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# Financing old-age care – with a special reference to Germany

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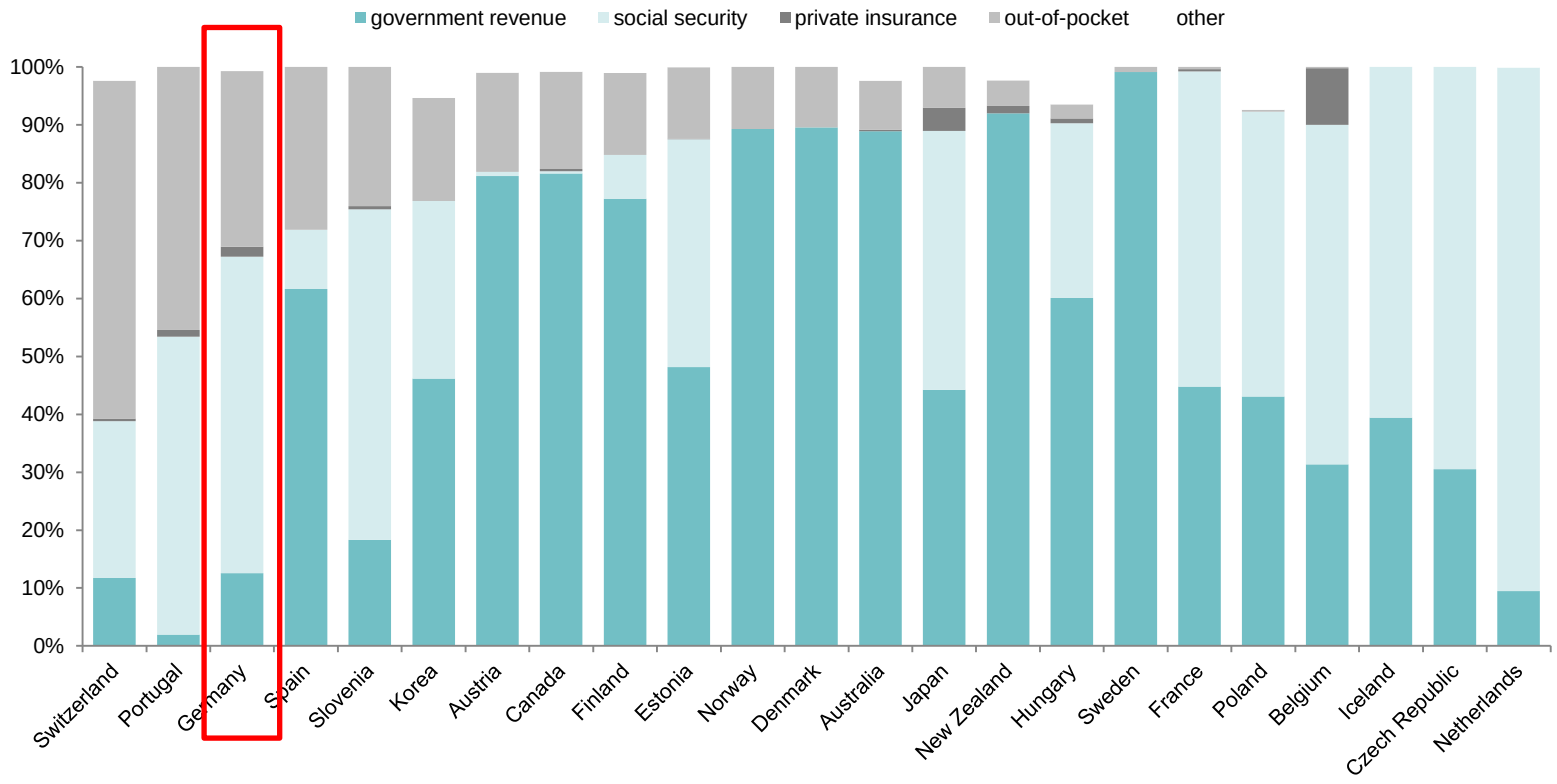
# General principles of old-age care in Germany

- Traditionally, care used to be a family responsibility, with growing involvement of social assistance
- Since 1995, old-age care insurance is mandatory in Germany – modeled along the lines of the Bismarckian model of social insurance

# The German care insurance

- Universal coverage with a single program: LTC insurance → predictable sources of revenue streams
- Either public or private insurance (according to membership in health care insurance), about 88% in public, 12% in private scheme
- Public insurance is based on contributions by employers and employees (2.35% in 2015, 2017: 2,55% (planned))
- Pensioners and unemployed are also covered
- Voluntary private insurance contracts to top up statutory benefits
- Benefit values are fixed in Germany, not consistently adjusted for inflation
- Quality assurance in LTC: Self-regulation, standards and inspections (Medical advisory boards)
- Provision contracts: providers have to meet accreditation criteria (qualified personnel, adequate wages, quality management system, expert standards)

# Long-term care expenditures by sources of funding, 2007

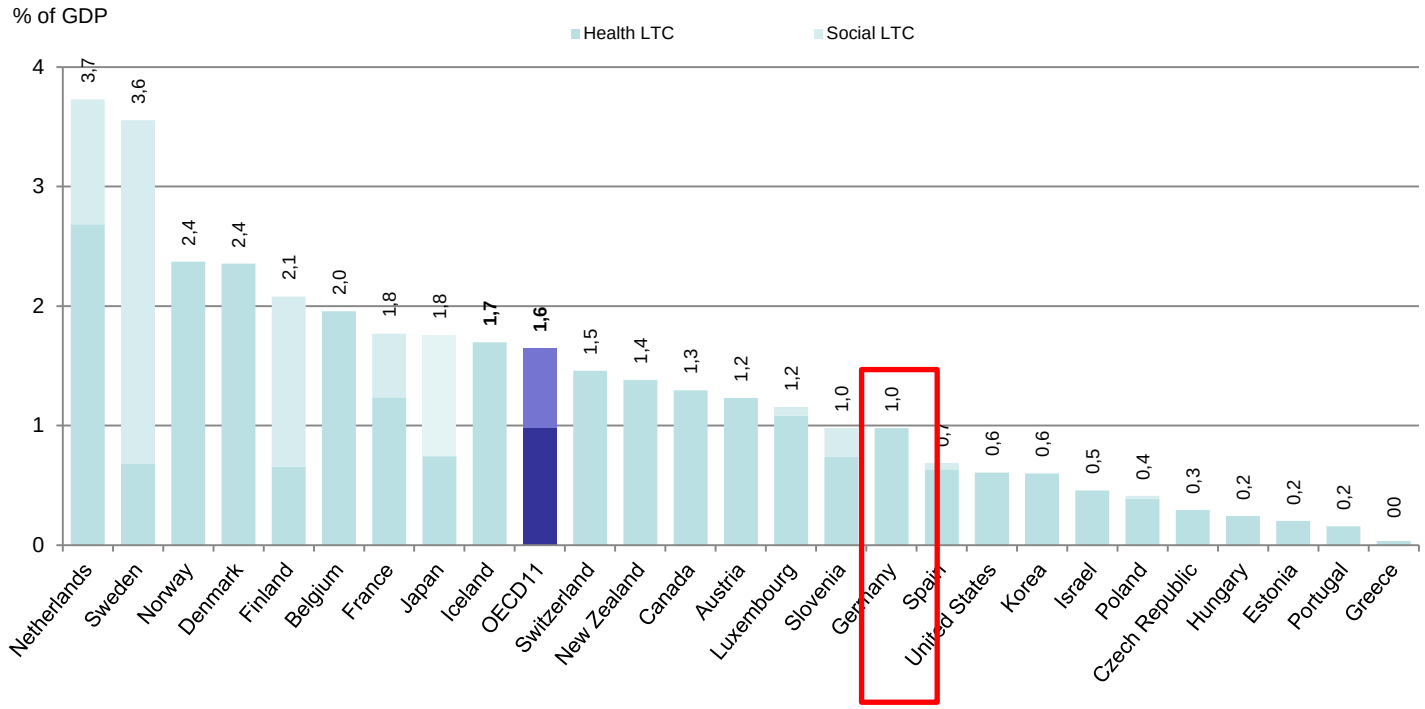



Source: OECD Health System Accounts, 2010.

# Alternative Care Financing Arrangements

- Tax based models (Nordic countries): tax-funded long-term care services for the entire population, large autonomy of local governments, non-earmarked subsidies.
  - LTC expenditures: 2%-3.6% of GDP
- Personal care through the health system:
  - Care services primarily performed by professional nurses
- Income-related universal benefits
  - Progressively increasing the share of costs paid for by the public system as the income of recipient decreases
  - Not intended to cover the full costs of personal care.

# Long-term care public expenditure (health and social components), as share of GDP, 2011 (or nearest)




Source: OECD Health Statistics 2013,
http://dx.doi.org/10.1787/health-data-en.

# Expenditure and funding in an international comparison

- Germany spends relatively little on care (1.6% of GDP, France: 1.3%, Denmark: 2.5%, Sweden: 3.6%, Netherlands: 4.3%, OECD data for 2013)
- Care insurance covers only about 55% of total expenditure, government about 12%; about 1/3 is paid by private insurance and households – one of the highest shares of private funding in the OECD, 10% or less in most other European countries

# Benefits of the German care insurance

- Cash benefits to pay relatives or care services
- Benefits in kind: care services or nursing homes
- Combination of benefits is possible
- Benefit levels are not related to contributions, but on assessment of care needs according to three levels of care intensity
- Informal carers benefit from implicit pension contributions and are entitled to work at reduced hours

# Maximum monthly benefits

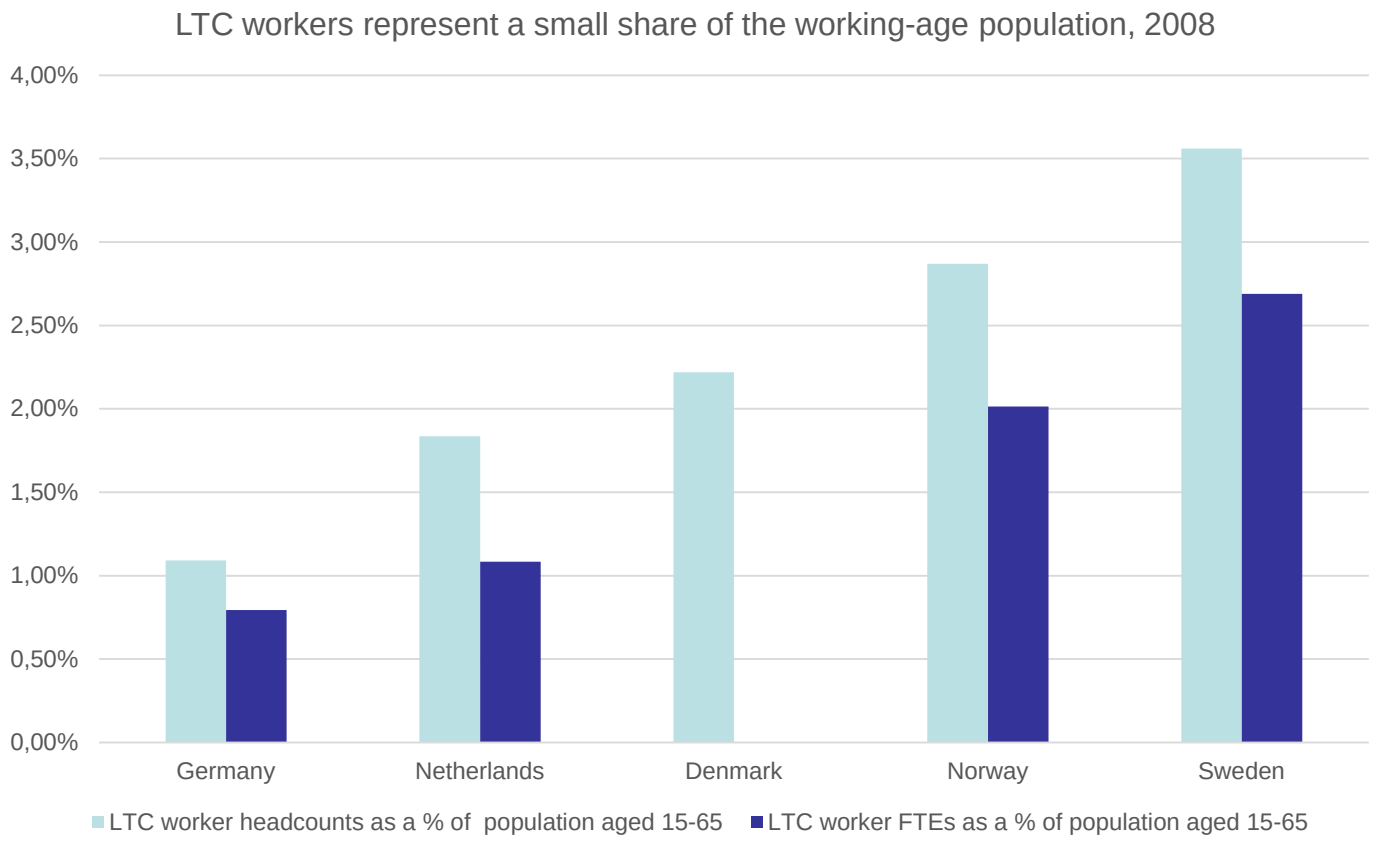
| | dependency level (values as of 31/03/2015) | | | |
|---|---|---|---|---|
| | I | II | III | III (hardship cases) |
| Benefits in kind | 468 € | 1.144 € | 1.612 € | 1.995 € |
| cash benefits | 244 € | 458 € | 728 € | |
| institutional care | 1.064 € | 1.330 € | 1.612 € | 1.995 € |

# Means-testing in the German system

- If LTC insurance benefits do not cover actual costs (of nursing homes) social assistance steps in – about 439 000 are supported
  - 66% of beneficiaries are women
  - 71% of beneficiaries were supported in care institutions, 28% at home
- Means-testing: taking into account pensions, other income or wealth of care beneficiary, spouse and family (in particular children) – but intra-family obligations have become weaker over time

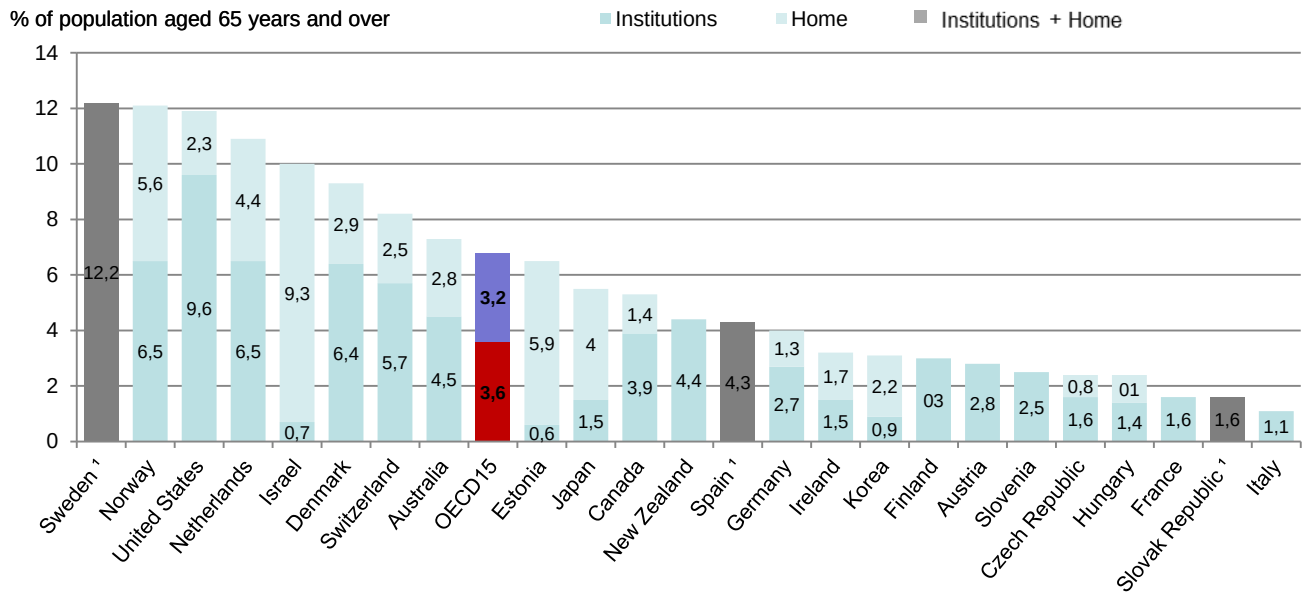
# The performance of the German system

- In March 2015 about 2.7 mio. were dependent on care (about 3% of resident population)
- 1.8 mio. at home and 750.884 in nursing homes
- 1.1% of total employment (DK: 2.2, SE: 3.6); 15 care workers per 100 persons above 80 (DK: 36, SE: 44)
- Employment: predominantly women, high part-time share, moderate remuneration, relatively low tenure, some tendency to lower professional standards
- Particular issue: care migration (formal or informal)




Source: OECD Health Data 2010 and Korea National Statistical Office.

# Long-term care workers as share of population aged 65 and over, 2011 (or nearest year)




1. In Sweden, Spain and the Slovak Republic, it is not possible to distinguish LTC workers in institutions and

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

# Challenges

- Basic principle of universal insurance seems appropriate, but…
- Constant problem pressure in terms of lacking resources to ensure sufficient quality and quantity of formal care services
- German system is 'too small' given demographic demand for care services
- Persistent need to adapt funding: higher contributions (i.e. non-wage labor costs), more taxes and or more private savings/insurance?
- Ambiguous strategy towards informal care – encouraging intra-family care via (subsidized) care leave arrangements may be problematic in terms of quality and quantity as well as endanger more substantial female labor market participation
- Despite some tax breaks (up to 510 € p.a.) only very limited development of a formal market for household-related services (not only for the elderly), cf. CESU in France

# Policy conclusions

- In principle, German system is quite universal and solidaristic – but care is underfunded, and there is too much reliance on ('cheap', less professional) informal care
- Establishing a better and more universal system of formal and professional services for the elderly requires not only appropriate funding (probably combination of taxes, private savings, employer involvement – decoupling from wages), but also effective quality standards and monitoring

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