

# 10 Years of Social Long-term Care Insurance in Germany

## What We Wanted, what We Got, what We Expect

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### 1. What Did We Want?

More than 20 years before the difficult birth of LTC insurance in 1994, the situation of long-term care was under dispute from three different strands: First, the “Social policy group” voiced a profound change in elderly care, in particular more professionalization, more quality, more places etc. Second, since most of LTC was paid either by the person or family itself or by Social Assistance, the “public finance group” wanted to free the communal and *Länder* budgets. These showed increasing numbers of recipients of “help for care”, either at home or institutions, and an increase in expenditures from around 1 billion DM in 1970 up to around 14.5 billion DM in 1994 (for the OBL, or around 18 billion DM for Germany). These two groups somehow “acted together” and therefore, the best idea was to give birth to a “fifth social insurance”. The third group, the “economists”, pointed to the fact that an insurance (built after the model of health insurance) will result in ever increasing expenditures. That is why this new (social) LTC insurance (LTCI) shows marked differences to traditional branches of Social Insurance. For short, the main differences are<sup>1</sup>: (1) the burden for the employers was compensated by annulation of one red-letter-day; (2) LTC insurance is a differentiated fixed indemnity system according to three grades of care (low, middle, high) and in-cash, (400, 800, and 1,300 DM) vs. in-kind (up to 750, 1,800 and 2,800 DM) benefits as well as home and institutional care. (3) There is a differentiation between “pure care costs” and “expenditures for

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1 For more details cf. EISEN/MAGER (1999).

accommodation” (so-called “hotel expenses”) as well as for “investment”; only the first kind of expenditures are covered by LTC insurance!

## 2. What We Got!

To evaluate qualitatively what we got, one has to look at the goals pursued with the enactment of LTC insurance. For short, these goals are related to *allocation* (rise efficiency and quality of service provision), to *distribution* (institutional distribution: reduce the burden for Social Assistance; personal distribution: end the dependency on Social Assistance because of LTC; family-oriented distribution: secure a sustainable financing of benefits) and to *stabilization* (restrict the burden of contributions – *Beitragssatzstabilität*, and restrict excessive use of benefits). Hence, we should discuss three problems: (1) Inhowfar dependency on Social Assistance could be reduced? (2) Inhowfar efficiency and quality of services could be improved? (3) How far contributions’ stabilization resulted because of increasing co-payments?

### 2.1 LTC and Social Assistance (SA)

A first glance at the figures shows a change in expenditures of SA clearly: Since 1995, when the law “started to pay”, expenditures of SA for “help for care” decreased from 9.1 billion € to 2.9 billion € in 2002 (HAUSTEIN/KRIEGER, 2004, p. 205). The gross expenditures of Social LTCI increased in this period from 5.3 billion € to 17.3 billion €. Looking at the number of SA receivers, a similar picture results: a decrease in SA from 454,000 in 1994 to 246,000 in 2002, an increase in LTCI from 1,061,000 in 1995 up to 1,889,000 in 2002.

Given the institutional structure of LTCI, the real value of the indemnity decreased. This means that despite LTCI there still is a large burden on SA, the official statistics show a limited picture. However, it is obscure how far the importance of SA for financing LTCI is decreasing (cf. ROTHGANG/SCHMÄHL, 1997, p. 425). Despite the fall in expenditures, the decrease in *numbers* is different: While the number of SA recipients fell by 40%, the number of recipients of ambulant care in SA fell by 70%, while in stationary care the number fell by only 30%. According to figures of SCHNEEKLOTH (1997), there is still a high proportion of 39% of stationary care receivers in SA. And this figure could have increased because benefits are fixed and pensions may have increased by less than care prices.

### *2.2 Increasing the Quality of LTC in the Family*

The Social LTCI law intended to ameliorate care delivery and to strengthen the role of family care to retard the transfer to (much more expensive but also humiliating) nursing homes. Here too the expenditures show a clear picture: While SA in 1994 paid only 879 million € for home care, LTCI increased expenditures for ambulatory care up to 8.2 billion € in 2002. This widening in family care was accompanied by a remarkable increase in (private) service providers with now 12,000 entities with 190,000 employees. By various laws, quality and services' characteristics were defined and integrated into the care delivering business. This supports the supposition that quality of (professionally) delivered care services have been improved considerably. Nevertheless, the following point is relevant: The definition of LTC is based on a narrow technical notion of care: basic and instrumental activities of daily living. This means that – despite a LTC family benefit supplementary law – the situation of mentally ill persons (even) with aggravated needs of care is still unimproved. This is seen also by the government: on the basis “of the existing financial framework”, “the problems of mentally ill persons could not be solved profoundly” (cf. <http://www.bmgs.bund.de/deu/gra/themen/pflege/2336=2239.cfm>).

### *2.3 Stabilization of the Contribution Rate*

The “partial indemnity character of (social) LTC insurance” has resulted in moderate increases in expenditures despite an increase in the number of beneficiaries since 1995 from 1 million to 1.9 million. Furthermore, the contribution rate could be kept constant (1.7%). This in turn means that all quality improvements and price increases – in ambulatory and in stationary care – were put on the shoulders of the persons in need of care (or to their families or even to SA). Nevertheless, since 1998 the expenditures of LTCI exceed the receipts, implying that the early accumulated surplus disappears.

### 3. What We Must Expect

In the following five “cost drivers” in LTCI will be identified pointing to whether in the near or more distant future “a sustainable financing of benefits” is possible. Since increasing contribution rates – together with increased rates for pension and health care insurance – seem “socially unsustainable”, the existing LTCI may be put into question. Therefore, a great quest for reform must be started on two levels.

#### *3.1 Cost Drivers in (Social) LTC Insurance*

“Behind the curtain”, different actors are waiting to drive up expenditures of LTCI. Firstly, there is its character as a “partial indemnity insurance” with extreme and increasing co-payments the higher the grade of need. This is unusual in social insurance. Second, there is no indexation of benefits in reaction to price increases (“inflation”). And there are price increases despite the ban. Third, changes in the take-up rates between in-cash and in-kind benefits and between ambulatory and stationary care will lead to increases in expenditures (cf. SCHMÄHL/ROTHGANG, 1996). Forth, there is the demographic development which affects expenditures and receipts: Since the risk of care is highly correlated with age, and the proportion of elderly (above 65) will increase, the number of persons in need of care is expected to continuously increase (if the prevalence in age and gender remain the same)! Additionally, for social LTCI, the number of contributors will decrease because of the reduction in the birth rates. Furthermore, pensioners (even when and while they must pay contributions) earn on average lower incomes! A fifth driving force are quality aspects and medico-technical progress. Starting with the “rectangular hypothesis” (cf. BREYER/ZWEIFEL/KIFMANN, 2005, p. 519) more and more persons will arrive at a high age by spending more and more resources. There is hope this process is combined with more years in good health (disability free life expectancy). However, empirically based evidence points in the other direction. Also, halfway technologies are able “to prolong or extend the life span between diagnosis and death and to improve quality of life, but the healing of chronically ill is not possible” (OBERENDER/FLECKENSTEIN, 2004, p. 8). Therefore, taking into account that services’ prices may increase by more than prices for goods, changes in technologies of caring may be introduced.

There are scenarios for the time up to 2050 with over 5 million people in need for care. Expenditures, starting with 16.6 billion € in 2002, will grow up to 30 billion € in 2050 (cf. DIETZ, 2002). RAFFELHÜSCHEN (2003, pp. 74/5) calculated a “gap of sustainability” (i.e. a difference between present value of contributions

and present value of expected demand for services) which would result in a contribution rate of 4% in 2040!

### *3.2 Parametric Reforms*

The quest for reform can start with parametric reforms within the existing system, i.e. by turning some of the crucial parameters. Together with some improvements of services through a new definition of LTC taking into account the mentally ill, also a moderate dynamizing of benefits are within the scope of this type. Since the necessary increases in expenditures cannot be financed by increases in contributions by employers/employees alone, several other sources must be taken into account: (1) an increase in contributions of pensioners; (2) an increasing subsidy out of the federal budget; (3) or a shift toward the “citizens’ insurance” or “citizens’ premium” (cf. RÜRUP COMMISSION, 2003).

Besides these “monetary measures”, also changes should be considered to establish incentives for using the means more effectively. New “delivery models” are possible: managed care models, case- and/or disease-management models; fostering prevention; introducing Personal Assistance budgets along with case managers<sup>2</sup> to control costs; and integrating more the so-called young elderly as caring persons. This can be done with the help of a voucher system organized with or around “primary social networks”.

### *3.3 Structural Reforms*

These reform proposals embrace changes of the basic design, i.e. away from public provision toward public control of private provision, at least in steps. Besides the abolition of (social) LTCI from the canon of social insurances, there is the idea of “freeze-in model” where benefits remain fixed on the now ruling levels, but the increasing “insurance gap” can be closed by private (supplementary) insurance or by own resources (or in case of need by SA).

In principle, these “privatizations” represent (partial) shifts from PAYG to capital funding. Advocates in favour of these shifts point to several advantages: Firstly, a mixture of both systems may lead to improved risk diversification. However, the different pillars are characterized by quite different “cultures”, so a mixing can lead to unforeseen complex consequences.

2 Cf. besides Arntz/Spermann (2004) also Kemper/Pezzin (1996).

It seems inevitable that the demographic developments ask for higher savings. Supporters of privatization believe, secondly, that these additional savings were generated “cheaper” in private systems, “cheaper” because a) PAYG reduces savings (à la Feldstein) and b) capital markets have a higher rate of return.

However, these arguments do not hold against scrutinizing, taking into account that (1) the “old debt” must be paid back via taxes; (2) the probable higher rate of return is combined with higher risk; and (3) also capital funding is not immune from demographic changes. All in all, the “advantages” of funded systems reveal themselves as “myths” (cf. ORSZAG/STIGLITZ, 2001, and EISEN, 2004).

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