Social Long-Term Care Insurance Act in Germany

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1. The political and legal background

The German Social Long-Term Care Insurance Act (*Pflegeversicherungsgesetz*) adopted in 1994 and entered into force on 1 January 1995 is widely in line with the tradition of social protection in Germany,(Note 1) which is based primarily on social insurance, while adding at the same time some new structural features to the established overall system of social protection. In accordance, to understand the new long-term care insurance scheme a basic knowledge of the institutional arrangements of the German welfare state and of its performance is necessary.

The concept of *social market economy* (*soziale Marktwirtschaft*) which underlies the German 'social state' (*Sozialstaat*), i.e. the specific German version of the welfare state, is distinguishable from other welfare states by the fact that the 'social aim of the state' (*soziales Staatsziel*) is laid down in the constitution, i.e. the Basic Law (*Grundgesetz*). Social market economy combines elements of a market economy with strong labour market regulations, worker co-determination, and a system of social protection which is based on the social insurance principle and geared to maintain the living standard of the insured persons in case of events that are traditionally recognized as social risks, i.e. sickness, maternity, invalidity, old age, accident at work and occupational disease, and unemployment. A minimum of subsistence is guaranteed by a comprehensive social assistance scheme, and measures to favour families are provided. The economic and social order built along these lines developed on a rather strong consensus between the main political parties as well as between the social partners, i.e. employers' associations and trade unions.

The dominant feature of the German welfare state as far as social protection is concerned can be characterized as follows: social protection of workers and employees against the risk of loss of income in the event of sickness, maternity, occupational accident and disease, invalidity, old age, and death of the breadwinner of a family is based on *social insurance* with contributions and benefits roughly proportional to wage income, but restricted by upper limits.

The *insurance principle*, which is characterized by contribution-funding, is meant to keep with the concept of a free, achievement-orientated society, because it guarantees a link between the contributions made and the benefits received in return. Funding by contributions does accord with the principle of subsidiarity, too, because the insured persons provide for social security on their own. Besides, everyone who pays contributions acquires a legally protected individual right to benefits which are based on his previous contributions. Unlike the principles behind social welfare and public assistance which are based on the concept of need and are mostly means- or at least income-tested, with the insurance principle there is a legal entitlement to benefits which is subject to no other conditions than that contributions have previously been paid. In addition, the contribution funds are earmarked and cannot, on principle and by law, be touched by the State. The danger of deficit spending which is inherent in the tax-funded systems of social protection is thus avoided (at least to some degree). As a result, the insurance principle meets with wide acceptance in the population and there is less reluctance to pay contributions than to pay taxes. In social insurance, the insurance principle is combined with the principle of solidarity which is inherent to the social aim of the State entrenched in the German constitution, i.e. the Basic Law.

The division of the overall system of *social insurance* into the five separate branches of sickness, care, invalidity and old age, occupational accident and disease, and unemployment underlies the organisation of the German system of social insurance. Such subdivision and specialization permit tasks and responsibilities to be clearly defined, ensure clear structures within the overall system, and guarantee that those who are responsible for the highest risks contribute most to the funding. Subdivision in this sense also means the co-existence of different providers of social security. In the case of invalidity, old age and survivors' pensions there is the so-called „three pillar principle" with statutory, occupational and private provision, whereby the statutory pension insurance scheme should provide the conventional old age income security.

In the *statutory sickness insurance* scheme there is a competitive structure within the statutory system itself, as there are several categories of sickness insurance funds, with the additional possibility of supplementary or (in the case of self-employed persons, civil servants, high-wage earners) alternative cover by the separate category of private health insurance. In the case of the *social long-term care insurance* scheme there is the social long-term care insurance, on the one hand, and the private long-term care insurance, on the other hand. The substitute function of private insurance is one of the features of German social long-term care insurance, which distinguishes it from its *Japanese counterpart.*

The principle of administrative autonomy of the social insurance institutions means that those who are directly involved in the system should organize and run the system themselves. The co-operation of employers and employees on the one hand, and of service providers at the other should be enlisted to bring the relevant social forces on board of the social insurance institutions. Administrative autonomy is believed to mean at the same time decentralization, deconcentration and deregulation, sensitivity both to the insured and to public opinion as well as efficiency and continuous quality improvement. The State should restrict its role to laying down the legal framework of the system, under which those directly involved are responsible for the details organization and management. This includes the establishment of self-governing bodies, which are subject only to legal supervision by the State.

In Germany, the social aim of the state which is immanent in the Constitution, i.e. the Basic Law (*Grundgesetz- GG*)(Note 2) has interacted with the labour and economic system as a constitutional sub-system in order to withdraw state social policy and social security as a whole from the exclusive competence of the state. State social policy and private social security complement each other to form a nexus of cooperative social security institutions. These can, on the one hand, be of state origin or take on para-state forms. On the other hand, we also find social security organized on a private-enterprise basis, i.e. private insurance and company social policy. In addition, there are the important efforts of the „third sector", i.e. the non-profit organizations „between the State and the Market" in the field of social benefits and services.

In accordance with the insurance principle, the corresponding social benefits and services are based in the main on cash benefits, with the notable exception of statutory sickness insurance and social long-term care insurance. There, the predominant principle is that of providing services in kind, and the body responsible for insurance uses the health and care markets in order to acquire services which it places at the disposal of the insured.

The German system of social protection is thus oriented strongly towards earners and especially employees, to the full-time job, the stable one-earner family, and standard life-cycles. German child care policy has always aimed at enabling mothers to refrain from work or to withdraw from the labour market in order to care for their children rather than at establishing services which would enable them to combine work with family duties. As a result, Germany has a much lower number of places in infant-care facilities, i.e. child cribs and kindergartens as well as a much lower proportion of all-day child-care facilities and schools than, for instance, France, where child-care policy is based on a different concept which tries to combine remunerative work and family life as being simultaneous rather than (in Germany) successive activities.

2. The actual demographic, social, economic and political challenges

The most important problems of the system of social protection caused by demographic, economic and societal trends are the following ones:

- -ageing of the population due to a decrease of in birth rates and a rise of life-expectancy;
- -an increase in female labour-force participation;
- -a shrinking of the average family size with a growing number of one-parent families;
- -a reduction of the capability as well as the readiness to mutual assistance within the family which up to now is the basic social protection system for need of nursing care;
- -an increase in the costs of health care as well as social care that will be higher than the general increase in wages.

„*Dependency*"/„*need of long-term social care"/ "nursing care*" has always been a social contingency, but provision for it has always taken different forms. The reasons why the problems of providing better or adequate social protection for dependency have recently been the subject of intensive discussion in Europe are well known: (a) on the *demographic* level: demographic changes due

to the ageing of populations and the increase in life expectancy which have resulted in greater numbers of elderly dependent persons;
(b) on the *sociological* level: a change has taken place in the way old age is perceived in so far, as the perceptions of old age are being more and more diversified, the idea of deficiency is giving way to the idea of competence, and generally a more positive concept of old age is gaining ground with the result that old age, ageing and the aged are being given broader consideration in social policy;
(c) on the level of *care infrastructure*: changes in family structures and lifestyles are taking place with the result that there are fewer opportunities in which care for dependent persons can be provided informally. (Note 3)

Demographic development in Europe (as well as in Asia with a certain time-lag) is characterized by an ageing of the population due to a prolonged life expectancy and a decline in birth rates. The role of women and family structures are increasingly changing, too. These changes are characterized by a decrease in the number of marriages, rising divorce and separation rates, an increase in extra-marital partnership and cohabitation, a shrinking of the average household size, a rise in the number of one-parent families, and especially in one-person households, as well as by a higher rate of women in the workforce and in economic activities, in general. Thus, the large family is being increasingly replaced by single-person households (which in metropolitan areas amount to more than 50 per cent of all households) and small family units (father, mother and one child) with the result that services which in the past used to be rendered by the family more and more often require external solutions, such as child-care facilities and nursing services for the aged and the disabled.

As the population ages and as more *women* take up paid employment, the issue of the effect of the above-mentioned developments on the social protection of those who are in need of care as well as for those who care (and in order to do so often interrupt their working careers) is becoming more important. In the past the responsibility for looking after persons in need of special care lay mostly with women for whom paid employment had only a secondary role. (In *Germany*, the term „Tochterpflege", i.e. daughter's care - and in *Japan* rather „daughter's-in-law care" - has been coined to characterize this situation.) The social security system was developed on the basis of this assumption, too. For their social protection needs, women were expected to rely on their husbands, i.e. the male breadwinners for financial support during both their working and retirement years.It is increasingly recognized that family carers need to be given a genuine chance of reconciling caring responsibilities with a working career by providing support services and other facilities in order to enable people with caring responsibilities to pursue a working career, if they so wish.

The *Long-Term-Care Insurance Act* (*Pflegeversicherungsgesetz*) came into force on 1 January 1995. Until then there was no general social protection scheme to cover the risk of the need for long-term care, but there were only benefits from the statutory accident insurance in case of accidents at work or occupational diseases, from compensation schemes for war victims etc., from public service laws for civil servants, from regional (*Land*) social service arrangements, and, above all, from means-tested social assistance. As everyone runs the risk of being in need of long-term care especially in old age and after a fulfilled working life, this lack of appropriate social protection against this vicissitude of life was increasingly felt unacceptable. In line with German social insurance tradition a social insurance for long-term care as a separate fifth branch of the social insurance system has been established with its own financial base and for administrative reasons "under the roof", i.e. within the institutional and administrative framework of the existing statutory health insurance scheme. The overall effect will be a shift of costs of long-term care from the individual in need of nursing care as well as from his family towards the social long-term care insurance funds which are financed by the compulsorily insured citizens and their employers.

3.The provision for the risk of dependency on long-term care in former social legislation and the case for reform

Since the beginning of the 1970s the need for long-term care has been recognized as a social problem and come under public discussion. All socially active groups and associations, science, the political parties, the *Länder* and regional authorities and the federal government entered into this discussion. The suggestions for reform differed in their contents and in respect to the structure of long-term care insurance all possible solutions were discussed. The following issues were of general importance:

- Will there be better protection for the whole population in the sense of a national insurance or will it mean protection in the sense of an insurance only for certain categories of persons, e. g. for employees or for persons covered by statutory health insurance?
- Life-long protection or protection only for certain stages in life, e. g. the age after sixty or seventy?
- Will the services provided be limited to basic care or will they include care and treatment, home care, aids for mobility and communication including services of medical rehabilitation?
- Will benefits be granted either as financial benefits or as benefits in kind, or will there be a combination of the two of them?
- Will the financial assistance be restricted to the cost for basic care or will the cost be fully assumed? Or will the person in need of long-term care contribute to certain parts of the costs, e. g. for board and logding?
- Will the pensions be taken account of?
- Will the domestic carepersons receive the new benefits, e. g. be covered by pension and accident insurance?

Eventually the following four basic models could be singled out which could provide social protection for persons in need of long-term care:

(i) improve services under the *Federal Social Assistance Act,* and maintain the means-test in principle:

(ii) finance the Long-term Care Act from *general taxation* (which would, however, neglect the subsidiarity principles in social assistance);

(iii) establish a private long-term care insurance, either on a voluntary basis or as a statutory compulsory private insurance;

(iv) find a solution within social insurance

- either by integrating long-term care into the existing social insurance branches, e. g. into pension insurance or statutory health insurance (the “Dutch model”) (as today in Germany, Japan, Luxemburg and Flanders (Belgium);
- or by establishing a new independent branch for social long-term care insurance either independent in structural terms or affiliated to an existing social insurance branch for instance the health care system.

The numerous suggestions finally resulted in a solution based on social insurance. In principle, employers and employees pay equal shares of contributions, with the contribution being income-related. Dependent family members also covered. Persons who were already in need of long-term care when the long-term care insurance came into force were immediately entitled to benefits. It was also suggested that long-term care insurance should be affiliated to the health insurance funds in structural terms (social long-term care insurance under the roof of statutory health insurance).

In view of the numerous initiatives a bill on the improvement of long-term care was introduced by the federal government on 9 October 1986. It was based on the following main issues:

- All persons in extreme need of care who are covered by statutory health insurance or are entitled to benefits under the Federal War Victims Relief Act will be provided with care at home and be supported by domestic helps. The services provided include 25 units per month at the duration of up to one hour which can be claimed flexibly.
- If a careperson is temporarily not available, the person in extreme need of care is entitled to a replacement for up to four weeks per calendar year.
- Benefits of medical rehabilitation also have to be granted in order to avoid or reduce the need for long-term care.

The core issues of the 1986 bill were left unchanged in principle and included in the Health Care Reform Act of 20 December 1988 (see Sections 53 et seq. Social Code-Book, as amended version).

The new benefits for persons in extreme need of care were a breakthrough. Until then the statutory health insurance benefits were restricted to medical treatment, with the provision of basic care being excluded. However, the new benefits were limited to ambulatory care at home with a limited quantity of services and benefits and restricted to the then estimated number of approximately 600,000 persons in extreme need of care in the old territory of Germany: With effect from 1 January 1989 in the health insurance scheme (Articles 53 - 57 Social Code - Book 5) insurance funds covered the costs for the four-week holiday of the domestic care-person and since 1 January 1991 the health insurance funds have paid care allowances to the amount of DM 400.000 per month for approximately 700,000 persons in extreme need of care in the whole of Germany or have covered the costs for 24 care units provided by social services to the equivalent of DM 750.00 per month.

The opening-up of health insurance for care services and benefits was not to be seen as the overall solu-

tion to the problem of care, but rather as the legislator's signal to the persons in need of care and their families that they are not left alone in the long run. In 1994 the long expected political breakthrough was achieved and statutory long-term care insurance was established. The development of social insurance which began over 100 years ago with the introduction of statutory health insurance - 1883 - was completed.

Accordingly, up to 1995 there existed no comprehensive social protection against the risk of need for long-term care. The above-mentioned schemes that provide for comprehensive benefits to persons in need of long-term care such as social compensation legislation and statutory accident insurance legislation cover a strictly limited and thus rather small group of persons. The statutory sickness insurance which covers more than 90 per cent of the German population provided up to April 1, 1995 only for limited benefits towards long-term care in severe cases where the person in need was living at home.

Therefore there was a case for reform in the German system of social protection as regards the need for long-term care. It was then estimated that there were about 1.650.000 *persons*, i.e. about 2 per cent of the total population of about 80 million *in need of long-term care* in Germany. In 1994 about 1.2 million persons in need of care were looked after at home, whereas about 450.000 were taken care of in institutions. The majority of persons in need of long-term care - more than 1.2 million - are over 60 years, about 650.000 between 60 and 80 years, and nearly 600.000 over 80 years old. The increasing importance of the need for long-term care was primarily determined by demographic developments. The problem was aggravated further by the trend towards small families and households, especially towards one-person households. It is further assumed that up to the year 2010, the number of people of 60 years and older will rise by another 2.8 million. That means that the number of people in need of long-term care will rise by about 1/4 million over the next 20 years, too.

A dual process of social change lead to a growing need for long-term care services. On the one hand, the numbers and proportions of people at advanced ages are constantly increasing. People above the age of 75 represented less than 3.5 per cent of the population of West Germany in 1960, but more than 7 per cent in 1990. By 2020 more than 10 per cent of the German population will be 75 or older, and almost 3 per cent of the population will even be 85 or older. This development is in so far important, as the risk of becoming dependent on care by third parties increases sharply with age. Today, the percentage of elderly people needing care in private households is about 3 per cent at ages 70 - 74, 6 per cent at 75 - 79, 11 per cent at 80 - 84, and more than 25 per cent at 85 or older. Considering that more than 15 per cent of elderly people beyond the age of 85 are living in institutions, the conclusion can be made that the risk of becoming dependent upon care beyond the age of 85 is almost 50 per cent.

On the other hand, the growing demand for care must be met and financed by a shrinking part of the population. In the past, most of the care for the elderly has been rendered by women within private households (so-called „daughter's care"). Decreasing birth numbers and growing female labour force participation make for a rapid reduction of this potential for family care. Whereas for every 1000 person above the age of 75 there were about 5000 potential care-givers in the „daughter-generation", i.e. ages 45 - 69 in 1960, this number amounted only to 2200 in 1990. The population forecasts project a further decline of the ability of families to provide care in the years to come. Therefore there is a growing need for the provision of services which may serve as functional equivalence to the fading resources of the traditional family system. Up to the mid-1990s, such alternatives had been only poorly developed in Germany, mainly because home-care by family members had always been given priority and had in some way even been institutionalized in the German welfare state. For the field of social services is governed by the constitutionally enshrined principle of subsidiarity, which underlies the whole German social welfare system and which states that both the state and larger collectivities such as regions, municipalities, but also social security and social assistance institutions should assume responsibility for the well-being of the individual only for tasks which the individual, his/her family and other smaller units cannot perform. Consequently, the role of the state was and has been rather limited in all fields which closely effect family life.

4.The German Social Long-Term Care Insurance Act

4.1 The outline of the law

The new social long-term care insurance scheme (*Pflegeversicherung*) came into force at three different stages: from January 1, 1995 on compulsorily insured

persons were liable to pay contributions, whereas benefits for domiciliary care were granted from April 1, 1995 on and benefits for residential care only from July 1, 1996. Besides, the law gives those who are entitled to benefits the right of substituting services in kind, i.e. professional services by cash benefits, i.e. it makes it possible for persons who are entitled to benefit to replace benefits in kind for the services of professional carers by cash benefits in cases when non-professional family members provide the care. Up to now, this possibility of substituting informal care for professional services has led to a preferential use of cash benefits (in spite of the fact that the amount payable as cash benefits has been deliberately set at a lower level as the alternative benefits in kind).

Though priority is given to *family care* it is necessary at the same time to provide for an adequate supply of long-term care residential facilities. (In accordance the Scandinavian policy of abolishing institutions is not considered to be a path to follow in Germany.) As regards the provision of long-term care services and institutions, once again the principle of subsidiarity plays an important role in so far as the provision of these services and institutions is left primordially in the hands of autonomous voluntary welfare organizations. These *non-profit-oriented organizations* are traditionally linked to religious and ideological leanings: the Catholic „Caritas“, the Protestant „Diakonisches Werk“, the Jewish „Wohlfahrtsstelle der Juden in Deutschland“, the „Arbeiterwohlfahrt“ which is rooted in the labour movement, the all-embracing, somewhat „grass root“-oriented „Paritätische Wohlfahrtsverband“ and the well-known „Rote Kreuz“ (Red Cross), which are losely associated in a common „umbrella“ organization on the federal level (*Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege*). A further very traditional element which played an important, even decisive role in the establishment of the social long-term care insurance scheme has been the above-mentioned long tradition of social insurance in Germany which goes back to the 1880s.

Though other solutions to the problem of dependency and need of long-term care were available and were debated, it was no surprise that in the end not the ‘market’ or the ‘transfer’ solution, but the ‘social insurance’ solution was adopted. The ‘*market solution*’ may be subdivided into different variants (as, by the way, the ‘transfer’ and the ‘social insurance’ solutions, too).

Liberals tried to limit the state’s role in social protection and advocated therefore a either voluntary long-term care insurance or a compulsory long-term care insurance which would require all adult citizens to insure privately against the risk of dependency and which would thus follow the model of the compulsory private insurance against liability for car accidents. The role of the state was to be limited to subsidize this insurance for those who were not able to contribute themselves, i.e. the economically inactive members of society, low-wage earners etc. One of the main arguments for such a market solution was the assumption that the risk of dependency upon nursing care was not a general risk such as sickness, invalidity and old age, but a risk which only concerns a small minority of the population and could and should therefore be left to private provision. This argument does not take account of the fact that the risk of the „old old“, i.e. the 70 + and of the „very old“, i.e. the 75 + is rather high: whereas less than 10 per cent of people above normal pensionable age - 75 - are dependent upon long-term care, this risk is much more widespread in the above-mentioned age groups. Thus, the risk of becoming dependent upon long-term care is much more widespread (and will still become more widespread in our ageing societies) than the proportion of elderly people - 60 + or 65 + - receiving care at any one time might suggest.

Besides, any ‘market solution’ would lead to a dual burden for the actually active population which would have to cover the cost of those in need of care today (which was up to the coming into force of the social long-term care insurance Act mostly borne by the social assistance scheme which is financed from general taxation) and accumulates at the same time funds for their own care in old age. This additional burden on the active population seemed to be highly inappropriate under the given situation on the labour market and in social security.

From 1 January 1995, the risk of long-term care has been safeguarded within the framework of the new statutory and compulsory social long-term care insurance scheme (*soziale Pflegeversicherung*). The scheme works basically as follows (Note 4).

Within the social long-term care insurance scheme (as distinct from the statutory health insurance scheme as such) the term “*care*” covers help in the performance of the acts of everyday life such as care of the body, feeding, mobility or household help (as distinct from medical treatment and care). “Care” thus means dependence care due, as a rule, to a physical illness, to a mental disease or to any other handicap concomitant with old age. Though the elderly will be the main beneficiaries of the new

scheme, persons in need of care of all age groups, including children are covered.

Persons entitled to claim benefits are those who require help in performing regular day-to-day activities. The need for long-term care is subdivided into three care categories or nursing levels, the degree and frequency of care required in the single case being the primordial criterion for the assignment of a person in need of care to one of these categories: (I) persons in considerable need of long-term care (*erheblich pflegebedürftige Personen*); (II) persons in severe need of long-term care (*schwerpflegebedürftige Personen*); (III) persons in extreme need of care (*schwerstpflegebedürftige Personen*).

A distinction has to be made first between benefits and services granted in relation to home care and institutional care, second between benefits in kind and financial benefits and third between benefits granted to persons in need of care and benefits to carepersons. Benefits in relation to home care are granted depending on the degree of the need of long-term care (categories I to III). A person in need of long-term care may use both benefits in kind and financial benefits simultaneously, this means for example, that a person in need of long-term care of category III can claim 60 visits by home-care services and draw at the same time one third of the care allowance.

All persons who live in Germany are legally obliged to enter the statutory long-term care insurance scheme as is the case with regard to statutory health insurance the rule being that everybody who is covered by the statutory health insurance scheme is also affiliated to the social insurance for long-term care. A vast majority of the German population - more than 90 per cent - have been covered by the new insurance scheme. Persons who are not subject to statutory health insurance may be released from this obligation provided they prove that they are covered by a *private long-term care insurance* offering benefits of a nature and extent which are essentially comparable to those of the statutory long-term care insurance scheme. Mid-1995 8.5 million individuals were affiliated to such a private long-term care insurance scheme (Table 1).

4.2 Basic principles

The provision of benefits is governed by *two main principles:* (1) *"prevention and rehabilitation come before nursing*" and (2) "*home-care comes before institutional/ residential care*". Besides, there is a strong intention to maintain and strengthen the traditional pattern of care within the family as far as possible. Therefore the social care insurance scheme only covers need of care of a certain relevant frequency and quantity, i.e. the need of long-term care of a specific degree. In addition it must be emphasized that the benefits of long-term care insurance do not aim at covering the total amount of the costs of care but are intended to provide only a supplement to the help provided by the family or to ease the financial burden of institutional care.

Table1

HOME CARE BENEFITS	CATEGORY I	CATEGORY II	CATEGORY III
Monthly long-term care allowance	205 euros	410 euros	665 euros
Maximum monthly total for non-cash long-term care benefits	384 euros	921 euros	1,432 euros
- Maximum for hardship cases	-	-	1.918 euros
Outside care for up to four weeks/year when carer takes holiday or cannot work : (requirement at least 12 months' prior care)			
a) Maximum payment for professional substitute	1,432 euros	1,432 euros	1,432 euros
b) Maximum payment for relative no employed for the purpose	205 euros	410 euros	665 euros
Maximum for documented expenses incurred by carer	1,432 euros	1,432 euros	1,432 euros
Maximum monthly benefits for day and night care in authorised part-time care institution	384 euros	921 euros	1,432 euros
Maximum monthly benefits up to four weeks/year in a long-term full-service care home	1,432 euros	1,432 euros	1,432 euros

In order to avoid, overcome or reduce the need for long-term care, increased *prevention* and *rehabilitation measures* are required. Only in this way the conditions for a self-determined and autonomous life style of people in need of care can be maintained or regained.

As regards the *range of benefits* granted it must be differentiated on the one hand between *institutional/residential care* and *home care* as well as between in the case of the latter *cash benefits* and *benefits in kind.* For the majority of people in need of long-term care, it is crucial that they are able to live in a chosen environment, e.g. in their family, for as long as possible. Therefore the new law is centered on the improvement of the conditions for *home-care*. Home care encompasses cash benefits and benefits in kind.

Benefits which are needed in excess of the abovementioned amounts have to be paid for by the persons in need of care themselves. Therefore complementary private care insurance may be taken in order to cover such additional benefits. Possibilities of the *tax deductions* for such voluntary provision have been introduced in fiscal legislation. Besides, benefits of the means-tested social assistance scheme can be claimed in case of financial hardship (*see above*).

In order to promote the willingness to provide long-term home-care within the family or the neighbourhood and to acknowledge the considerable efforts of the persons providing such care, the social protection of those persons has been improved, too. Periods of non-professional nursing activity are put on the same footing as insured periods of gainful employment for the purposes of *statutory invalidity and old age pension insurance*. A person who regularly provides for people in need of care on a voluntary (unpaid) basis for at least 14 hours per week, is now *compulsorily insured* in the statutory pension insurance. Statutory pension insurance contributions during the period of care are borne by the care insurance scheme of the cared person. This provides an incentive for voluntary care work, and as care for frail people is overwhelmingly provided by women, it may also strengthen the position of women in the old age pension system. The grading of such periods is guaranteed by the severity of the need of long-term care of the patient and the resulting degree of necessary care provided.

As the benefits provided by the care insurance scheme are legally deemed to be benefits in kind, they are not provided abroad, but may only be taken up in Germany. There is no “export” of care insurance benefits.

The *German* scheme of social long-term care insurance is not a comprehensive social insurance system, because benefits and services for highly dependent persons are insufficient with respect to those who have the highest care needs, the scheme not aiming to pay the totality of long-term care costs, but only up to a given ceiling. Therefore social assistance still plays a considerable role in ensuring long-term care for these persons whereas persons who are affiliated to a private health insurance scheme are obliged to affiliate themselves to a private care insurance scheme as well. Besides, those persons in need of care who do not reach the level of considerable dependency are not entitled to social care insurance benefits at all and have to be cared for by the family, other forms of private provision, or by the social assistance scheme which serves in so far as persons do not fulfill the requirements for other social benefits and services and cannot care for themselves.

4.3 Funding

Statutory long-term care insurance is financed through contributions which are scaled according to income. The contribution assessment ceiling that applies to health insurance also applies to long-term care insurance: euros 3,375 per month (2002).

In the case of employees, the insured and the employer each bear half of the contribution. Where the insured person is claiming social security benefits, e.g. unemployment benefits or social assistance, the respective provider of these benefits is liable to pay the contributions. Contributions are paid following the same method used for statutory health insurance payments: The employer deducts the contributions directly from the employee’s wages and transfers them to the employee’s health insurance fund.

Spouses who have no income from work of their own and *dependent children* are covered without additional contributions as is the case in statutory health insurance. In the case of *pensioners*, half of the contribution is paid by the pensioner and half by the pensions’ insurance funds. The Federal Office of Employment, i.e. the unemployment insurance scheme pays the contributions of *unemployed persons*.

The contribution rate is 1.7 per cent of contribution income up to the amount of a contribution income ceiling in the health insurance scheme, divided equally between employers and employees. A public holiday -

Buß- und Bettag, which always falls on a Wednesday, i.e. on a working day, was, however, cancelled (except in the state of Saxony where employees pay 1.35 per cent and employers 0.35 per cent) in order to compensate for the additional employers' contribution.

4.4 The provision of services

In order to safeguard the provision of long-term care, the insurance funds have entered into contracts with the carriers of domestic and institutional long-term care facilities and other organizations providing services and benefits. Through so-called supply contracts, these long-term care facilities have been integrated into public benefit systems with legally defined rights and obligations. The carriers of services and institutions are obliged to provide nursing care for the insured and, in return, are eligible to remuneration from the long-term care insurance funds.

Up to the present day, about two thirds of nursing homes are non-profit, i.e. public or voluntary ones. (There are, however, no reliable comparative data and studies for the evaluation of nursing homes belonging to the private, the voluntary or the public sector.) One basic idea of preferring non-profit-organizations with respect to institutional care was that they were believed to provide a higher level of care than private, i.e. commercial nursing homes. At the same time it is assumed that the objective of commercial providers, namely to maximize their profits, entails the risk of their clients being exploited for financial reasons, because the individual consumers who are mostly elderly people have difficulties in judging the quality of the care facility they are living in. On the other hand, it must be borne in mind that public or voluntary, i.e. non-profit providers of services do not just give better service because they do not have to make a profit. When profit-seeking is forbidden, there may be a lack of incentive for high quality performance and poor staffing, the formal as well as informal reduction of working-time as well as deficits in intensive personal care (which especially with respect to mental patients are often substituted by medication) being widely held to be current shortcomings in public and voluntary in-door facilities.

Under the new law on care insurance, there is *no longer an exclusive preference for the non-profit sector*. In-patient long-term care which is covered by care insurance is only possible in nursing homes which have a contract with a care insurer. While deciding with which nursing home they should make such a contract, the insurers may give preference to the institution which guarantees the best quality at the best price. Therefore there is a case for the introduction as well as for the continuous control of quality standards. In the past, the quality controls on homes which by the so-called supervision of homes (*Heimaufsicht*) oversaw the economic performance of homes, specific standards concerning the buildings, as well as (but only at a lesser degree) the attention, care and supervision which were provided in the respective institution. It is obvious that this type of quality-control was not as effective as it should have been given the fact that the supervision of homes was part of the local administration which runs homes of its own and which is responsible for granting social assistance benefits to people in need of care who cannot foot the bill of living in a nursing home on their own. Accordingly, there is a case for the introduction of controls by supervisory bodies which are independent from both *supply* (i.e. the public, voluntary and private providers of nursing homes) as well as from *demand* (i.e. the care insurers and social assistance administrations). For this reason it has been suggested to convert the existing departments of home supervision into supervisory boards which should consist partly of representatives of the insurers and partly of independent experts(Note 5).

5. The private provision for dependency

In so far as the social long-term care insurance scheme does not provide benefits which exceed specified amounts (*see above*) there may remain a gap in cases of exceptional need of care which can be filled up by complementary private dependency insurance. That means that on the one hand there is a case for a private alternative for the benefits provided in the social long-term insurance scheme for persons who are privately insured with respect to sickness as well as a case for complementary private insurance which aims at topping up the benefits provided under the public scheme. As social protection schemes experience increasing budgetary constraints, an extension of the benefits of the social long-term care insurance scheme cannot be expected. Therefore further demands will rather have to be met by alternative ways of funding which do not increase the economic pressure on the social protection system. Private complementary social insurances can in this respect provide an alternative to close the gaps in the coverage of the risk of dependency/long-term care provided for by the public scheme.

As regards the alternative private long-term care insurance which covers those persons who are privately insured against the risk of sickness and maternity, they are characterized by compulsory affiliation and are therefore based on the principle of solidarity. This means that the private schemes are by law prevented from selecting among those who want to affiliate to this scheme, but are legally held to insure all persons who have been insured privately against sickness and maternity. This framing of the private long-term care insurance scheme which constitutes an alternative to the public scheme prevents the insurance company from denying affiliation to the scheme because of age, sex, health condition at the moment of the conclusion of the insurance contract, and medical record in the past of the insured.

As the public scheme does only grant a basic coverage for the insured persons, there is a second market for private insurance in so far as additional benefits are required. In this respect, the 'market solution' which was discussed at the beginning (*see above 4.1*) and which was advocated by liberals trying to limit the State's role in social protection has a role to play, too, and will get still more importance in the future. Rather than being calculated on the basis of your income, premiums for compulsory private long-term care insurance are graded according to your age when you sign the policy. By law premiums cannot exceed the maximum contribution for statutory long-term care insurance. If you took out private health insurance after 1 January 1995, this ceiling will apply after a five-year period during which you have been covered by private health or long-term care insurance. Public servants whose medical costs are reimbursed in part by the government if they ever need long-term care do not have to pay more than half the maximum amount.

Refusals for reasons of higher abnormal risk are not allowed. Men and women pay the same amount of contributions. Children are also covered without paying extra contributions. Premium loading may not be charged for persons who have already had private health insurance when long-term care insurance came into effect on 1 January 1995. The maximum contribution amount to compulsory private long-term care insurance must not be higher than the contribution amount in social long-term care; spouses without income or with marginal income pay half the contribution and are also covered, thus couples with one spouse earning marginal income will only pay 150% of the maximum contribution amount to compulsory long-term care insurance.

Persons who became member of the private compulsory long-term care insurance after 1 January 1995 are only entitled to limited contributions after a qualifying period of 5 years. During this period premium loadings may be charged. There is no reduction in contributions for spouses. Employees and pensioners receive subsidies from the employer or the pension insurance fund in line with the same principles as those persons covered by social long-term insurance. The benefits of compulsory private long-term care insurance are the same as for social long-term care insurance.

6. Perspectives

In order to finance the care institutions in the new *Länder*, 800 million DM of the federal and the *Länder* budgets will be earmarked annually for this purpose over the next eight years, with 640 million DM coming from the federal budget and 160 million from the *Länder* budgets. Thus, the total sum of 6.4 billion DM was made available for financing care institutions during the period from 1995 until 2002.

For economic reasons compensation was thought to be necessary in order to make up for the *burden placed on the economy by the employers' contributions to long-term care insurance*. During the first stage of long-term care insurance this financial burden placed on the economy amounted to 7.35 billion DM with a contribution rate of 1%. On 1 July 1996 the burden increased to 13,3 billion with a contribution rate of 1.7%. For reasons of compensation the *Länder* (except the state of Saxony, as already mentioned), by way of a decision taken by the respective *Länder* parliaments, abolished one public holiday which always fell on a workday in connection with the introduction of the first stage of long-term care insurance.

The Long-term Care Insurance Act also provides for the following compensations of the employers:

- Nursing care is no longer covered by statutory health insurance.
- The number of hospital beds which are occupied by persons in need of long-term care will be decreased.
- The expenses in relation to the continued payment of wages and salaries in the event of sickness will be cut down by stricter controls of persons claiming to be unfit for work.

These measures and the abolition of one public holiday compensate the employers' contributions to a

wide extent for the first and second stages of long-term care insurance. The authorities responsible for granting social assistance will also be relieved financially to the amount of 7 billion DM annually which corresponds to their expenses for nursing care so far.

Since the mid-1970s all European countries have generally moved to a *policy* where *institutional care* is increasingly substituted by *community care*. The idea behind this reversal of policy is both to unburden public budgets, to develop the potential for self-help and to let older people remain as long as possible in their ‘natural’ environment with its established social network. It must be noted, however, that the care potential within the family system is seriously shrinking, as declining birth-rates and the increasing labour force participation of women have considerably reduced the number of persons available for help in private households.

As regards personnel and infrastructure, it can be said that in the majority of European countries (though to a lesser degree in Scandinavia), there are problems regarding carers’ qualifications and an adequate infrastructure of care establishments and services to satisfy the demands of dependency. Obviously, in order to improve social protection of dependent persons, it is not sufficient to introduce adequate social benefits, especially cash benefits, but there must also be appropriate structures for administering and rendering benefits and services. For a long time, dependent persons were primarily cared for either at home or in institutional settings. As already mentioned above, it has only been in the last few decades that a whole range of social care establishments and services have been set up which provide out-patient care services and accommodation in day-care facilities. Even in those countries which have a well-developed system of social protection (e.g. Germany), the services in support of home care are often inadequate.

Social care for these people should be based on the principle of the multidimensional nature of the ageing process in both the healthy and the sick elderly persons. Care must therefore be multidimensional, too, as a wide variety of professional categories are to be involved in the various services needed. This does not only refer to professionals such as general practitioners, neurologists, psychiatrists, psychologists/psychotherapists, internists, nurses, old people’s nurses, social workers, physiotherapists, etc., but also to relatives and voluntary workers which may require special training in dealing with mentally impaired old people. For ability to deal with this group of people forms part of the care concept, which also includes preventive measures, provision of specialised treatment, and rehabilitation techniques. Self-help groups may be effective depending on the type and severity of the mental disorder.

Community services in their various forms can, if they are available and applied at the right time, help an elderly person to remain his/her personal, family, and social surrounding, if treatment and help needed are granted. All services must work in close contact with other institutions such as health and social services, the authorities, the courts and medical doctors to create a network of care while at the same time avoiding the danger of restricting the personal liberty of the elderly. Community and day care services are of a preventive nature as well as in so far as they help to prevent withdrawal, isolation, resignation and mental handicap.

”The greying of Europe” is a metaphor which is used to illustrate the fact both that people are living ever longer and also (except - for the time being - in Ireland) that birth rates are falling, that an ever declining number of working people (i.e. contributors to national insurance schemes) are having to support an ever increasing number of older people (i.e. pension beneficiaries), and that ”old” people - who are becoming older and older as a result of medical progress - are in need of ever more frequent treatment, care and general looking after for ever increasing periods of time (whereby the increasing individualisation of society, which is expressed among other things in the growing number of one-person households and a contraction in the size of multi-person households, is intensifying this development further). Against this demographic and social background and in view of an economic development characterised by high unemployment, an increase in impermanent and precarious jobs and the social insecurity and uncertainty resulting from this and other causes, *making provision for one’s old age* in a general sense presents four main challenges, of which two are financial; and two are largely non-financial:

- organising the regular system of provision for old age which aims at maintaining a standard of living enjoyed up until retirement in such a way that it is able to cope with the demographic and economic changes that have already occurred and those which are imminent in the future;
- guaranteeing a minimum old age provision for everyone, which fulfils the responsibility of the welfare state for ensuring a social subsistence minimum for

everyone;
- providing for the individual should he / she require care and looking after; and also
- generally establishing the necessary conditions to provide a life fit for old people against the background of the developments detailed above.(Note 6)

Hitherto, the socio-political discussion on old age, ageing and "the old" has focused on these above-mentioned issues of financial security for old age (i.e. income provision) as well as on the provision of health care for old people, the provision of a welfare safety net in cases where people become dependent on care, and most recently also on questions of so-called assistance for the aged. Consequently, the systems for ensuring (financial) provision in old age and health provision in the neighbouring European countries, and in particular those in the other 14 member states of the European Union, have already been the subject not only of detailed comparisons of the social benefit systems as a whole but also of individual in-depth studies concerning specific problems(Note 7).

A comprehensive research project on questions of social security in cases where care is required is nearing completion(Note 8). Also in respect of assistance for the aged, an initial exploratory part-study, which takes stock of the situation in individual selected countries, is already available(Note 9). Nevertheless, particularly this area of legal, institutional and infrastructural prerequisites for a life fit for old people is still one of the largely unexplored fields not only of comparative research into social policy but also in the comparative study of social law in Europe, as there is not only a lack of comparative analyses which shed light upon the overall systems in which "*assistance for the aged*" (Altenhilfe) in the wider sense is embedded, but also of studies on the duties, objectives, individual measures and legal basis of assistance for the aged within the context of the relevant overall systems of social security.

Notes

(Note 1) For a more general overview on the situation in Europe see *Schulte, B.,* Old-Age and Dependency, in: van Langendonck, J. (ed.), The New Social Risks / Les nouveaux Risques Sociaux, EISS (= European Institute of Social Security) / Yearbook 1996/Annuaire ESS (= Institut Européen de Sécurité Sociale) 1996, London / The Hague: Kluwer Law International, 1997, pp. 149 - 195.

(Note 2) See Articles 20 and 28 Grundgesetz (GG) (= Basic Law).

(Note 3) See for this view Council of Europe, 6th Conference of European Ministers responsible for social security, Lisbon, 29 - 31 May 1995, 'The situation of dependence in relation to protection afforded by social security', Strasbourg 1995, and *idem*, The special needs of dependent persons, costs and financing. Summary, proposals and questions for discussion, Strasbourg 1995. -
For a Thorough International Comparison of Securing Long-Term Care Systems see Eisen, R. (project leader), Pflegeversicherung in der EG (Securing Long-Term Care in the European Community). Research Project (PflEG-Projekt), Frankfurt/Main: Johann-Wolfgang-Goethe-Universität, 1998 (*forthcoming);* for an outline see *Eisen, R.*, An International Comparison of Securing Long-Term Care Systems, in: Ritter, G. (ed.), Problems of Structural Change in the 21st Century. National and Comparative Research from Argentina, Brazil and Germany (Paper and Proceedings of the first Arnoldshain Seminar, October 18 - 20, 1995), Vervuert: Iberoamericana, 1996, pp. 348 - 368.

(Note 4) See Gesetz zur sozialen Absicherung des Risikos der Pflegebedürftigkeit (Pflege-Versicherungsgesetz - PflegeVG), Bundesgesetzblatt (BGBl.) 1994 I p. 1014; for the debate in German Parliament see Deutscher Bundestag (ed.), Einführung einer gesetzlichen Pflegeversicherung - Öffentliche Anhörung des Ausschusses für Arbeit und Sozialordnung des Deutschen Bundestags am 21. 22. Mai und 3. Juni 1992, Bonn 1992 (recorded proceedings) - most recently - Erstes Gesetz zur Änderung des Elften Buches Sozialgesetzbuch und anderer Gesetze (Erstes SGB XI-Änderungsgesetz - 1. SGB XI-ÄndG), BGBl. 1996 I p. 830 (zur Begründung vgl. Fraktionen der CDU/CSU und F.D.P. "Entwurf eines Ersten Gesetzes zur Änderung des Elften Buches Sozialgesetzbuch und anderer Gesetze (Erstes SGB XI-Änderungsgesetz - 1. SGB XI-ÄndG"), in: Bundestags-Drucksache 13/3696 v. 6.2.1996), and Gesetzentwurf der Bundesregierung „Entwurf eines Gesetzes zum Inkraftsetzen der 2. Stufe der Pflegeversicherung", in: Bundestags-Drucksache 13/3811 v. 16.2.1996).

(Note 5) See for this proposal Spieß, C./Wagner, G., Inpatient Long-term Care in Germany - Selected Problems of Insurance and Services (Diskussionspapier aus

der Fakultät für Sozialwissenschaft der Ruhr-Universität Bochum), Bochum: Ruhr-Universität, 1994.

(Note 6) For a survey of these challenges for the policy on provision for old age, see also *Schulte B*., Perspectives on provision for old age in the European Union - Twenty theses (Perspektiven der Alterssicherung in der Europäischen Union - Zwanzig Thesen.) Zeitschrift für ausländisches und internationales Arbeits- und Sozialrecht (ZIAS), 8 (1994), P 240 ff., with further references.

(Note 7) See also the numerous pertinent publications by the European Commission on the systems of social security in the member states and individual aspects of them: most recently *European Commission*, Social Security in Europe 1995, Luxembourg 1996, as well as in particular in the near future *Hauser R / Döring D* (project leader). Provision for old age in the European Community, (Alterssicherung in der Europäischen Gemeinschaft (ASEG)), Frankfurt/Main: University of Frankfurt, 1993 ff. (also *Hauser R*, Situation and trends of convergence of social security in the European Union: The example of provision for old age. (Stand und Entwicklungstendenzen der Annäherung der sozialen Sicherung in der Europäischen Union : Das Beispiel Alterssicherung.), in *Schmähl W / Rische H* (publisher), Internationalisation of Economics and Politics and the Scope for National Social Policy (Internationalisierung von Wirtschaft und Politik und Handlungsspielräume einer nationalen Sozialpolitik), Baden-Baden, 1996 (in print)).

(Note 8) See also Eisen R (project leader), Social security in cases where care is needed in the European Community. (Soziale Absicherung bei Pflegebedürftigkeit in der Europäischen Gemeinschaft (PfIEG)), Frankfurt/Main: University of Frankfurt, 1994 ff.

(Note 9) See also Maydell, B. von / Schulte, B. (project leader), Assistance for the old in Europe. Legal, institutional and infrastructural conditions (Altenhilfe in Europa. Rechtliche, institutionelle und infrastrukturelle Bedingungen) - Country reports for Denmark, Germany, France, Netherlands, Spain, United Kingdom and general comparative report, Stuttgart 1996.

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