European countries, are tolerated by the German Job Centers and Health Authorities. If officially recruited with the help of the International Placement Services (ZAV) of the German Federal Employment Agency, migrants work as home helps, but in fact perform carework. Up to now, the different interest groups (home-help employers and employees) see no advantage in passing appropriate statutory regulations. However a legal solution is strongly recommended because the demand for affordable home help and non-professional care is expected to rise dramatically in the following years.

3 Key barriers

3.1 Structural

Long-term care delivery in Germany comprises at least four components:

- services of the long-term care system,
- services of the health care system,
- social care efforts and
- informal care efforts.

The long-term care system and the health care system are separate systems, their finance and delivery being regulated by different codes of law. Each system involves several key actors.

For the long-term care sectors these are, among others:

- those authorised to coordinate (GPs and social services of hospitals, rehabilitation facilities and inpatient facilities for the elderly),
- those responsible for care assessment (the medical review board of the health insurance funds),
- those responsible for guaranteeing quality (the medical review board of the health insurance funds and home care services, recognised advice centres or authorised professional carers in the case of care provided by informal carers),
- the care providers themselves (in Germany home care services and institutional facilities are run by private, charitable and public bodies).

The health care system is made up of different sectors such as in-patient and out-patient care with their respective key actors in primary and secondary care services as delivered by doctors, nurses and therapists. To summarize: There is large fragmentation that would need integration, coordination, communication, professionalization efforts etc. in order to provide the comprehensive services of individuals in need of care.

3.2 Procedural

From a more procedural perspective, the fragmentation of the care system may have at least two effects:

- Processes (understood as entities) may be fragmented into distinct steps. Sometimes the person in question needs to seek a cascade of approvals before being granted a certain medical or nursing support.
- Processes may operate side by side. Long-term care is based on the outcomes of several distinct processes which need to be well integrated in order to ensure the comprehensive maintenance of a

person in need of care. At present, information concerning the person in need of care, diagnostic findings etc. can't be shared in a straightforward manner between the key actors (GPs, hospital specialists, home care services etc.) who are involved with the long-term care of this person.

3.3 Financial

A good example of fragmented processes (cf. chapter 3.2) is the funding of long-term care. The latter is met by the long-term care insurance fund (which at present covers approx. two thirds of the expenses), the person in need of care, and, where necessary, is supplemented by "Care Assistance". If someone becomes in need of care he or she has to take at least two, often three, steps in order to minimize his or her expenses arising in this context:

- Step one: First of all, the person's entitlement to insurance benefits has to be assessed. In most cases, benefits covered by long-term care insurance are insufficient to meet her care needs. This leads to
- Step two: The person in need of care pays privately for extra services or uses other means to meet the rest of the needs identified (e.g. uses the help of an informal carer etc.). If the person in need of care cannot afford additional private spending for services he or she is entitled to a public "Care Assistance Allowance" (CAA). This would lead to
- Step three: An assessment has to be made of the person's entitlement to a public CAA provided by local authorities. In this case, benefits are means-tested according to family income.

3.4 Professional

The cooperation of different professions usually involves friction with detrimental effects due to the fact that the members of the different care providers are committed to different ideals and values, or just acting in their own best interest. Of great significance is the mediatory role of gatekeepers (cf. GPs) and people who are specialised in long term care issues (nursing staff, social service staff etc.). These gatekeepers are often not adequately trained in gerontological issues and they sometimes do not communicate well with the "experts" whose role is to provide assessments and recommendations concerning the person requiring care.

3.5 Issues of status and legitimacy

Both the health care system and the long-term care system strongly assert their autonomy. Symptomatic is a marked tendency of the different professional interest groups to emphasise their own self-importance, this being also reflected in the negotiation processes between them. Furthermore, as in other industrialized countries, the interplay between the different insurance systems and care sectors is shaped by a comparably strong focus on acute medical care and the respective regulations (cf. the DRG system and its consequence: an increasing demand for out-patient follow-up care, the need for an appropriate discharge management etc.). Recent reforms of the health care system have addressed the coordination deficits between sectors and have promoted care integration by several laws for new contracting options. But these reforms are concerned predominantly with the level of medical care.

4 Key enablers

4.1 Shared vision

Within the last few years, the need for more effectively integrated care with goals and visions shared between the different care services and professionals has been widely accepted as a challenge for current health and care policies. The above-mentioned issues of severe lack of integration between care sectors and the absence of a culture of cooperation between health and social care professionals, as well as between the professional and informal sectors, have recently been addressed by several health and LTC reforms, but unfortunately without sufficient reference to each other. Some effects of health care reforms are e.g. clear pathways for certain groups of chronically ill patients (Disease Management Programme - DMP) and new local networks of interdisciplinary medical cooperation (Integrierte Versorgungsverträge §140a ff., MVZ etc.). It is doubtful, however, whether these current changes will lead to a comprehensive systemic move towards integrated care – at present, health care delivery is characterized by the coexistence of different traditional and innovative organizational forms of care delivery. The scope of health care reforms is limited by their focus on medical care resp. the medical profession (see above). Since nursing or social work organisations etc. are not expected to join innovative local contracting options as equal partners, few positive effects of reforms towards inter-professional cooperation can be identified so far. An important innovation for the development of shared visions at the local level of LTC is the implementation of care support centres, based on the Long-term Care Further Development Act (2008). These aim to offer case management for the long-term care of elderly people and advice for people with care needs. Furthermore, the care support centres are also empowered to fulfil some coordination tasks regarding long-term care services. For the first time in the development of LTCI, the new centres have been made responsible for developing forms of cooperation between nursing and social work – a gap between those professional groups and the medical profession that has yet to be bridged. Moreover, since the last elections the new government is undecided as to whether to support the long-term institutionalisation set in motion by the former government.

4.2 Clarity of roles and responsibilities

The roles and accountability of care professionals are clarified and defined in legislation, a fact that cannot necessarily be equated with a patient-oriented distribution of responsibilities in daily practice enabling shared and well-coordinated delivery of care. In contrast to other countries (e.g. the UK) in most communities there is a lack of local negotiation processes and established local coordination structures such as round tables. Indeed, there are no standards in operation to inform local integrated pathways e.g. for hospital discharge or home care arrangements.

4.3 Appropriate incentives and rewards

Quality management: As part of the Long-term Care Further Development Act (2008) new steering instruments for quality management have been implemented: e.g. for the first time (in Germany) quality reports about home care services and care homes, generated by the Medical Review Board in unannounced audit visits (once per year from 2011), will be made accessible for clients and the public, if only in an aggregated form. New regulations were introduced for procedures to establish expert nursing guidelines for specific topics (e.g. decubitus prevention, wound treatment) which will become obligatory for care practice. These measures can be understood as a 'step into the right direction' – although under fire for not being sufficiently comprehensive. The main limitations of current quality assessment are as follows:

- Their coverage is mostly restricted to one single care sector (e.g. residential care) – overarching quality management instruments (for whole pathways) are still to be developed.
- As in current international scientific (public health/health services research) debates, the question of how to measure the outcome quality of such complex interventions as e.g. LTC remains unsolved. Available indicators and instruments often concentrate on rather narrow outcomes (e.g. decubitus prophylaxis) or structural or procedural quality parameters.

Due to these measurement problems, the effectiveness of quality management as a steering instrument for establishing good quality remains limited.

Steering by financial incentives: The complex arrangement of different care sectors and their financing rules implies several disincentives for a patient-oriented LTC, e.g. care efforts invested in one sector lead to benefits in another. In Germany, geriatric rehabilitation is covered by the Social Health Insurance, whereas the consequential rehabilitative gains (avoiding LTC needs in elderly) are made by the statutory *LTC* insurance. This leads to a lack of interest on the part of health insurances to invest in geriatric rehabilitation, because gains are booked by the LTC insurance. Some current reform proposals promote the idea of integrating a preventative/rehabilitative budget into the LTC insurance system.

4.4 Accountability for joint working

The variety of organisational interests presented, caused by complex funding and the steering mechanisms of LTC, aggravate problems of accountability for comprehensive and coordinated patient pathways through the system. Since impartial, user-oriented case-management schemes are not established comprehensively, many of the individual actors involved try to compensate for these steering deficits within their daily work – in spite of their frequent lack of training or of sufficient resources in terms of aspects of knowledge. Often, single actors report a lack of information about local services and – as mentioned above – community based coordination of services is underdeveloped. Funding aspects, case management and coordination tasks often amount to unpaid extra work for professionals.

5 The funding of long-term care services

In Germany long-term care expenses are covered in principle by four parties. Expenditures are incurred

- by the statutory long-term care insurance (social and private),
- by private insurers based on additional insurances,
- by the welfare ("Care Assistance") and
- by the persons in need of care, family members and other informal carers.[3]

The expenditure of the statutory long-term care insurance amounted in 2008 to approx. 18.2 billion euros (home care benefits: 8.9 billion euros, in-patient benefits: 9.3 billion euros) (AOK Bundesverband). The expenditure of the compulsory private long-term care insurance schemes and voluntary additional insurance companies amounted to approx. 0.6 Billion euros (PKV: Verband der privaten Krankenversicherung e.V.). The gross expenditure on "Care Assistance" amounted in 2008 to approx. 3.26 billion euros (Statistisches Bundesamt Deutschland). Expenses covered by the statutory long-term care insurance, additional insurance schemes and the welfare system amounted to approx. 0.9% of the GDP in 2008. There are no figures concerning the expenditure of people in need of care, their relatives and other informal carers.

The expenditure of the social statutory long-term care insurance in 2008 was:

Expenditures	in billions of €
Expenditure on benefits:	18.20
Therefrom: cash benefits	4.24
benefits-in-kind	2.60
nursing leave	0.29
day care / night care	0.11
additional benefits in the context of care	0.06
respite care	0.27
social security of caregiver	0.87
care products / technical aids etc.	0.46
in-patient care in nursing homes	9.05
in-patient care for the handicapped	0.24

Source: Bundesministerium für Gesundheit (BMG).

[3] The calculation of overall costs should also take into account the loss of income of persons who act as carers for another person (opportunity costs).

6 Financial sustainability

The "Expert advisory board for the survey of macroeconomic developments", amongst others, investigates the financial sustainability of the long-term care system. This expert advisory board continuously records the income and expenditures of the involved insurance systems.[4] The complexity of the subject involves, on the one hand, factors which are known and constantly subject to long-term extrapolations (e.g. demographic change, costs of labour, development of family structures etc), but also unexpected or unplanned developments (e.g. keeping to unreasonable election pledges, unexpected court decisions, global economic crises etc). At least the latter factors necessitate more or less short-term adjustments of the system. The standard procedure to assure financial sustainability is adjusting the insurance contributions.[5] At present, there is a lively political debate about how the statutory long-term care insurance should be financed in future. According to the opinion of many experts, augmenting insurance contributions will not guarantee financial sustainability in the long run.[6]

There is no doubt that in future the number of people 80 years or older will increase. But will the period of recourse to nursing care stay constant or will it increase? The following prognoses concerning the development of the total number of people in need of nursing care are available:

- Robert Koch-Institut (2004: 46-47):
    - Status-quo-Prognosis: According to this prognosis, in 2040 Germany will face 3.2 million people, insured in the social statutory long-term care insurance, who require care.
    - Prognosis based on the so-called compression-theory: According to this theory, in 2040 Germany will face 2.7 million people in need of care.
    - Prognosis based on the so-called medicalization thesis: According to this thesis in 2040 Germany will face 4.4 million people requiring care.
- According to Schnabel (2007: 11-12) based on a status-quo-prognosis Germany will have
    - 2.7 up to 2.8 million people in need of nursing care up to 2020 and
    - 4.0 up to 4.7 million people in need of care up to 2050.

As for the financial consequences, expenditures for people in need of care will grow dramatically: In 2005 the costs of nursing care – including the co-payment in the case of in-patient care – amounted to 26.7 billion euros (Schnabel, 2007: 21). In 2020 these costs will amount to 37 billion euros, in 2030 to 47

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4 With regard to the statutory long-term care insurance it is regulated by law: The expenditures must not exceed the income.

5 They allow to control income accounts. They do not affect expenditures. This is, augmenting insurance contributions does not assure that people in need of care receive always the same amount of benefits in-kind. Actually in the long run they have to throw in additional private spending to assure an established standard.
A way to control expenditures would be to modify the care assessment, for example a) to change the definition of "need for care" or b) to change its application in the context of care assessment.

6 For an overview of the different financing concepts that are discussed cf. the final report of Heinz Rothgang for the Hans Böckler Stiftung (2007).

billion euros and in 2050 to 72 billion euros (Schnabel, 2007: 23, figure 6).7 The shortfall that will have to be filled by the person in need of care, family members or the welfare will grow from at present approx. 8 billion euros to at least 24 billion euros (Schnabel, 2007: 22, figure 7). This means a strong financial burden for the people in need of care, family members and the welfare system. It will be necessary to find ways to disburden the municipalities who are in Germany the payers of "care assistance" and to extend their involvement in the governance of long-term care.

7 This outlook is based on two assumptions: a) On a status-quo-prognosis concerning the development of the total number of people in need of nursing care and b) on the assumption that the rise in process of prizes in the field of long-term care will equate to the rate of inflation.

7 Good practice

The following examples of good practice are given:

- The "statutory long-term care insurance": Since 1995 this insurance has relieved the budgets of the municipalities (the payers of "care assistance"). Their expenses for care assistance have clearly been reduced. Since 1995 it has also safeguarded, to a certain extent, the private means of people in need of nursing care, and hence the potential inheritance of the family members. It should be noted that the implementation of the idea "statutory long-term care insurance", especially the funding of the (real) statutory long-term care insurance is controversial.[8]
- The "care support centres" (Pflegestützpunkte): These are currently in the process of being established and extended to form a widespread network (one care support centre per 20,000 citizens) of low-threshold advice and coordination centres for persons in need of care and their relatives. These are intended to embrace various tasks including: qualified counselling, arranging help, coordinating the support options, gaining voluntary carers, advice on amenities and accommodation.
- A legal regulation states that: Geriatric rehabilitative care is standard insurance benefit (not a matter of discretion). Every (old) patient is eligible.[9]
- The website "www.heimverzeichnis.de": It serves as an orientation guide for people who are looking for an appropriate care or nursing home (for older persons). The website provides a list that a) comprises all German nursing homes for older persons, b) displays their services and offers in a standardised way and c) presents information concerning the quality of life rendered possible by the nursing homes.[10] The website is exemplary for the further development of standards from "quality of care" to "quality of life" and is financially supported by the Federal Ministry of Food, Agriculture and Consumer Protection.
- The "Care Conferences" (Pflegekonferenzen): In order to enhance and strengthen the structures of care at the municipal level, some German states (e.g. Hamburg, North Rhine-Westphalia and Berlin) stipulate the implementation of "care conferences". The main task of these conferences is to participate in the development of care structures in the municipalities (the planning of care, the coordination of the tasks of all relevant groups and actors related to care). The care conferences can be considered as a direct reaction to the often criticised and unclear rules of responsibility in the long-term care insurance (Rosendahl, 1999: 157).

8 Cf. the final report of Heinz Rothgang for the Hans Böckler Stiftung (2007).

9 At the present it is not clear whether the law "works" as intended or not. The problem is that it is the health insurance funds who have to pay for geriatric rehabilitative care, not the long-term nursing care funds. The law seems to work when the need for rehabilitation occurs abruptly (geriatric rehabilitative care as an option of the discharge management at hospital). It does not seem to work when the need for rehabilitation arises bit by bit (for example at home).

10 The latter holds only for nursing homes that were assessed by evaluators working for www.heimverzeichnis.de.

8 Ongoing tensions

Unresolved problems, which continuously compromise the governance of LTC in Germany, include:

- *Underdeveloped inter-professional and inter-organisational cooperation*: difficulties in coordination and cooperation within LTC delivery (which cannot be understood as one LTC system but as several sectors involved) remains a central challenge for innovative governance approaches. The fragmentation of care provision implies structural problems (e.g. several social insurance schemes forming together the legislative basis of provision), as well as cultural (e.g. weak tradition of inter-professional teamwork and dominance of medical sector) and financial aspects (e.g. resource problems especially in nursing care, disincentives for a preventative and rehabilitative LTC delivery).
- *Limited scope of current reforms:* the reforms for integrating care sectors have concentrated mainly on medical care. The development of a comprehensive definition of needs for care and the consequences for the Medical Review Board's assessment practice is an ongoing process that should bring benefits. With regard to this area, more efforts towards a user-orientation for persons with dementia should be made. Assistance services for persons with dementia and informal carers should be included from a threshold level up to palliative care.
- The important and controversial question of "how to make LTCI sustainable for the future" emerged as a big issue for the new Federal Government after the elections in 2009. The strategies under consideration range from continuing the old-age insurance based on solidarity between generations, to introducing a pay-as-you-go basic-system plus a funded system. This quandary seems to be provoking a fundamental debate about the principles on which the German welfare system should be based in the future.
- The establishment of a comprehensive and sustainable method of quality control in LTC. The current implemented rating-system of care services in nursing homes has been criticized for methodical errors. The instrument does not evaluate qualitative criteria of LTC as it was intended, so improvements have to be drawn up and implemented.
- The debate about a stronger political influence of local authorities in terms of budgetary and steering matters referring to regional and local affairs of LTC.

9 Embedding good practice in everyday practice

Care Conferences as a local structure to facilitate the realization of care policy were established to compensate for the lack of statutory regulations in planning and steering LTC. Successful implementation of targets and tasks depends largely on common planning and cooperation of different players in the care system. The model works with high commitment even though the members are not forced by law to participate. The advantages for all actors involved and the benefit to persons with care needs are confirmation of the positive potential of an innovative approach to governance.

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