Institute for
FUTURES STUDIES

Hildegard Theobald

Long-term Care Insurance in Germany

Assessments, benefits, care arrangements and funding

Arbetsrapport/Institutet för Framtidsstudier 2011:13
ISSN: 1652-120X
ISBN 978-91-85619-91-7

Hildegard Theobald

Long-term Care Insurance in Germany: Assessments, benefits, care arrangements and funding

Arbetsrapport/Institutet för Framtidsstudier, 2011:13
Working Paper/Institute for Futures Studies, 2011:13

Stockholm 2011

Long-term Care Insurance in Germany: Assessments, benefits, care arrangements and funding

Hildegard Theobald
University of Vechta
Centre for Research on Ageing and Society
Driverstr. 22
49377 Vechta
Germany
hildegard.theobald@uni-vechta.de

Abstract

With the introduction of Long-term Care Insurance (LTCI) in 1995/96 Germany established a national policy scheme to provide public support in situations of care dependency. The institutional regulations of LTCI strive to combine universal support with cost containment policies, the promotion of family care-giving and the development of a market-oriented care infrastructure. After intense debate a mandatory policy scheme based on a social and private insurance branch was established. Since 2000 in debates on the development of the funding scheme the introduction of a "Citizen`s Insurance", i.e. a social insurance scheme for the whole population and capital-funded private insurance schemes are contrasted. Based on a literature review and statistics the paper, first, reveals institutional features of LTCI and their interrelationships to patterns of inequalities based on socio-economic class, gender, migrant background and region. Second, it analyses different modes of funding and relate them to political actors and their ideas.

Abstract

Under åren 1995/96 införde Tyskland en äldreomsorgsförsäkring i syfte att ge offentligt finansierad omsorg till äldre med omsorgbehov. Lagstiftningens utformning syftade till att kombinera universella bidrag med höga ambitioner att kontrollera kostnaderna. Samtidigt ville man främja att omsorg utfördes i en familjekontext och att marknadsorienterade omsorgstjänster utvecklades. Efter en intensiv debatt etablerades en försäkring för hela befolkningen men uppdelad på två program; en socialförsäkringsdel och en privatförsäkringsdel. Sedan 2000 har en ny debatt blossat upp kring två olika finanseringsförslag som förts fram. Här har en *Bürgerversicherung*, dvs. en socialförsäkring för hela populationen, ställts mot fonderade privata försäkringar. Utifrån tillgänglig forskning och statistik visar den här arbetsrapporten, för det första, hur det institutionella regelverket samspelar med ojämlikhetsmönster relaterade till klass-, kön-, och migrationsbackgrund, samt till region, och, för det andra, hur de olika finanseringsansatserna står i relation till de olika politiska aktörerna och deras idéer.

Content

1. Introduction: Long-term Care Insurance in Germany

The establishment of Long-term Care Insurance (LTCI) in Germany in 1995/96 significantly restructured Germany's public long-term care support. Before, the responsibility for providing care to Germany's elderly population lay mainly with the family, while based on the principle of subsidiarity public support was only available after a means-test within a tax-based social assistance framework. The law on LTCI established a social-insurance and mandatory private insurance scheme to grant universal public support in strictly defined situations of care dependency. LTCI in Germany was created at the beginning of the 1990s in a situation of welfare state constraints characterised by criticism towards comprehensive public welfare spending and an increasing emphasis on individual responsibilities and market solutions (Landenberger, 1994; Meyer, 1996).

Against this background the law was a compromise on the balance of private, family, public and market responsibilities between more economically - and more social-policy oriented politicians and social actors. The LTCI law aimed to combine several goals, namely the introduction of universal social rights, cost containment strategies, the promotion of ageing in place, with an emphasis on family care, and the expansion of a market-oriented care infrastructure (Theobald, 2011, forthcoming). The goals are reflected in the definition of social rights valid in the whole country, the construction of funding schemes and the regulation of family care-giving and professional care provision based on free choice for users between both types of care provision and care providers.

Prevalent benefit use and care arrangement patterns emerging within the framework of LTCI still confirm a family-oriented strategy of long-term care provision mainly supported by cash payments. However, a more detailed analysis of current care arrangements reveals considerable differences in the interplay of family care, professional care provision and further paid care services depending on gender, socio-economic class and migration background. Furthermore, the development of a market-oriented care infrastructure based on price competition resulted in considerable regional differences, which run counter to the goal of the insurance to provide equal support in defined situations of care dependency throughout the country. Public long-term care support is embedded and simultaneously limited by mode and principles of funding; i.e. the introduction of a separated social- and private insurance scheme and cost containment strategies. The basic presumptions surrounding the two distinct schemes on the role of state respectively public, market or private responsibilities are the subject matter of continual discussions.

The paper aims to give a broad overview of social rights, benefits, modes and principles of LTCI funding and an analysis of outcomes related to patterns of care provision and the financial development of this insurance. First, the interrelationship of LTCI with other valid policy schemes in the sector provide a background for the analysis and are outlined to reveal the position of LTCI and further available public support. Second, the basic features of LTCI are presented (sections 2 and 3). The paper goes on to describe and explain assessment procedures, benefit use, prevalent care arrangements patterns, and the situation of informal carers against the background of LTCI (sections 4 and 5). Funding schemes are presented and discussed with regard to their financial development and difficulties, alternative funding concepts and processes of policy-making with their political and social actors (section 6). Finally, LTCI features and their outcomes related to care provision and funding are summarised and discussed in the conclusion (section 7).

2. Social policy schemes related to long-term care support

In Germany, a mix of social-policy schemes introduced on a central level, i.e. Social Statutes (SGB), define distinct social rights with regard to long-term care support. The Social Statutes (SGB V, IX, XI, XII) differ widely with regard to their aim, target groups, institutional designs, the central-regional-local interplay, mode of funding, as well as in their quantitative significance. The quantitatively most significant social statute for long-term care support, the Long-term Care Insurance LTCI (SGB XI) introduced in 1995/96, aims to provide universal support on three clearly defined levels of care dependency, i.e. levels of needs related to personal care and household assistance, which are expected to last for at least six months (lin greater detail see appendix table 1). The corresponding benefits are only meant to partially cover care needs and thus leave a considerable level of private responsibility–to be covered either with private economic means respectively informal, family care provision or public support defined within further Social Statutes (in greater detail see appendix table 1).

Prior to the introduction of LTCI long-term care needs had been mainly covered and regulated since 1962 by the Assistance to Long-term Care (Hilfe zur Pflege) within the tax-based Federal Law on Social Assistance (now SGB XII). Following the introduction of LTCI, the Assistance to Long-term Care scheme was re-regulated and now provides support after a means-test of beneficiaries, when care needs are below the threshold of the LTCI or to supplement LTCI benefits to secure a needs-oriented support. Before granting social assistance benefits, offspring may be obliged to take over costs for long-term care provision. 5% of beneficiaries using home-based care and 29% using residential care services received additional social assistance benefits based on the Assistance to Long-term Care scheme in 2007 (Federal Statistical Office, 2009).

Another scheme, the "Elder Assistance System" (Altenhilfesystem SGB XII), also tax-based, obliges local authorities to foster the independence and participation of older adults in society by promoting services on local levels. Local services are generally defined as universal by federal law, while the type of support and related eligibility criteria–for instance the type of care needs–are decided at local levels. In contrast to the LTCI and the Assistance to Long-term Care within SGB XII, this is not related to individual social rights. Developing certain local offers is placed within the remit of local authorities, which may adapt the mode of implementation to suit local level needs and circumstances. Typical service offers are, e.g. meals-on-wheels, transport services, advisory services but also senior clubs or communication centres. The considerable discretionary room has led to widely differing local service structures, and some offers have even been reduced since the introduction of the LTCI (Bönker et al., 2009).

Finally, within the framework of the Social Health Insurance scheme (SGB V) home nursing is provided for all members of the insurance (87.8% of population in 2007) based on needs in three defined situations (statistics on insurance members see Rothgang, 2011).[1] The support is comprehensive and may be related to user charges. Home-nursing can be granted for short periods in order to reduce or avoid hospital treatments, when it is necessary for the success of a medical treatment or to maintain living in the own flat for people in need of psychiatric nursing services. For periods of up to 6 months (below the threshold of the LTCI) services can even include basic nursing care, such as bodily care or household services.

The different schemes discussed above are also available in cases of disability. The Federal Law on Rehabilitation and Participation of Disabled People (SGB IX), which came into effect in 2001, provides the framework for the integration of the different schemes related to home-based care. Eligibility for the scheme requires "Physical, cognitive impairment or mental health problems, which last (or can be expected to last) for longer than six months and which do not correspond to age-related behaviour." In a situation of long-term care needs, the benefits of the different available schemes–LTCI, Assistance to Long-term Care or Home-nursing, Elder Assistance system–are combined to create a comprehensive care arrangement with the local authorities responsible for case/care management services. The eligibility criteria are also generally valid in cases of disability, with the exception of the Assistance to Long-term Care scheme that provides universal benefits without means-testing

---

[1] A further 10.6% of the population receive home-nursing services funded by private health care insurances.

to secure a need-oriented support. Based on model projects a personal budget–a regulated cash benefit–was introduced in a trial in 2004. This became permanent in 2008 and thus became an individual social right that helped to establish integrated home-based care provision based on the benefits of the different schemes. The level of support differs widely with an average level of support of €1000 per month (Metzler et al., 2007).

Needs assessments are organised differently within the diverse legal frameworks. Within the Elder Assistance system and the Assistance to Long-term Care scheme (SGB XII) needs assessment are defined by local authorities. Different forms of needs assessments were established at regional levels related to the personal budget (SGB IX) (Metzler et al., 2007). Within the framework of the LTCI (SGB XI) the organisation of assessments is defined in great detail on a central level, while the regional level medical services of the Health Insurance Funds are responsible for carrying out assessments (in greater detail see section 4.1 on assessments below). Finally, home-nursing services are prescribed by medical doctors (SGB V).

3. Long-term Care Insurance: Basic features

The policy LTCI scheme aims to combine three fundamental goals: universal protection of the whole population in defined situations of long-term care needs; cost containment related to substantial public costs, which may emerge within the framework of a universal policy scheme; and ageing in place embedded in family-oriented support. The long-term care scheme was negotiated within a federalist framework encompassing the Christian-Democratic-Liberal government on the federal level and politicians of the Social-Democratic Party dominating the Council of the Federal States, which must approve the law, as well as other societal actors (for a detailed analysis of processes of policy development see section 6 on funding and Theobald, 2011; Theobald/ Kern 2011). The goals–universalism, cost containment and ageing in place embedded in family support–were pursued along three lines; first, by introducing a new type of universal social rights, second by defining distinct funding principles, and third by restructuring care provision that maintained family care provision and strengthened market principles.

- Social rights and benefits; Universalism and medium public funding

In order to combine universalism and cost containment, private and public responsibilities related to social rights were exhaustively debated in policy-making processes and resulted in the development of a distinct type of universalism reflected in policy design. The type of universalism falls into three categories: definition of the threshold, the level of public support and the types of benefits.

-- Definition of a considerably high threshold of care needs eligible for public support and a focus on functional impairments.

The construction of the threshold to insurance benefits provides the starting-point for access to public support. The federal law on LTCI clearly defines three levels of care dependency mainly oriented towards functional impairments as thresholds to a distinct level of public support (benefits) (in greater detail see appendix table 1). Support for household services only is not covered by the insurance framework; a minimum of 45 minutes of care provision related to personal hygiene, eating or mobility and further 45 minutes related to household assistance is required (Care dependency level 1). The orientation of eligibility criteria towards functional impairments was motivated by cost containment efforts. In particular the neglect of psychological and cognitive impairments, i.e. related to dementia illness, resulted in an intense societal debate including a wide range of social actors, such as the Alzheimer Society or welfare associations. Reforms were introduced (in 2002 and 2008) to increase public support for people suffering from dementia and for their informal carers. The Complementary Nursing Act of 2002 introduced an additional benefit of €360 p.a. for beneficiaries suffering psychological impairment, i.e. mainly dementia illness, which could be used to purchase different types of care services. With the 2008 reform the amount of the additional benefit was increased to €2,400 p.a. and the benefit threshold was lowered to enable access to this distinct benefit for applicants who do not meet the eligibility criteria of care dependency level 1 (MDK Bayern, 2008). Up to 2008 only few LTCI beneficiaries eligible for the benefit actually claimed it, partly owing to the low level of the benefit (Sauer/ Wißmann, 2007). Raising the level of benefits and the opening-up to applicants not eligible according to the LCTI's threshold resulted in an increase of benefit use (Rothgang, 2010; Rothgang et al., 2010). The introduction of the new benefits is only meant as a first step to expand public support for this group. At the moment there is an on-going reform process, which aims to change the current definition of care-dependency within LTCI law to facilitate access of people suffering dementia illness to the policy scheme (Wingenfeld et al., 2008a,b; see section 4.1 on assessment procedures below). The threshold is viewed critically by German population. According to a representative inquiry among members of social LTCI, 40.6% of participants criticize the restrictive access to the insurance and further 24.1% have reservations (Zok, 2011).

-- Definition of the level of public support, which leaves a considerable amount of private responsibility

The policy scheme provides medium-level public support in the form of a lump sum benefit according to care dependency levels, which must be complemented either by private means or family support. The level of benefits was negotiated in intense debate during the LTCI policy-making process (in greater detail see section 6 on funding below and Theobald; 2011; Theobald/ Kern 2011). LTCI benefits provide public support on a medium level regardless of beneficiaries' family or economic situations. Where service providers are involved in care arrangements, users purchase services based on their benefits and calculated at market prices whatever their socio-economic or family situation. The benefits may be supplemented with social assistance benefits after rigorous means tests (see above). Based on estimations private out-of pocket payments amount to 33.3% of total LTCI costs (Rothgang et al., 2010). By granting only medium-level public funding, the long-term care scheme represents a significant departure from traditional health care insurance in Germany (Landenberger, 1994). While public debate on the level of benefits was laid to rest with the introduction of LTCI, the population remains unhappy about the low level of benefits. In a representative inquiry in 2011 40.1% or participants reported their dissatisfaction with the level of public support (Zok, 2011).

-- *Definition of different types of benefits*

The definition of distinct types of benefits was related to cost containment policies, but also to ideas on the existing interplay of family and formal care provision. In the process of policy-making the provision of "in-kind services only", comparable to the health care insurance schemes, was rejected by almost all actors as not coherent with existing patterns of care arrangements. Finally, a mixed system of public benefits related to free choice was introduced with lower-level cash benefits to acknowledge family care provision and higher benefits adapted to the prices of the more costly home-based and residential services (see Meyer, 1996). The introduction of service benefits was related to concerns on care quality assurance and requirements for a stable means of funding of costly institutional services. The lower-level benefit related to family care provision was to avoid "economisation of family care" and to reduce spending levels. A more recent comparison of spending levels between LTCI in Japan, which provides only service benefits and LTCI in Germany questions the assumption of saving costs by the introduction of cash benefits (Campbell et al., 2010).

- *Mode and principles of funding*

Mode and principles of funding reveal the interplay of public and private responsibilities from two perspectives. First, the mode of funding defines the inclusion of distinct groups among populations within a policy scheme and based on this determines the form of solidarity among societal groups. Here, private- and social insurance based as well as tax-based schemes cam be contrasted (see also Korpi/ Palme, 1998). Second, they define the interplay of public, collectively paid and individual or family funding responsibilities with regard to care provision. Within the LTCI framework almost the whole population is insured, albeit divided in two branches of insurances; social LTCI (87.8% in 2007) and mandatory private insurance (10.6% in 2007) of the population (statistics on insurance members see Rothgang, 2011). The types of benefits, the definition of care dependency levels and assessment procedures correspond in both branches of the insurance, while each branch organises its own funding and redistribution among the members (in a greater detail see section 6 on funding below). Furthermore, two dimensions of the LTCI framework reflect the distinct mix of private and public responsibilities related to funding of care provision. The first dimension concerns a general regulation on the amount of public funds available. Within the framework of social LTCI, insurance contributions based on a contribution rate stipulated by law provide a ceiling for expenditure within the insurance scheme and thus restrict expansion of public support. The second dimension concerns the interplay of public and private support related to the definition of benefits and the mode of calculation of private out-of-pocket payments (see definition of level of benefits above).

- Regulation of care provision

Care provision was also (re)organised to contribute to cost containment goals (compare types of benefits available above). Both informal family care and market-oriented formal care provision should contribute to cost containment goals. While less costly care within the family framework should be maintained by providing cash benefits, an increasing orientation towards market principles ought to deliver high-quality but cost-efficient care services and enable choice for the beneficiaries between different care providers. Formal care providers are involved in more complex care activities and in control of care quality, while social support, daily care work and “keeping an eye on”, should be provided by family members or wider social networks (see also Meyer, 1996; Pfau-Effinger et al., 2008). As a precondition for cost-efficient prices a care market was opened up on equal terms for the then quantitatively dominating non-profit care providers and for-profit care providers, while public providers were always insignificant (see Theobald, forthcoming). Competition should be based on care quality but also on the prices for care offers. Prices are negotiated between care insurance funds and providers (or provider organisations) and may differ between providers. Price competition was regarded as precondition for the establishment of a cost-efficient care infrastructure. In the policy-making phase, the Liberal Party in office with the Christian-democratic Party on the federal level only accepted a social insurance scheme combined with a strong role of a care market and user demand (Burau et al., 2007).

4. Assessments and benefits

4.1 Assessments

Within the framework of LTCI eligibility criteria, corresponding benefits and the responsibility of different political levels and actors to carry out assessments are clearly defined and valid for the whole country. The eligibility criteria are defined on a federal level within the law, the medical services of the Health Insurance Funds on regional levels are responsible for assessments and–in cooperation with the Medical services of the Health Insurance Funds on the federal level–for the development of the instruments or procedures. Country-wide instruments or procedures strived to guarantee equal access to equal benefits throughout the country. Within the framework of private LTCI a private company conducts assessments based on the same eligibility criteria and types and levels of benefits. Assessments are not oriented towards the development of a care plan.

LTCI law defines three levels of care dependency related to care needs within three areas of personal care– personal hygiene, mobility, eating–and to household chores. As indicators for care needs a mix of certain criteria are applied; i.e. the number of necessary care activities, frequency of activities and time used for care provision (in a greater detail see appendix table 1). The developed instruments assess the number of care activities, frequencies and the time required in every single case and compare them with the eligibility criteria defined by law. Based on assessors' experiences of each care activity, estimations are available for the average time used per activity, which form the basis to calculate the time required for each case.

While the introduction of central-level assessment procedures reduced regional inequalities, adherence to certain socio-economic and ethnic groups still has a significant impact on the results of the assessment procedures. In addition, the orientation of assessment procedures towards functional impairments disadvantages applicants suffering from dementia conditions. A comparison between assessment results of applicants within the framework of social and private LTCI reveals significant differences. Within the framework of the social LTCI applications are more often rejected than within the framework of the private LTCI. Furthermore, beneficiaries within the framework of the private insurances are more often assigned to higher levels of care dependency; i.e. to care dependency level two instead of one with regard to home-based care and to care-dependency level three compared to level two with regard to residential care (Federal Ministry of Health, 2007). There is no convincing explanation for the differences based on care needs. An analysis of the assessment reports in one region within the framework of social LTCI revealed that applicants with a Turkish migrant background are more likely to be rejected compared to German applicants and more often assigned to care dependency level one (see Okken et al., 2008).

The functional orientation of the LTCI eligibility criteria and the corresponding assessment procedures neglect the long-term care needs related to dementia, such as e.g. the increasing need of supervision. The introduction of new benefits for the needs of this group of beneficiaries in 2002 (reformed in 2008) with the Complementary Nursing Act were followed by the establishment of an own assessment procedure. The introduction of the additional benefits and assessment procedure is only meant as a first step to adjust the definition of care dependency to the situation of applicants with dementia conditions. At the moment there is an on-going reform process, which strives to redefine care-dependency, with an assessment based on the levels of autonomy in different areas and even include cognitive and mental impairments. To date an expert group has already recommended the new definition of care dependency, while cost calculations reveal that higher expenditures are to be expected (Wingenfeld et al., 2008a,b; Rothgang et al., 2008). The political debate on the implementation of this new assessment procedure is still underway.

4. 2 Beneficiaries and the use of different types of benefits

The introduction of LTCI based on the principle of universalism led to a significant increase in the number of beneficiaries (who had hitherto received benefits according to the Federal Law on Social Assistance), from approx. 563,000 care dependent in 1994 to approx. 2.34 million in 2011 (Eisen/Mager, 1999; Federal Statistical Office, 2011). An analysis of statistics of members of social LTCI reveals that roughly half of population will become care dependent during the course of their lives based on the definition of LTCI (see Rothgang et al.; 2009). According to insurance statistics men at the age of 60 year will experience about 1.25 years in care dependency until death on average (6% of years of further life expectancy) and women at the age of 60 years 2.59 years until death (10.5% of years of further life expectancy). The average time period in a situation of care dependency of approx. 4.0 years for women and approx. 2.5 years for men is at odds with the 42% of men and 27% of women who receive benefits for less than six months.

The use of different types of benefits will provide the starting-point for the analysis of the interplay of different types of care provision. In 2009, 11.5% of adults 65 years or older received benefits, whereof 2.8% chose home-based care services, 4.2% cash payments and a further 4.0% institutional care services (see table 1 below; Federal Statistical Office, 2011).

Table 1: Benefit use in 1999-2009

Benefits	**In % of beneficiaries**			**In % of population 65+**
	1999	**2001**	**2003**	**2009**
	2005	**2007**	**2009**	
Residential care services	28,4	29,6	30,8	3.8
	31.8	31,6	30.7	
Home-based services/ combination of cash payments/services	20,6	21.3	21.7	3.0
	22,2	22,4	23.7	
Cash payments only	51,0	49.1	47,5	4.6
	46,1	46,0	45.6	
Total				**11.5**
Beneficiaries living at home only: users of service benefit	28.8	30.3	31.3	
	32.5	32.8	34.3	

Source: Federal Statistical Office (2001-2011). Pflegestatistik 1999-2009.

Since the introduction of LTCI a (falling) majority of beneficiaries preferred cash benefits to home-based care services. Overall, from 1999-2005 we find an increase of beneficiaries living in residential care (27.7% to 31.8%) and a small reduction of the quota since then to 30.7% in 2007. The use of home-based care steadily increased from 1999-2009, from 20.6 to 23.7% (Federal Statistical Office, 2001-2011). The increasing use of residential care services can be explained by population ageing based on an almost stable age-related quota of beneficiaries voting for residential care benefits. (Rothgang et al., 2009). The reduction of residential care service use since 2005 may be due to the emergence of migrant carers within the family context, who are mainly employed by beneficiaries who live alone and have comprehensive care needs in order to avoid a move to a residential care facilities (Theobald 2011).

Based on insurance statistics of 2008, an analysis of patterns of benefit change in single cases showed that about half of beneficiaries did not change their type of benefit at all, with approx. 23.3% of beneficiaries using a cash benefit only, and approx. 11.8% using home-based and further 12.0% residential care provision only (for the following see Rothgang et al., 2009). Changes of benefits within individual developments are often characterized–approx. 24.9% of all beneficiaries–by a change from informal care provision based on a cash benefit to home-based or residential care services. With 2.2% of all beneficiaries a transfer from professional home-based or residential care services to informal care provision is very rare. Further cases are often changing between formal and informal care provision.

Factors impacting on a change of care provision from informal to formal, professional care provision are (old) age, health status, e.g. in particular dementia or cancer and living alone. Age, health status and living situation also impact on the use of benefits in general, where they build a basis for distinct benefit use related to gender, socio-economic status and ethnicity. The risk of care dependency is strongly related to age and gender. Thus in 2009 55% of the beneficiaries were 80 years old or older and 67% of the beneficiaries were women (Federal Statistical Office, 2011). The interrelationship of care dependency, age and gender can be explained by the health status–with a poorer health status in old age and health differences between men and women (Borchert/Rothgang, 2008; Rothgang et al., 2009). The higher level of care-dependency among women is not a German phenomenon. A study in 12 European countries clearly confirmed the development of a specific profile of morbidity related to a higher risk of care dependency (Stiehr/Spindler, 2006).

The gender-oriented patterns of family status and living-situation in old age are also correlated to gendered patterns of benefit use, above all to cash benefits and residential care services. While men more often “opt” for cash benefits–53.9% of men versus 41.5% of women in 2009–women are more likely to “choose” residential care services, 33.6% versus 22.5% (Federal Statistical Office, 2011). Above all, women in old age living on their own more often move into residential care facilities. In contrast, men are more likely to be cohabiting and are more often cared for by wives or partners (Rothgang et al., 2009). Besides gender and age, adherence to certain socio-economic classes and ethnic groups impacts significantly on both the take-up rates and the selected types of benefits. In general, due to their poorer health status, citizens on lower-socio-economic strata are more often care dependent (Theobald, 2004; Borchert/Rothgang, 2008).

Furthermore, studies in daily care provision found that people who are lower on the socio-economic scale more often opt for cash payments instead of services, while members of the (upper) middle-classes tend to use more home-based or institutional services (Blinkert/Klie, 1999; Heusinger/Klünder, 2005). Ethnicity also plays a role when it comes to deciding which type of benefit is chosen. In their analysis of assessment process in one region, Okken and colleagues (2008) found that the Turkish migrant group were far more likely than the German group to choose cash benefits (91% to 42%) and less likely to opt for home-based services (9% to 29%). The respective figures for residential services were below 1% to 29%. The significant group differences are partially related to the group-specific impact of age and gender. In the German group, gender and old age is related to an increasing use of home-based and above all residential care services. This impact could not be found for the migrant group (in greater detail see section 5 on care arrangements below).

5. Care arrangements

5.1 Formal care provision

The still dominant use of cash payments within domestic care provision reflects a basically family-oriented care strategy in Germany. In 2009, 65.7% of beneficiaries living at home voted for a cash payment and were mainly cared for by relatives (see table 1 section 4.2 above). In this section we use this as a starting-point to analyse the use of different types of formal care provision in greater detail based on further representative statistics and research findings.

Research in daily care provision reveals a complex pattern of a combination of different types of paid care work, i.e. professional care services, further types of care services or paid care work. Professional care services in Germany are mainly used to provide bodily care (Federal Statistical Office, 2011). According to a representative inquiry in 2002, 23% of long-term care insurance beneficiaries living at home purchased additional private services or paid assistance, such as delivered meals or privately organised household support, and a further 11% received support from voluntary workers, e.g. visiting services. Private services are more often purchased by recipients of public services, while only 9% among the cash benefit recipients used private services (Schneekloth, 2006). Cash benefits are mainly used to pay informal carers, in particular offspring or neighbours (Evers, 1997; Heusinger/Klünder, 2005). In addition, according to a representative survey in 2002 approx. 3 million citizens aged 70 years or older stood in need of some form of assistance with housekeeping, of whom approx. 2% received benefits according to the Federal Law on Social Assistance and 13% purchased private services (Schneekloth, 2006).

More recent representative statistics, which include only privately organised household work, confirm the (ever increasing) role of privately organised support. According to representative statistics, in 2009 11% of all German households used some assistance with regard to household tasks mainly based on undeclared work (Enste et al. 2009). In 2010, 12.2% of people aged 65 years or over regularly or occasionally use household support. For households with members in need of care, there is a marked increase to 25.5% and another slight one for households with a member receiving LTCI benefits, to 26.8% (Own calculations on basis of German Socioeconomc Panel GSOEP). Tax deductions were introduced to reduce grey market activities and create a regular market for household services. Since 2009, tax deductions of up to €4,000 p.a are available for 20% of the costs in cases of regular, standard employment; up to €510 p.a. related to legal employment with lower social security standards and wages up to €400 per month. Within the framework of the law, long-term care support based on traditional family tasks are described as one type of activity, which should be facilitated by tax deductions. Statistics show that employment based, in particular, on lower security standards has increased since the introduction of tax deductions, but more than 90% of services within the private household are still conducted on an undeclared basis according to estimates (Gottschall/Schwarzkopf, 2010).

Since the end of 1990s a new type of grey market activity has emerged, namely the provision of 24-hour care services within the domestic context to severe care-dependent older, often female, beneficiaries living on their own (Neuhaus et al., 2009). Typically, two carers from new EU member states like Poland, the Czech Republic or Hungary take turns to offer this type of care on a two or three-month rotational basis. According to estimates about 120,000 migrant carers delivered 24-hour home care services in about 60,000 households in Germany, which will be about 5% of LTCI beneficiaries living at home (own calculations on the basis of Lutz, 2009; Neuhaus et al. 2009; Federal Statistical Office, 2011; Theobald, 2011).

Despite a cultural orientation towards family care provision, the largely family-oriented care strategy is not congruent with the attitudes of the population in general. A representative inquiry in 2002 into the opinions of informal carers and care recipients already described a trend towards the recommendation of professional services. 30% of informal carers and care recipients recommended informal family care only, while 39% recommended a mix of informal care and professional services. A further 20% voted for assisted living facilities and 4% for institutionalised services. Even among the recipients of cash payments about 60% recommended a mix of formal and informal care provision. Here, clear differences can be detected between care recipients and informal family carers, with care recipients preferring more informal, family care provision only (Runde et al*.,* 2003). A more recent representative survey confirms the findings in the population as a whole. According to the representative Health monitory of 2007 about 60% of participants prefer a mix of informal, family and formal support, while only 17% vote for family care provision only and 12% for professional care provision only; a further 11% could not decide (Bauer, 2008).

Besides cultural values, the limited use of professional services is also due to criticism related to the care offers available. Due to the predetermined restrictive time limits of home-based services and the frequent change of professional carers, professional care services do not meet the needs of care recipients and informal carers. The unburdening effect for informal carers is assessed as too limited, there is a lack of information on available services and the available services are too costly (Federal Ministry of Families, Seniors, Women and Youth, 2002; Runde et al., 2003; Reißmann, 2005; Pfau-Effinger et al., 2008; Eichler/ Pfau-Effinger, 2009). While publicly financed care services–depending on the level of care dependency–delivered between 0.5 to 1.8 hours a day, informal family care amounted to 5 hours a day on average (Schneekloth, 2006; Schneekloth/Wahl, 2006). The majority of highly-burdened households organise support privately, either from family or social networks, or by using private services or privately paid care (Runde et al*.,* 2003).

5.2 Inequalities: Living-situation, gender, socio-economic status and migrant background

General patterns of formal and informal care provision depend – to a great extent – on living situation, gender, socio-economic class and ethnicity, which can contribute to an explanation of the general patterns. The use of different types of benefits–either cash payments or services–can be viewed as an initial indicator (see table 1 section 4.2 above). Care services are more often used by beneficiaries who live on their own with precarious social and family support or older adults on higher socio-economic strata and they are more likely to be German nationals than migrant populations (Blinkert/Klie, 1999; Klie/Blinkert, 2002; Heusinger/Klünder, 2005; Baykara-Krumme/Hoff, 2006; Okken et al*.,* 2008). The differences can be explained by group-specific social, family, economic and cultural resources. The care arrangements are not related to a balanced care situation, where one type of support is substituted for another. On the contrary, it may indicate a lack of care provision and an overburdening situation for some groups of informal carers. In a representative study in 2002 14% of care recipients reported a lack of care services and a further 12% a shortage of domestic support (Schneekloth, 2006).

The introduction of the LTCI increased the number of care recipients who are able to remain in their own homes; while 40.9% of insurance beneficiaries were living in their offspring's households in 1997 this figure had dropped to 35.1% in 2002 (Runde et al*.,* 2003). Despite changing living situations, representative statistics confirm a situation of intense contact and support between offspring and parents who live near one another (Künemund, 2006). In a situation of precarious family or social support, however, living alone often equates with inadequate or lack of care provision because publicly provided home-based care is not able to compensate for the lack of informal care provision where high levels of care-dependency exist (Blinkert/Klie, 2006, 2008). The mode of care provision differs significantly between male and female main informal carers. Male carers can be found sharing care arrangements with other informal and formal carers, in particular care services that usually take care of bodily needs. The increase of sons as informal carers can partly be explained by male unemployment but also by the impact of the LTCI and the availability of publicly supported care services (Schneekloth/Wahl, 2006).

Several research projects into the impact of socio-economic class reveal a complex pattern of class-related economic and cultural factors that influence the construction of care arrangements (Blinkert/Klie, 1999; Klie/Blinkert, 2002; Heusinger/Klünder, 2005). Economic factors are related first to the (private) costs for the purchase of care services, which are developing embedded in the design of the long-term care insurance (examples on average costs for care provision see appendix tables 2 and 3). Within the framework of this insurance, the level of care dependency and the type of care provision determine the amount of public support, while the economic situation of the care recipient is not considered. Only below a certain income threshold are beneficiaries eligible for additional social support within the framework of social assistance. The economic burden related to the purchase of services differs depending on the income situation. Statistics show that the use of privately-paid home-based services is related to the income of the beneficiaries. In a representative study in 2202, 8% of the beneficiaries stated that they buy privately home-based care services; this proportion rises to 18.6% for beneficiaries with an income of €2500 or more. Only 4.9% of all beneficiaries, however, had an income of €2500 or more (Runde et al*.,* 2003). In the main, beneficiaries either complement the granted services with informal, family care or they reduce the level of support; only 5% receive additional social assistance benefits (Runde et al*.,* 2003; Federal Statistical Office, 2009). In a recent representative European inquiry based on Eurobarometer, a trend became visible that, in general, participants with higher education levels more often vote for the use of home-based care services. The judgements in the population did not differ related to the availability or quality of services, but the possibility to finance services were gauged differently (Dittman, 2008).

Second, economic factors are related to opportunity costs when informal carers interrupt or reduce their (formal) employment. In 2002, 10% of informal carers had interrupted employment and a further 11% had reduced their working hours in order to meet their caring responsibilities. Fully 51% of the main informal carers of employment age had not been gainfully employed before (Schneekloth, 2006). The combination of informal care-giving and employment is strongly influenced by socio-economic class, i.e., both the employment status before the advent of care dependency and the impact of informal care provision. For example, while 44.9% of blue-collar workers had not been gainfully employed at the advent of care dependency, the comparable figure for high-qualified white-collar workers is 27.1% and 20% for highly-qualified self-employed workers. Furthermore, only 32.2% of the first named group continued in employment without any changes compared to 45.0% in the second group (Runde et al., 2003).

Class differences are also related to cultural factors, which, in turn, are related to parental care (see Heusinger/Klünder, 2005). While the role of the family members in parental care provision is emphasised in all socio-economic classes in Germany, expectations differ widely as to what care tasks should be assured by offspring. Despite an emphasis on the responsibility of the family, the upper middle-classes, in particular, would not expect their offspring to take on their care. The use of professional home-based services and, under certain circumstances, a move to residential care, is accepted. Also, in the (lower) middle-classes, paid assistance might be called upon to unburden informal carers (mainly offspring), but assistance is more likely to be sought in grey market services. Families at the lower end of the socio-economic scale expect free provision of care and are more unwilling to accept a move to residential care. Cultural factors also affect access to information about public support. The complex public support structure in Germany–related to a care market with a wide range of providers within the framework of the LTCI, but also at municipal levels–impedes service use, in particular for lower socio-economic classes. Local information centres (Pflegestützpunkte) were established after the 2008 reform and free-of-charge, individual right to information up to case/care management services introduced with the aim of facilitating service use (MDK Bayern, 2008).

As already indicated in the analysis of the take-up rates of cash benefits or services, ethnicity or migrant background strongly influence patterns of care arrangements. The differences can be explained by a combination of economic, social and cultural factors. An analysis of a representative study of the living situation of migrants without German citizenship indicates discrimination in several respects (see Baykara-Krumme/Hoff, 2006). Life situations are characterised by lower incomes, lower educational levels, below-average housing standards, and, although only slightly, poorer status of health. The family situation is comparable to the situation of the control group of German citizens characterised by dense intergenerational contacts, but with two differences. First, the proportion of the elderly, mainly widows, living with offspring is much higher than in the German sample. Second, on average the number of offspring in each family is higher than in the German sample.

A qualitative study on the long-term care situation in Turkish migrant families revealed a strong emphasis on family responsibility, especially with regard to daughters/daughters-in-law, which is based on cultural ideas and socio-structural resources (see Lorenz-Meyer/ Grotheer, 2000). While home-based care was generally accepted, institutionalised care was seen as something that should be avoided. Existing home-based care services and residential care facilities in particular are only rarely adapted to the cultural ideas of different migrant groups. In a situation of a limited availability of culturally-sensitive care services, the provision of a cash payment to support family care tends to strengthen the care-giving responsibilities of the daughters/daughters-in-law. The traditional assignment of care responsibilities to these relatives will create increasing conflict with the more employment-oriented younger generation in the near future.

5.3 Regional inequalities

Finally, the use of care services is also influenced by regional factors. The introduction of a care market based on quality and price competition resulted in different regional care infrastructures. In their comparison of care infrastructures on district levels (Kreise), Rothgang and colleaques (2009) found significant differences with regard to three dimensions; First, available home-based service providers and residential care facilities; second, take-up rates of both types of services; and, third, the cost of care services (for the following see Rothgang et al., 2009). Related to the age structure of population, with those of 50 years or older, and related to the number of care dependents using home-based care services, the number of professional carers is significantly higher in districts in the new federal states than in the old federal states. With regard to residential care facilities the situation seems to be different. Calculated on places per population aged 75 years and older in residential care facilities, there is no distinct difference between the new and old federal states. Districts with the highest number of places are to be found in Schleswig-Holstein, Lower Saxony, Mecklenburg-Western Pomerania, Brandenburg and Northern Bavaria. However, in contrast to home-based care provision, the quota of care staff in residential care facilities in the new federal states is (much) below the quota in the old federal states, which may indicate an under-supply with care staff.

In general take-up rates correspond with the available capacity of home-based or residential care facilities (see Rothgang et al., 2009). In the new federal states (with the exception of Berlin) wide-spread use of home-based care services and a more limited use of residential care services complement each other. In the federal states of Berlin, Hamburg and Bremen the use of home-based care services is also above average, which is complemented in Hamburg with a further high level of residential service use, while cash payments are more prevalent in Berlin and Bremen. In Bavaria and Baden-Württemberg the use of residential care provision dominates home-based care provision. In Hesse and Rhineland-Palatinate where home-based and residential care provision are both more rarely used, cash payments are dominant.

Finally, the costs of home-based care provision and residential care services differ markedly between the federal states. Within home-based care provision, 80% of care offers are organised as care packages offering precisely defined activities, including defined care tasks related to one activity, e.g. comprehensive bodily care. In LTCI care offers care packages and their prices are negotiated between care providers and their organisations or associations and care insurance funds. Competition on prices and quality of care offers was established to develop a cost-efficient and high-quality care infrastructure. However, competition on in the care market has led to considerable price differences between regions. In general, both with regard to home-based and residential care services, care services are far less expensive in the new than in the old federal states (overview on average costs for care provision on regional level see appendix tables 2 and 3). Price differences can be explained by lower wages of care workers and quality differences of services, i.e. mainly staff quota in residential care service and partly by a different composition of care packages within home-based care services. In addition, mostly private, for-profit providers started to pay wages for carers below tariffs, which has been followed by a partial wage decline even within non-profit providers (Augurzky et al., 2007; Buestrich et al., 2008; Dahme/Wohlfahrt, 2007).

The different price structures influence the demand on care services. Within home-based care services, beneficiaries mainly purchase care provision within the limit of the lump sum benefit and try to avoid private out-of-pocket costs (see section 5.2 above). More low-price home-based care provision in the new federal states may explain the higher demand for home-based care services. In contrast, the use of residential care services is also related to the level of unemployment and thus to the available informal care potential. In the new federal states in general, and despite the low prices of residential care services, the high level of unemployment reduces moves into residential care facilities (Rothgang et al., 2009).

The stated regional differences raise significant ethical questions. Within the LTCI framework equal benefits are granted throughout the country to provide equal support in defined situations of care dependency. Price differences between regions result in very different ranges and quantities of care services available to beneficiaries on the same level of care dependency. Furthermore, the different quality of care services, e.g. staff ratio, also questions the basic idea of equal access to equal public support within LTCI.

5.4 Situation of informal carers

The German law on LTCI focuses on the priority of domestic care and especially aims to support and maintain informal family care. As a consequence several regulations–financing of informal care provision, social policy regulations and different types of leaves–were introduced to support care giving within family framework. Cash benefits on a lower level – meant as a financial compensation but not wages – are available to support informal care-giving (for the level of benefits see table 1 in the appendix). This amounts to approx. €4-5 an hour (Pfau-Effinger et al., forthcoming). Cash benefits are paid to beneficiaries themselves to strengthen their position within care provision. Beneficiaries may thus decide how to use the cash benefit. In addition, due to the idea of care within family framework, there is no official care contract with defined care tasks, number of hours etc.. Despite a low regulatory level, cash benefits are mainly used to pay a nominal sum for informal care provision, in particular to offspring or neighbours. Related to spousal care, cash payments are mainly viewed as a part of the household income (Evers, 1997; Heusinger/Klünder, 2005). Cash payments provide informal carers with an incentive to carry out informal care-giving only in difficult life situations, for example, in a situation of unemployment (Heusinger/Klünder, 2005; Schneider/Reyes, 2007).

Several social policy regulations aim to secure informal care provision (see also Pfau-Effinger et al., forthcoming). For informal care activities of at least 14 hours a week (and up to an employment of 30 hours a week) pension credit points on an average wage level are available, which are in fact oriented towards women with lower or medium qualification levels (Schneider/Reyes, 2007). Informal carers are covered by accident insurance schemes. On the other hand, they are not independently covered by social health care insurances nor by unemployment insurance schemes despite the right of the care recipient to change arrangements. Indeed the care recipient may die.

Respite care based on professional services or informal care provision of to four weeks a year are available to cover holiday or sick leave for informal carers, a further four weeks a year are available in a situation of crisis in care arrangements (see benefits see appendix table 1). During these periods informal carers do not receive any cash payments. The Nursing Care Time Act in 2008 established two leave schemes. One scheme grants a ten-day unpaid leave when a sudden need for care (re)arrangement arises. The second allows carers to interrupt their employment on an unpaid basis for up to six months, which can complemented in certain cases by coverage of unemployment insurance and health care insurance. The entitlement only applies to employers with at least 15 employees. During the leave employment is protected and dismissal is not possible. Both regulations have been heavily criticised for lack of compensation during leaves (Rothgang, 2010).

Informal care provision is still a female dominated area. In a representative survey including population 40-85 years 15% of women and 8% of men report that they provide long-term care in private households in general. Representative statistics on main informal caregiving for LTCI beneficiaries revealed female dominance, however, related to changing gender patterns in care provision. The proportion of women among main informal carers was 73% in 2002, and thus already a reduction compared to 83% in 1991 (Schneekloth, 2006). 60% of the main informal carers were 55 years or older with an average age of 59 years and were either partners (28%) or daughters/daughters-in-law (32%) of the care recipient. While the inroads made by men is mainly related to care of a spouse, even the proportion of sons acting as a main informal carer increased between 1991 and 2002 from 3% to 10%.

Research on the situation of informal cares revealed a complex picture of rationalities, care burdens and consequences. Based on a Eurobarometer inquiry in 2002 63.4% of German participants would recommend family care provision for their parents, while 25.4% recommend home-based care provision and a further 11.4% residential care services (Alber/Köhler 2004). According to a more recent representative survey, carried out by Health Monitory in 2007, 89% of all participants reported that, they prefer to organise care privately as long as possible, while 11% prefer care given within a residential care facility. Adherences of the upper socio-economic classes and younger populations (18-39 years) report significantly more often that care provision should be organised outside the family framework, e.g. within residential care facilities (Bauer, 2008). Within the family framework about 60% vote for a mix of formal and informal family care provision (Bauer, 2008 see section 5.2 above). Informal care provision is increasingly based on positive feelings or reciprocity, while the idea of care-giving as a moral duty remains strong. In a representative survey with LTCI beneficiaries and informal carers in 2002 62.3% regarded care provision as a moral duty in a marriage and 52.1% as a moral duty related to further family members (Runde et al., 2003). According to the Health Monitory in 2007 the inclination of informal care-giving arose less from financial interests, e.g. cash payments available or the need to avoid the costs for care services but more from feelings of solidarity (Bauer, 2008).

Rationalities for care-giving are strongly related to experience of a care burden. Research showed that informal carers taking on care tasks based on positive feelings of solidarity felt less (over)burdened than informal carers who cited moral duty or financial reasons for their decision (Reißmann, 2005). Feelings of moral duty may help to explain the high proportion of informal carers (up to 80%) who report being burdened or overburdened by care provision tasks (see. e.g. Runde et al., 2003; Schneekloth, 2006). A further reason for the high proportion of overburdened carers may be the sheer extent of the task. In a representative survey informal carers reported providing an average of 5 hours informal care a day (Schneekloth, 2006). In a European comparative study EUROFAMCARE the readiness to take on care responsibilities was significantly lower in situations where carers felt less emotional attachment and higher feelings of obligations. Moreover, readiness to continue with further informal care-giving depended on the level of support either by professional or paid care or further informal carers (Döhner et al., 2007).

In international comparative studies, time-intensive care provision has proved to generate negative consequences for informal carers in particular (Costa/Ranci, 2010; OECD, 2011). Costa and Ranci (2010) used Eurobarometer (EU 15) to analyse the consequences of different levels of the intensity of informal care-giving. They distinguished between informal care-giving with low intensity (up to 14 hours a week), medium intensity (15 to 27 hours a week) and intensive care-giving (over 27 hours a week). They found that medium and intense care-giving impact negatively on labour market participation, household income and social integration. Medium and intense informal care is more often accomplished by women, particularly by those with lower educational levels (Costa/Ranci, 2010). The OECD study also reveals that in Central Europe in particular, intensive care-giving (over 20 hours a week) was related to decline of employment and even mental health problems (OECD, 2011). The report states that intensive care-giving is related to further disadvantages such as older age, lower level of education or lower level of income.

6. Funding: Basic features, concepts and reform developments

The introduction of LTCI aimed to provide a sound financial basis for public support related to long-term care needs. The definition of mode of funding and the construction of basic features take a prominent position in the course of policy-making. Besides a sound financial basis, principles of funding should significantly contribute to cost containment policies. In the following section we trace the discussions on mode and principles of funding and the basic features of the insurance scheme. Predictable societal developments, such as demographic ageing, but also the financial development of social LTCI have fed a new debate on a sustainable funding scheme since 2000. The reasons, concepts and related arguments put forward in this new debate and the central actors will be discussed. Finally, the concepts are assessed against their capacity to provide a sustainable protection of the risk of care dependency.

6.1 Policy-making and basic funding principles of LTCI

With the introduction of LTCI the tax-based social policy scheme towards long-term care needs based on means-testing was replaced by an insurance based near-universal scheme divided in two branches. Beginning in the late 1970s risks of care dependency and the lack of public support triggered a long, intense societal debate around the issue of social rights embedded in an adequate, sustainable funding scheme (Meyer, 1996). Ever increasing costs for residential care at local levels within the framework of the Federal Law of Social Assistance finally provided the main incentive for the establishment of a new pillar within the German social insurance system in 1995/96 (Campell/Morgan, 2005).

In the course of the 1980s political parties, social partners or governments of federal states developed proposals and established first regulations on a federal state level. On the federal level Social Minister Norbert Blüm argued for a limited expansion of benefits for domestic care within the framework of health care insurance and called on private insurance companies to establish private insurance plans related to institutional care services. Due to the expected high costs of institutional care services, private insurance plans should cover this type of care services (Meyer, 1996). First care plans had been established by private the private sector in the 1980s but take-up rates remained very low. At the introduction of LTCI only 300,000 people had signed private care plans, while 80% of residents in institutional care facilities relied on social assistance support (Hauschild, 1994; Rothgang, 1997). Furthermore, from the end of the 1980s first laws on the federal level granted universal support in strictly defined risk situations. With the Health Reform Law of 1989 the cost for respite care for informal carers could be refunded and, following the 1991 reform, a limited group of very frail people became eligible for cash payments or in-kind services within the Statutory Health Insurance Scheme. The health care related schemes were abolished with the introduction of the LTCI.

The final construction of the funding scheme can be viewed as a compromise reached by political actors on federal and federal state levels and further social actors, e.g., social partners embedded in a distinct institutional framework (see also Meyer, 1996; Theobald, 2011). During the debate the necessity to establish a sustainable funding scheme was combined with ideas on the balance between individual and collective or public responsibility. The latter ideas are reflected in a controversy between a social insurance or tax-based solution (emphasizing collective responsibility and solidarity) and a more market-oriented solution based on voluntary or mandatory private insurances plans (for the essential features of the perspective of different actors see Meyer, 1996; Behning, 1999).

Left-wing oriented political or social actors contrasted the options of a tax-funded long-term care system versus a social insurance-based system. Both concepts were built on a broad agreement on the significance of public funding based on solidarity. Proponents of a universal tax-funded system, for example Social-Democrats on a federal level or politicians of the Green Party, emphasized the advantages of general solidarity in a tax-funded system. They advised against the difficulty of common solidarity in an insurance based system, which enables more affluent citizens to withdraw from solidarity by using distinct insurance schemes. Furthermore, they referred to the progressive character of taxes and the consideration of different types of incomes, whether from rents, leases or stock market trading in addition to earned income. The left-wing proponents for a social insurance system, e.g. Social- Democratic Party on the federal states levels or most of the unions agreed with the arguments, but pointed out the strong position and advantages of insurance holders based on insurance contributions, where contributions are directly related to benefits. Furthermore, they emphasized the cultural dominance of a social insurance system in Germany's social policy tradition. As a compromise they proposed strengthening public support by defining universal social rights and expanding membership in social insurance schemes, for example by raising the social security contribution ceiling.

The Liberal Party in office with the Christian-Democratic Party on the central level, employers' organisations, the private insurance sector, the economic wing of the Christian-Democratic Party and, initially also the federal state Baden-Württemberg, favoured a private insurance solution emphasising individual responsibility. The goal to reduce tax-based social assistance expenditure at local levels, however, cast doubts on the potentials of a voluntary private insurance scheme. In the course of the debate a concept of a mandatory private insurance scheme emerged, which included elements very close to a social insurance system, e.g. obligation for the private insurance funds to contract whole population, non-use of risk-oriented contributions based on gender or health to enable universal access to the insurance scheme, the insurance of children without contributions, etc. Due to the increasing similarity between both types of insurances, discussion shifted to the issue of the mode of funding; i.e. a pay-as-you-go or a capital-funded system. The proponents of the latter pointed to demographic changes as a fundamental difficulty for a pay-as-you go financed system. The establishment of a capital-funded system, however, required the introduction of an additional tax-based policy system to reduce current social assistance costs on local levels.

In 1990 Norbert Blüm, the Christian-Democratic federal social minister, proposed for the first time for a social insurance system related to the health care insurance funds (for the essential features of the perspective of different actors see Meyer, 1996). Simultaneously, the Social-Democratic Party and the Green Party also voted for a social insurance solution instead of a tax-funded system. Due to the expected high fiscal burden stemming from the reunification, the funding of a tax-based system seemed to be unrealistic. The proposal of Norbert Blüm's proposal met with strong resistance from the employer association, private insurance industry, the Liberal Party and the economic wing of the Christian-Democratic Party. In September 1991, the executive committee of the Christian-Democratic Party concluded the introduction of a social insurance scheme, albeit one that granted only basic coverage. As the Council of the Federal States had to approve the new law, a working-group was set up with (social-democratic) members of the Council of the Federal States and representatives of the federal Ministry of Social Affairs–in fact a Grand Coalition–to work out a proposal.[2] In 1992, owing to the increasing pressure of the Christian-Democratic Party, the Liberal Party agreed to a social insurance scheme that emphasised individual responsibilities and the role of the market (see below).

With the starting-point of a social insurance scheme, further strategic decisions were made to combine ideas on public and private responsibilities, solidarity and to ensure cost containment goals:

- In Germany, social insurance contributions are traditionally shared in equal parts by employers and employees. In this case, supported by the Liberal Party the employer organisations were successful in gaining the abolishment of a bank holiday for their share of the contribution, which meant a considerable departure from the German social insurance system (Landenberger, 1994). The abolishment of a bank holiday was accepted as a compromise a year of negotiations between the unions and Social-Democratic Party on one hand, and the federal government and the employer organisations on the other. The latter had initially proposed the

---

[2] At the time the Conservative-liberal government did not hold a majority in the Council of the Federal States and had to negotiate the shape of the new policy scheme with the Social-Democratic Party.

introduction of waiting days in health insurance compensation, which met with strong resistance (Meyer, 1996). The norm of shared contributions by employers and employees is still widespread in German population. According to a representative survey in 2011 64% of members of social LTCI demanded a contribution of employers to the rising costs of LTCI in future reforms (Zok, 2011).

In contrast to the statutory health insurance system, a standard contribution rate to the insurance was fixed by law (1.7% of gross-earnings up to a certain threshold) valid for all social long-term care insurances funds. Due to different membership structures and corresponding different levels of long-term care risks within social LTCI funds, the stipulation of a standardized contribution rate for all social insurances required the establishment of a defined (monthly) procedure to balance the different costs for long-term care provision per month (see Rothgang, 2011).

- The contribution to social LTCI funds was defined as a ceiling of expenditure, thus making public support available, i.e. in principle a rise in expenditure is only possible based on an increase of aggregate wages. Contribution rates should only be raised to balance the impact of demographic changes. The insurance funds were made responsible for the negotiation of care offer tariffs and care rates in residential care facilities. The insurance funds were obliged to negotiate cost-efficient prices to avoid an increasing gap between lump-sum benefits and costs for care service provision. The definition of the ceiling was strongly driven by the cost containment goal of the insurance scheme and also reflected the more critical attitude towards welfare state expenditure in general that dominated the debate in the early 1990s.

- With an eye to strengthening redistribution, a wide range of actors supported a social insurance scheme that covered a high proportion of the population at the start of the negotiations (for the following see Meyer, 1996). In the process of policy-making the Liberal Party invited representatives of private insurance industry in 1993 to present their ideas on private insurance plans to the Christian-Democratic and Liberal federal government. Both coalition parties agreed on the role of private insurance funds. According to the agreement reached it would be mandatory for members of the social health care insurance to be insured under social LTCI and mandatory for members of private health care insurances to be insured by private LTCI. To gain acceptance for their proposal the private insurance sector agreed to a wide range of regulations typically related to a social insurance fund, e.g. no insurance contributions for children, the insurance contribution rate stipulated by law providing the ceiling for contribution rates defined by private insurance funds, adoption of care dependency and benefit levels from social LTCI, as well as the introduction of mechanisms to balance costs between private insurance schemes (due to their different risk structures).

The introduction of a mandatory private insurance for members of private health care insurance funds meant considerable advantages for private insurance companies (see Meyer, 1996):

- Mandatory assignment of members of the private health care insurances creating and stabilizing private market in the area in the future.
- Solid growth of volume of business
- Additional opportunity to establish complementary insurance schemes promising long-term profits.

6.2 Financial development and reform debates since 2000

One main goal for introducing LTCI was to reduce public costs related to long-term care within social assistance scheme and partly within health insurance funds. As projected, the establishment of LTCI meant a reduction of social assistance costs on local levels–from €9 billion a year in 1994 to €3.5 billion in 1997 and within the health insurance system with an estimated approx. €3.3 billion due to the abolition of the long-term care support and the reduction of hospital days (German Federal Parliament, 2003; Federal Statistical Office, 2010). Despite the reduction, the introduction of LTCI resulted in a considerable expansion of the available funds, with €15.94 billion within the framework of the social LTCI and €2.1 billion within the framework of the private LTCI in 1997 (see appendix table 4).

Since 2000 three significant issues have triggered a new debate on the mode of funding, mainly with regard to the social LTCI (see Rothgang, 2006; 2007).

- Financial development within social LTCI

Since 2000, in some years expenditures within the framework of LTCI exceeded revenues based on insurance contributions, which contradicted the goals and the regulations within the policy scheme (see table 4 in the appendix). The resulting deficits reflect an income problem and are not related to the development of expenditures, i.e. between 1997–2004 the increase of expenditures of LTCI was below the annual inflation rate. The difficulties are related to developments on the labour market–with aggregate wages determining the basis for contributions–and social policy changes. The low increase of aggregate wages since 2000, the reduction of social security based standard employment and reforms of labour market policy colluded to produce a low increase of income (Rothgang 2006, 2007).

- Demographic developments: Population ageing and reduction of informal family care potential.

The risk of care dependency is strongly age-related. An analysis of age-related prevalence 1999–2007 brought a mainly stable risk of care dependency with only a small decline for both women and men in general, albeit related to an increased assignment of beneficiaries to the less costly care dependency level one. This could either be explained as a result of stricter assessment procedures or as a (weak) indicator for compression of morbidity (Rothgang et al., 2009). Under the premise of stable age-related rates of care dependency and an ageing society Rothgang (2004) estimated a rise in the number of cases of care dependency with 160%-180% between 2000 and 2040. Furthermore, increasing female labour market participation, the increase of single households and a decline of the norm of long-term care as a familial obligation will result in a reduced family (female) care potential and will be followed by the decision on the more costly care service benefit (Runde et al., 2003; Blinkert/Klie, 2004; Rothgang et al., 2009). Against the background of societal developments and based on the premise of an average annual wage increase of 3%, Rothgang and colleagues (2009) estimated only a modest increase of insurance contributions for the long term.

- Adjustment of benefits to the increasing costs of care provision and improvement of benefits, particularly concerning dementia conditions

Demographic and social changes will endanger the financial sustainability of social LTCI. However, the above calculations are based on unchanged benefits and do not therefore consider the rising costs for care service provision. With constant benefits the purchasing power of thereof will be reduced by 50% in 2040 and thus delegitimise the insurance (Rothgang et al., 2009). From a long-term perspective insurances benefits have to be adjusted to the increasing costs of care services. Furthermore, people suffering from dementia do not receive adequate support and there is an agreement in society that public support has to improve. Adjusting or improving benefits for dementia sufferers requires reforms of the mode of funding to secure financial sustainability of social LTCI in the future (see Rothgang et al., 2009, Rothgang, 2011).

6.2.1 Reform concepts

Public deficits, demographic and social changes, and the necessity to adjust and improve benefits inspired a societal and academic debate on sustainable mode of funding into the future. As was the case in the course of the establishment of the original policy scheme, the different strategic options for reforms also reflect normative ideas. In the following we will outline and discuss basic ideas of significant proposals. In the course of the debate two basic concepts can be distinguished; the introduction of a "citizen`s insurance" (Bürgerversicherung) and the introduction of a (complementary) capital-funded element with a partial shift to a private insurance scheme.

6.2.1.1 Introduction of a citizen`s insurance

With the introduction of LTCI, two branches of a mandatory insurance were established:a social LTCI (87.8% of population in 2007) and a private LTCI (10.6% of population in 2007) (Rothgang, 2011). Membership within an existing health care related insurance scheme was declared mandatory with free choice only for the members staying voluntarily within social LTCI (4.5% of population in 2007 with an income above the social security contribution ceiling) (Rothgang et al., 2010; Rothgang, 2011). The financial development in each branch has differed widely since the introduction. While financial development within social LTCI was characterized by deficits in certain years since 2000, over the same period development within private LTCI has been characterized by low level of expenditure and a marked surplus (see table 4 in the appendix). Due to these differences, by 2008 the steadily increasing reserves of private LTCI amounted to €18 billion, while by 2008 the reserves of the social LTCI had dropped by €4 billion (Rothgang ,2011).

The contrasting development is not caused by the level of insurance contributions but by distinct levels of expenditure. In 2008, long-term care-related expenditure per member within social LTCI amounted to €241 p.a. in contrast to €60 and €121 p a. respectively, when the direct financial contribution of the state for civil servants is considered within private LTCI (Rothgang et al., 2010). The distinct levels of expenditure can be explained by the different risk structures of members of both branches of insurances, with a considerable smaller proportion among the members receiving benefits within private LTCI compared to social LTCI (Theobald, 2004; Gasche, 2007; Rothgang, 2011).

Besides age, the risk of care dependency is strongly related to socio-economic status, with adherences of the lower socio-economic strata being more at risk of becoming care dependent (Theobald, 2004; Borchert/Rothgang, 2008; Rothgang et al,.2010). An age-related comparison of membership of social LCTI and private LTCI in 2008 found that in all age-groups up to 90 years the risk of care dependency is considerably higher for members of the former insurance than the latter. Under the premise of the same age-related level of care-dependency the number of care-dependent members within private LTCI would increase to 51%. The younger age structure of members within private LTCI contributes to but is not decisive for the lower level of expenditures (Rothgang, 2011).

Due to the more favourable risk structure within private LTCI, the level of average insurance premiums is 204€ per month in private insurance schemes compared to 246€ in social LTCI. In contrast, the members of private LTCI can draw on approx. 50% higher premium-relevant average gross earnings. In 2005, private LTCI members were able to cover their expenditure with insurance contributions of 0.6% of gross earnings, in contrast to social LTCI with 1.8% of gross earnings (Rothgang, 2011).

The different risk and income situations of members of private and social LTCI causes ethical problems in an insurance which is meant to be a universal insurance scheme divided in two branches. It triggered an intense societal debate on how to balance the different risk and financial situations of both insurances, which resulted in calls for a "citizen's insurance" (Bürgerversicherung) (cf. Theobald, 2004; Lauterbach et al., 2005; Rothgang, 2007, 2011). The debate on a construction of a citizen insurance focused on three different models:

- the whole population should be included within one social insurance scheme to avoid the construction of two branches with two different risk groups.
- in addition to wages earned, other sources of income (rents, stock market trading, etc.) should be taken into account for the calculation of insurance contributions to become more independent of the development of aggregate wages.
- due to legal difficulties to establish one social insurance scheme the alternative of a transfer of balance payments from the private to social LTCI is discussed to the order of €1 to €2 billion.

The development of a citizen's insurance is also meant to contribute to the development of a sustainable funding in social LTCI in future and to provide resources to improve long-term care for dementia sufferers. Critics did not believe that the introduction of a citizen's insurance would solve financial problems in the long run and that such a measure could not, therefore, deliver secure sustainable financing (see e.g. Häcker/Raffelhüschen, 2007).

6.2.1.2 Introduction of capital-funding

In particular, the issue of an ageing population fostered a debate on the advantages of a capital-funded long-term care policy scheme. Available concepts for capital-funding can be distinguished related to several dimensions. First, they propose either a general system shift from a pay-as-you-go financed to a capital-funded system or to build up a complementary capital-funded element. Second, they suggest the assembling of a collective capital reserve or an individual capital stock, which can be established within social LTCI funds and private insurance funds. Third, wage-related or flat rate insurance contributions can be collected. In the following I will outline and discuss the main proposals in debate, which are made up of distinct combinations of the dimensions.

At the beginning of the debate the issue of a complete system shift from the pay-as-you-go financed system to a capital-funded system, where costs for long-term care provision are paid by a capital stock, were at the centre of the debate (see e.g. Nachhaltigkeitskommission, 2003). The proponents of a complete shift cited two advantages of a capital-funded system: greater independence towards demographic changes and thus more inter-generational justice (for the following see, e.g. Häcker/Raffelhüschen, 2007; Rothgang, 2009; Hagen/Lamping, 2011). The concept was greeted with a wide range of critical arguments. The main argument put forward against a complete system shift was the necessity to finance present long-term care needs of older population. All calculations showed a high economic burden–a double burden–and thus questioned the concept of a complete system shift.

More recent debate has focused on capital-funded elements as a complement to the existing pay-as-you-go financed insurance system. In general, a capital-funding element should create an economic buffer to meet the increasing financial needs of an ageing population. Concepts of complementary capital funding differ widely based on the dimensions of collective versus individual capital-funds, voluntary or mandatory complement, within social LTCI funds or based on private insurance schemes, or wage-related or flat-rate premiums. The proposals range from a mandatory collective capital-funding within social LTCI and based on wage-related premiums all the way to voluntary individual flat-rate premiums, which may even be risk-based within private insurance schemes (see e.g. Gasche, 2007; Rothgang, 2007, 2009; Hagen/Lamping, 2011).

The establishment of a complementary collective capital stock aims to build up a demographic reserve, i.e. a reserve, which can be used to contain future rises in insurance contributions due to demographic change (see Gasche, 2007; Rothgang, 2007; 2009). The reserve–capital stock–could be established within social LTCI based on additional wage-related or flat-rate insurance contributions to create a surplus of contributions, which could be used should insurance contributions not be enough to cover expenditure. Depending on the construction of the additional contributions, the reserve could be allowed to offset costs within a prescribed time period. However, a sustainable solution requires a stable flow of additional funds (see Rothgang, 2009).

A further approach, which was put forward by the association of private insurance companies and the Social Minister of Bavaria Christa Stevens, aims to establish a mandatory complementary private insurance scheme to build up a complementary capital stock (see Rothgang, 2009). This concept foresees a freezing of the level of benefits within LTCI and the introduction of a mandatory complementary private insurance scheme. Based on the revenues of the private schemes a capital stock will be built up and an additional 2% p.a. should be available to adjust benefits to the increasing costs for care provision. The premium should be based on a flat rate with a starting-point of €6 per month and an increase of €1 p.a. In essence, the concept enables the creation of a dynamic a capital stock to relieve the increasing financial burden in the future. According to Rothgang (2009) the concept contains of three major shortcomings.

First, depending on the level of the adjustment of benefits from 2030-2045, all additional benefits will be needed to finance adjustments and it would not be possible to build up further a capital stock either. Comparable to the collective capital stock within LTCI, the capital stock will only contain cost increases over a specific period of time. Second, from 2040 on, when the private insurance scheme would become the main insurance basis, a second administration would have to be established to negotiate contracts with providers, etc. The result would be a duplication of administrative costs and considerable coordination problems. Third, flat rate premiums are not meant to be balanced by public support, e.g. via taxes. The concept would thus be a considerable burden to those on lower incomes.

Apart from collective capital stocks individual-based capital stocks are being discussed in order to create a funding reserve within the framework of social LTCI or private insurance funds (for different models see Gasche, 2007). One recently proposed concept is the establishment of a "Care-Riester” (Pflege-Riester). This system is modelled along the lines of complementary capital-funded schemes introduced within the area of pensions (so-called Riester bonds). Based on Care-Riester, an individual capital stock could be built up voluntarily within the private insurance industry to complement public support in the future. Research on the spread of Riester bonds within pension schemes, however, reveals that only 50% of potential applicants have actually signed up to this type of security (see e.g. Hagen/Lamping, 2011).

6.2.1.3 Reform actors and processes

The concepts have been brought into political debate by different political and social actors. The Christian-Democratic and the Liberal parties, together with employer organisations, favour a capital funding model or at least the introduction of an additional capital-funded component. The Social-Democratic, the Green and left-wing parties, together with unions and the left-wing welfare associations vote for the development of a citizen's insurance (see above). In the coalition contract of the Grand Coalition, both coalition partners agreed to introduce a capital-funded demography reserve and to transfer payments between private and social LTCI to balance the different risk structures. Neither proposal came to fruition. In order to improve the financial situation of social LTCI, to enable the adjustment of benefits and to improve public support for people suffering dementia illness, the Grand Coalition introduced an increase of 0.25% in the contribution rate to 1.95% of gross-earnings–the first general increase since the introduction of LTCI in 1995/96. Previously, in 2005, based on a judgement of the Federal Constitutional Court the insurance contribution was raised by 0.25% for childless adherents. The general increase of contribution rate was expected to secure a sound funding despite adjustment of benefits in 2008, 2010 and 2012 until 2014/15 (on the adjustment of the benefit levels see table 1 in the appendix; MDK Bayern, 2008).

Based on a proposal of the liberal minister Daniel Bahr in November 2011, the Christian-Democratic-Liberal coalition, the insurance contribution rate will be increased by 0.1% from January 2013 to improve benefits to dementia sufferers. There is no further information on what type of improvements this will deliver, whether and how the new definition of care dependency will be introduced and financed etc. (see sections 3 and 4.1 above). Furthermore, the proposal suggested the introduction of a voluntary Care-Riester, i.e. the introduction of individual-based bonds within private industry, which would be publicly supported by tax deductions or transfers. The suggestion is congruent with liberal ideas on the mode of funding. No further information on the construction of the Pflege-Riester is available.

6.2.1.4 Discussion of the different dimensions of the concepts

Against the background of the risk of care dependency and attitudes within population, dimensions of reform concepts will be discussed and assessed on their capacity to secure universal long-term care provision and sustainable funding. Significant for the assessment of the concepts is the analysis of the dimensions of the risk of care dependency. The risk of becoming care dependent is spread differently in society. Based on present calculations about half of the population is at risk of becoming frail, whereof defined risk groups are over-represented (see section 4.1 above). People in the lower socio-economic classes and women based on health status, as well as people living on their own, will more often need long-term care provision. Furthermore, the time-period differs widely, ranging from beneficiaries in need of long-term care support in a very short period of time up to very long time periods for some beneficiaries, e.g. people with dementia conditions.

In the following the features of risk structures will be used to assess advantages and shortcomings of significant dimensions of the concepts:

Social versus private (insurance) schemes

Against the background of the risk structure payable, sustainable funding schemes that cover the risk of care dependency universally require considerable space for redistribution of funds among population. The introduction of two branches of LTCI already restricted leeway for redistribution and resulted in very distinct financial development patterns. Based on this, sustainable funding schemes should, ideally, be comprehensive and include populations as a whole. Furthermore, within private insurance schemes risk groups in society will either encounter marked difficulties to find a private insurance fund that will accept them or they will have to pay very high insurance premiums. As a consequence they will be uninsured or considerable tax-based support will be necessary to balance the premiums.

Voluntary versus compulsory schemes

Research related to Riester bonds within pension schemes shows that only 50% of potential applicants sign different types of bonds (see above). Based on voluntary, mainly private insurance plans there is a risk that some groups in society will not to be protected. According to a representative survey in 2011, only 18.1% of members of social LTCI had signed complementary private insurance plans; a further 24.7% are interested, but groups in need of long-term care provision, e.g. with chronic illness or with low incomes are below the average (Zok, 2011). In a situation of care dependency, long-term care provision requires a certain level of funding. While in the area of pensions economic differences among populations are widely accepted, this is not the case within the area of health care. In a representative inquiry of 2006 only 13% of population agree to the statement that people with higher incomes should receive better health care services, while 70% accept that people with higher earnings should receive higher pension benefits (Nüchter et al., 2008). In the long run, a voluntary insurance scheme will increase tax-funded social assistance costs and thus will question the necessity to sign private care plans.

Flat rate versus wage-related or income-related payments

Flat rate or even risk-oriented premiums will burden the population with lower incomes if tax-based transfers do not balance their economic situation, the latter, however, related to a considerable burden for the public budget. Furthermore, the consideration of further sources of income**,** such as rents or profits from stock market trading, will reduce the dependency of premiums from aggregate wage developments.

Pay-as-you-go financing versus capital funding

Capital funding has mainly been discussed as a complement to a pay-as-you-go financed system. In addition to the general argument of the insecurity of capital stocks (based on the experiences of the financial crisis) complementary capital funding elements can only be effective if they are organized in a mandatory manner, as a collective capital stock within social LTCI and based on at least wage-related premiums to ensure leeway for redistribution, to relieve the public budget and, in the German situation, to avoid a double administrative structure (see above).

In conclusion, sustainable funding of universal protection in a situation of care dependency in the German system is based on dimensions such as compulsory and comprehensive collective funding schemes, wage-or income-related premiums and may only be complemented by capital funding elements. The population as a whole and members of social LTCI support ideas on a solidarity funding scheme within LTCI. In a representative inquiry in 2006, 81% of population in the new and 79% in old federal states endorse wage-related insurance contributions and based on this, equal benefits for the whole population (see Nüchter et al., 2008). Roughly two-thirds of the population in new and old federal states support an increase of insurance contributions, if necessary to maintain the level of benefits. About 70% of population in the whole of Germany favours a consideration of all sources of income including wages, rents, stock market trading, etc., as a basis for insurance contributions. Finally, in a representative survey of members of social LTCI, 68% advocate the abolishment of the separation between social and private LTCI (Zok, 2011). Finally, quite apart from all policy design discussions, what is most significant for sustainable funding is economic development and developments in the labour market as financial basis for insurance contributions.

7. Conclusion: Universalism, cost containment, family care and (in)equality

With the federal law on LTCI in 1995/96, Germany established a new insurance-based policy scheme to provide public support in situations of care dependency valid in the whole country. The LTCI was negotiated between the federal government, the Council of the Federal States, which must approve the law, and further social actors, in particular employer organisations and workers' unions. The construction of LTCI strived to combine universalism, cost containment and ageing in place embedded in family support. These three goals are embedded in a distinct mix of private, family and public responsibilities that are reflected in the definition of a distinct type of universal rights, funding principles and regulation of care provision.

A strict definition of social rights in long-term care, i.e. with regard to the threshold, level of public support and the mix of types of benefits, aimed to reduce the expected high public costs related to a universal policy scheme. Funding principles, above all the introduction of a ceiling with regard to spending, should further contain public costs. Finally, an emphasis on informal family care embedded in market-oriented, cost-efficient care services should keep down the costs for care provision and thus contribute to cost containment.

Based on the universal principle of LTCI the number of beneficiaries increased considerably, with 11.5% of 65+ receiving benefits in 2009. According to the LTCI definition of care dependency, about half of population will become care dependent during their lifespan–for an average of 4 years for women and 2.5 year for men–albeit at markedly different intervals and for different lengths of time. The risk of becoming care dependent proved to be clearly related to age, living situation and health status, while, in turn, living situation and health status is related to gender and socio-economic class. Despite strongly regulated assessment procedures, results are influenced by the socio-economic class and migrant background of applicants, for which there is no convincing explanation at the moment.

The use of the different types of benefits indicates a largely family-oriented care strategy with a gradually increasing involvement of professional care services. A more detailed analysis of the use of benefits and care arrangement patterns revealed a double structure of care provision. We find a mix of professional care services concerning bodily care complemented by the use of further services or household assistance on the one hand, and care arrangements based solely on informal care provided by the family or wider social networks on the other. The interrelationship of the two patterns with gender, socio-economic class and migrant background–with men, members of the (upper) middle classes and Germans the more frequent users–can be explained by a mix of economic circumstances (private costs for services, opportunity costs for employment interruption) and cultural values related to the role of the family within care provision. Furthermore, the market-orientation of care infrastructure based on price competition resulted in a regionally stratified care infrastructure. This stratification is related to the capacity of the available care services, their quality based on staff ratios, the prices for care services and take-up rates. In particular, with regard to home-based care services, the prices for care packages determine the volume of care services used. The regional impact on the care infrastructure runs counter to the LTCI's basic goal of “equal public support defined by care needs throughout the country”. Equal benefits throughout the country has led to different levels of service support depending on the region.

The mode and principles of funding were defined in lengthy negotiations that weighed up tax-funded, social insurance and private insurance schemes. A funding scheme was eventually established based on two LTCI branches comprising a social and a mandatory private insurance, with insurance contributions stipulated by federal law defined as a ceiling for spending within social LTCI. In contrast to the social insurance tradition in Germany, employers were compensated for their contribution with the abolishment of a bank holiday. The financial development of social LTCI, expectations on population ageing and female labour market participation, the requirements to adjust benefits to the price increases of care provision and to improve public support for people with dementia fostered a new debate on sustainable funding. The idea of a "citizen`s insurance" (Bürgerversicherung) surfaced during this debate and capital-funded private insurance plans were discussed, mainly as a further development of the existing pay-as-you-go financed social insurance scheme. The demand for an introduction of a national citizen insurance–one insurance scheme for the whole population–is based on the different risk structures of the social and private insurance branches of LTCI, which have resulted in considerable surplus within private LTCI and deficits within social LTCI. The proponents of capital-funding argued with the issue of ageing population and intergenerational justice. A final comparison of the dimensions of the risk of care dependency and the features of the funding proposals showed a solidary policy scheme covering the entire population as most appropriate to secure sustainable funding for the whole population. The idea of a collective, solidary funding regime is also congruent with the attitudes of the population.

The introduction of LTCI considerably improved social protection related to the risk of care dependency. Despite criticism of some features, the insurance enjoys wide support among the general population (Nüchter et al., 2008; Zok, 2011). Nonetheless, some elements of the insurance–strict social rights, price competition related to care service provision, mode of funding, such as two branches for the insurance or spending caps–interact with economic and cultural factors and have led to distinct patterns of inequality with regard to gender, socio-economic class, migrant background and region.

References

Alber J. & Köhler U. (2004) *Health and Care in an Enlarged Europe.* European Foundation for the Improvement of Working Conditions. Official Publications of the European Communities, Luxembourg.

Augurzky, B., Borchert, L., Deppisch, R., Krolop, S., Mennicken, R., Preuss, M., Rothgang, H., Stocker-Müller, M. & Wasem, J. (2007). *Gründe für die Höhe der Heimentgelte in den stationären Pflegeeinrichtungen in Nordrhein-Westfalen*. Wissenschaftliches Gutachten im Auftrag des Ministeriums für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen, RWI-Projektbericht.

Behning, U. (1999) *Zum Wandel der Geschlechterrepräsentation in der Sozialpolitik.* Opladen: Leske + Budrich.

Bauer, U. (2008). Die Zukunft der Pflege. Qualitäts- und Strukturfragen aus Nutzersicht. In: Böcken J., Braun, B. & Amhof, R. (Hg..).*Gesundheitsmonitor 2008*. Gütersloh: Bertelsmann-Stiftung, 231-249

Baykara-Krumme, H. & Hoff, A. (2006). Die Lebenssituation älterer Ausländerinnen und Ausländer in Deutschland. In: Tesch-Römer, C., Engstler, H. & Wurm, S. (Hg.). *Altwerden in Deutschland. Sozialer Wandel und individuelle Entwicklung in der zweiten Lebenshälfte*. Wiesbaden: Verlag für Sozialwissenschaften, 447-517.

Blinkert B. & Klie T. (1999) *Pflege im sozialen Wandel*. Hannover: Vincentz*.*

Blinkert, B. & Klie, T. (2004). *Solidarität in Gefahr? Pflegebereitschaft und Pflegebedarfsentwicklung im demografischen und sozialen Wandel*. Hannover: Vincentz-Verlag.

Blinkert B.& Klie T. (2006) Der Einfluss von Bedarf und Chancen auf Pflegezeiten in häuslichen Pflegearrangements. *Zeitschrift für Gerontologie und Geriatrie,* 39, 423-428.

Blinkert B. & Klie T. (2008) Die Versorgungssituation pflegebedürftiger Menschen vor dem Hintergrund von Bedarf und Chancen. In: Bauer, U. & Büscher A. (Hg.) *Soziale Ungleichheit und Pflege.* Verlag für Sozialwissenschaften, Wiesbaden: Verlag für Sozialwissenschaften, 238-255..

Bönker, F., Hill, M. & Marzanati, A. (2009) Towards Marketization and Centralization? The Changing Role of Local Governments in Long-Term Care in England, France, Germany and Italy. In Wollmann, H.& Marcou, G. (Eds). *Service Provision in France, Italy, Germany and the United Kingdom: Between State, Local Government and Market*. Cheltenham: Edward Elgar.

Borchert, L. & Rothgang, R. (2008): Soziale Einflüsse auf das Risiko der Pflegebedürftigkeit älterer Männer. In: Bauer, U. & Büscher, A. (Hg.). *Soziale Ungleichheit und Pflege*. Wiesbaden: VS Verlag, 215-237.

Buestrich, M., Burmeister, M., Dahme, H. J. & Wohlfahrt, N. (2008). *Die Ökonomisierung Sozialer Dienste und Sozialer Arbeit*. Baltmannsweiler: Schneider-Verlag Hohengehren.

Burau, V., Theobald, H. & Blank, R. (2007). *Governing Home Care: A Cross-National Comparison*. Cheltenham: Edward Elgar

Campell, A. & Morgan, K. (2005). Federalism and the Politics of Old-age Care in Germany and the United States. *Comparative Political Studies,* 38, (8), 1-28.

Camphell, J.C., Ikegami, N. & Gibson M. J. (2010). Lessons From Public Long-term Care Insurance In Germany And Japan. *Health Affairs,* 29, (1), 87-95.

Costa, G. & Ranci, C. (2010). Disability and Caregiving: A Step Toward Social Vulnerability? In: Ranci, C. (Ed..). *Social Vulnerability in Europe. The New Configuration of Social Risks*. Basingstoke: Palgrave Macmillan, 159-188.

Dahme, H. J., & Wohlfahrt, N. (2007). Vom Korporatismus zur strategischen Allianz von Sozialstaat und Sozialwirtschaft: Neue „Sozialpartnerschaft“ auf Kosten der Beschäftigten. In: Dahme, H.J., Trube, A. & Wohlfahrt, N. (Eds.) *Arbeit in sozialen*

Diensten: flexibel und schlecht bezahlt?. Baltmannsweiler: Schneider-Verlag Hohengehren, 22-34.

Dittman, J. (2008) Deutsche zweifeln an Qualität und Erschwinglichkeit stationärer Pflege. Einstellungen zur Pflege in Deutschland und Europa. *Informationsdienst Soziale Indikatoren*, 40, (Juli), 1-6.

Döhner H., Lamura G., Lüdecke D. & Mnich, E (2007). Pflegebereitschaft in Familien: Entwicklungen in Europa, In: Igl, G., Naegele, G. & Hamdorf, S. (Hg). *Reform der Pflegeversicherung – Auswirkungen auf die Pflegebedürftigen und die Pflegepersonen.* Hamburg: Lit-Verlag, 166-179.

Eichler, M. & Pfau-Effinger, B. (2009). The „Consumer Principle" in the Care of Elderly People: Free Choice and Actual Choice in the German Welfare State. *Social Policy & Administration,* 13,(6), 617-633.

Eisen R. & Mager H-C. (1999) *Pflegebedürftigkeit und Pflegesicherung in ausgewählten Ländern*. Opladen: Leske + Buderich.

Enste D.H., Hülskamp N. & Schäfer H. (2009) *Familienunterstützende Dienstleistungen*. Köln: Deutscher Instituts Verlag.

Evers, A. (1997): Geld oder Dienste? *WSI-Mitteilungen*, 50 (7), 210-218.

Federal Ministry of Families, Seniors, Women and Youth (2002). *Vierter Bericht zur Lage der älteren Generation in der Bundesrepublik Deutschland: Risiken, Lebensqualität und Versorgung Hochaltriger – unter besonderer Berücksichtigung demenzieller Erkrankungen*. Berlin: Medien- und Kommunikations GmbH

Federal Ministry of Health (2007) *Vierter Bericht zur Entwicklung der Pflegeversicherung*. Berlin.

Federal Statistical Office (2009). *Statistik der Sozialhilfe: Hilfe zur Pflege 2007*. Wiesbaden:

Federal Statistical Office (2010). *Statistik zur Sozialhilfe: Hilfe zur Pflege 2008*. Wiesbaden.

Federal Statistical Office (2001-2011). *Pflegestatistik 1999-2009*. Wiesbaden.

Gasche, M. (2007). Finanzierungsseitige Reform der Pflegeversicherung. Warum und wie? *Wirtschaftsdienst*, 87(6), 359-364.

German Parliament (2002) *Enquete-Kommission Demographischer Wandel*. Referat Öffentlichkeitsarbeit. Deutscher Bundestag, Berlin.

Gottschall, K. & Schwarzkopf, M. (2010) *Irreguläre Arbeit in Privathaushalten.* Arbeitspapier 217. Arbeit und Soziales. Düsseldorf: Hans-Böckler Stiftung.

Häcker, J. & Raffelhüschen, B. (2007). Reformansätze zur Sozialen Pflegeversicherung auf dem Prüfstand. *Wirtschaftsdienst*, 87,(6), 351-355.

Hagen, K. & Lamping, W. (2011). Karenzzeit, "Pflege-Riester", Bürgerversicherung: was hilft weiter? *Wochenbericht des DIW Berlin,* 39, 3-15.

Hauschild, R. (1994). Vorschläge und Konzeptionen. *Bundesarbeitsblatt*, 45, (8/9), 12-21.

Heusinger, J.& Klünder, M.(2005) *„Ich lass mir nicht die Butter vom Brot nehmen!" Aushandlungsprozesse in häuslichen Pflegearrangements*. Frankfurt/Main: Mabuse.

Klie, T. & Blinkert. B. (2002). Pflegekulturelle Orientierungen. In: Tesch-Römer, C. (Hg..) *Gerontologie und Sozialpolitik*. Stuttgart: Kohlhammer, Stuttgart, 197-217.

Korpi, W. & Palme, J. (1998). The Paradox Of Redistrbution And Strategies Of Equality: Welfare State Institutions, Inequality, and Poverty In The Western Countries. *American Sociological Review*, 63, (October), 661-687.

Künemund, H. (2006). Tätigkeiten und Engagement im Ruhestand. In: Tesch-Römer, C., Engstler, H. & Wurm, S. (Hg.). *Altwerden in Deutschland. Sozialer Wandel und individuelle Entwicklung in der zweiten Lebenshälfte*. Wiesbaden: Verlag für Sozialwissenschaften, 289-327.

Landenberger,. M. (1994). Pflegeversicherung als Vorbote eines anderen Sozialstaats, *Zeitschrift für Sozialreform,* 40, (3), 314-342.

Lauterbach, K.W., Lüngen, M., Stollenwerk, B., Gerber, A. & Klever-Deichert, G (2005). Auswirkungen einer Bürgerversicherung in der Pflegeversicherung. *Gesundheitsökonomie und Qualitätsmanagement*, 10, 221-230.

Lorenz-Meyer, D. & Grotheer, A. (2000). Reinventing the generational contract: Anticipated care-giving responsibilities of younger Germans and Turkish migrants. In: Arber, S.& Attias-Donfut, C. (Eds.).*The Myth of Generational Conflict. Routledge*: Park Square, Milton Park, Abingdon, Oxon, 190-208.

Lutz H. (2009). Migrantinnen in der Pflege in deutschen Privathaushalten. In: Larsen, C. Joost, A. & Heid, S. (Hg..) *Illegale Beschäftigung in Europa. Die Situation in Privathaushalten älterer Personen.* München-Mering: Rainer Hampp, 41-52.

MDK Bayern Hg. (2008) *Prisma Gesundheit. Die soziale Pflegeversicherung*. Landsberg: ecomed Medizin.

Meyer J. A. (1996). *Der Weg zur Pflegeversicherung*. Frankfurt/Main: Mabuse

Metzler, H., Meyer, T., Rauscher, C., Schäfers, M. & Wansing, G. (2007), *Begleitung und Auswertung der Erprobung trägerübergreifender Persönlicher Budgets*, Wissenschaftliche Begleitforschung zur Umsetzung des Neunten Buches Sozialgesetzbuch (SGB IX) – Rehabilitation und Teilhabe behinderter Menschen. Abschlussbericht: Juli 2007.

Nachhaltigkeitskommission (2003). *Bericht der Kommission*. Berlin: Bundesministerium für Gesundheit und soziale Sicherung. Berlin.

Neuhaus A., Isfort, M. & Weidner, F. (2009) *Situation und Bedarfe von Familien mit mittel- und osteuropäischen Haushaltshilfen*. Köln: Deutsches Institut für angewandte Pflegeforschung e.v.

Nüchter, O., Bieräugel, R.,Schipperges, F., Glatzer, W., & Schmid, A. (2008). *Einstellungen zum Sozialstaat II*. Opladen/Farmington Hills: Barbara Budrich.

OECD (2011). *Help wanted? Providing and Paying For Long-Term Care*. Paris: OECD.

Okken, P-K., Spallek, J. & Razum, O. (2008). Pflege türkischer Migranten. In: Bauer, U. & Büscher, A. (Hg.). *Soziale Ungleichheit und Pflege.* Wiesbaden: Verlag für Sozialwissenschaften, 396-422.

Pfau-Effinger B., Och R. & Eichler, M. (2008). Ökonomisierung, Pflegepolitik und Strukturen der Pflege älterer Menschen. In: Evers, A. & Heinze, R.G. (Hg.) *Sozialpolitik.* Wiesbaden: Verlag für Sozialwissenschaften, 83-98.

Pfau-Effinger, B. Jensen, P.H. & Och, R. (forthcoming). Tensions between „consumerism“ in elderly care and the social rights of family carers: A German-Danish comparison. *Nordic Journal of Social Research*

Private Health Care Insurances (PKV). (2003). *Zur Versorgung der Versicherten im Rahmen der Pflegeversicherung*. Unveröffentlichte Statistik. Köln.

Private Health Care Insurances (PKV). (2010). *Zahlenbericht der privaten Krankenversicherung 2009/2010*. Köln

Reißman, A. (2005): P*flegebedarf und Institutionalisierung – Chancen und Grenzen häuslicher Pflege*. Bd. 5, Oldenburg: Paulo Freire Verlag.

Rothgang, H. (1997). *Ziele und Wirkungen der Pflegeversicherung. Eine ökonomische Analyse.* Schriften des Zentrums für Sozialpolitik, Band 7. Frankfurt/Main: Campus

Rothgang, H. (2004). Reformoptionen zur Finanzierung der Pflegeversicherung. Darstellung und Bewertung. *Zeitschrift für Sozialreform*, 6, 584-616.

Rothgang, H. (2006). Finanzierungsalternativen der Pflegeversicherung zwischen Eigenverantwortung und Solidarität. *WSI-Mitteilungen,* 4, 212-219.

Rothgang, H. (2007). Reform der Pflegeversicherung durch Weiterentwicklung des bestehenden Systems. *Wirtschaftsdienst*, 87,(6), 364-369.

Rothgang, H. (2009). Einführung von Kapitaldeckung in der sozialen Pflegeversicherung – Möglichkeiten Grenzen und Ausgestaltungsoptionen. In: Dräther, H. Jacobs, K. & Rothgang, H. (Hg.). *Fokus Pflegeversicherung. Nach der Reform ist vor der Reform*. Berlin: KomPart-Verlag, 95-121.

Rothgang H. (2010) Social Insurance for Long-term Care: An Evaluation of the German Model. *Social Policy and Administration*, 44, (4), 436-460.

Rothgang, H. (2011). Solidarität in der Pflegeversicherung: Das Verhältnis von Sozialer Pflegeversicherung und Privater Pflegepflichtversicherung. *Sozialer Fortschritt*, 4-5, 81-87.

Rothgang, H., Holst, M., Kulik D.& Unger, R. (2008). *Finanzielle Auswirkungen der Umsetzung des neuen Pflegebedürftigkeitsbegriffs und des dazugehörigen Assessments für die Sozialhilfeträger und die Pflegekassen*, Abschlussbericht. Modellprojekt: Entwicklung und Erprobung eines neuen Begutachtungsinstruments zur Feststellung der Pflegebedürftigkeit, Bremen, ZES.

Rothgang, H., Kulik, D., Müller, R. & Unger, R. (2009). *GEK-Pflegereport 2009. Schwerpunktthema: Regionale Unterschiede in der pflegerischen Versorgung*. Schwäbisch Gmünd: GEK-Gmünder ErsatzKasse.

Rothgang, H. Iwansky S., Müller R., Sauer S. & Unger R. (2010). *Barmer GEK Pflegereport 2010. Schwerpunktthema: Demenz und Pflege*. Schwäbisch Gmünd: Barmer GEK.

Runde, P., Giese, R. & Stierle, C. (2003) *Einstellungen und Verhalten zur häuslichen Pflege und zur Pflegeversicherung unter den Bedingungen des gesellschaftlichen Wandels*. Bericht. Universität Hamburg: Arbeitsstelle Rehabilitations- und Präventionsforschung, Hamburg.

Sauer, P. & Wißmann, P. (2007) *Niedrigschwellige Hilfen für Familien mit Demenz: Erfahrungen, Beispiele, Perspektiven*. Frankfurt/ Main: Mabuse.

SGB XI Law on Long-term Care Insurance.

Schneekloth, U. (2006) Entwicklungstrends beim Pflege- und Hilfebedarf in Privathaushalten – Ergebnisse der Infratest-Repräsentativerhebung. In: Schneekloth, U. & Wahl, H.W. (Hg.). *Selbständigkeit und Hilfebedarf bei älteren Menschen in Privathaushalten.* Stuttgart: Kohlhammer, 57-102.

Schneekloth, U. & Wahl, H.W. (2006) Möglichkeiten und Grenzen selbständiger Lebensführung in Privathaushalten im Lichte der Ergebnisse von MuG III. In: Schneekloth, U. & Wahl, H.W. (Hg.) *Selbständigkeit und Hilfebedarf bei älteren Menschen in Privathaushalten*. Stuttgart: Kohlhammer, 229-242.

Schneider, U. & Reyes, C. (2007). Mixed Blessings: Long-term Care Benefits in Germany. In Ungerson, C. & Yeandle, S. (eds.). *Cash for Care in Developed Welfare States*, Houndmills: Palgrave Macmillan, 137-165.

Stiehr, K. & Spindler, M. (2006). Lebensbedingungen von Frauen 50+in Europa. *Zeitschrift für Gerontologie und Geriatrie*, 39, (1), 5-12.

Theobald, H. (2004) *Care services for the elderly in Germany, Infrastructure, access and utilisation from the perspective of different user groups*. (SP I 2004-302). Discussion paper. Working Group Public Health Policy, Social Science Research Center (WZB), Berlin.

Theobald, H. (2011) Multi-level governance and universalism: Austria and Germany compared. *International Journal of Sociology and Social Policy,* 31, (2/4), 209-221.

Theobald (forthcoming). Combining welfare mix and New Public Management: The case of long-term care insurance in Germany. *International Journal of Social Welfare*.

Theobald, H., & Kern, K. (2011). The Introduction of long-term care policy schemes: policy development, policy transfer and policy change. *Policy and Politics*, 39, (3), 325-342.

Wingefeld, K., Büscher, A. & Gansweid, B. (2008a). *Das neue Begutachtungsassessment zur Feststellung von Pflegebedürftigkeit*. Bielefeld/Münster.

Wingenfeld, K. Büscher, A. & Gansweid, B. (2008b). *Das neue Begutachtungsassessment zur Feststellung von Pflegebedürftigkeit*, Anlagenband, Bielefeld/Münster.

Zok, K. (2011). Erwartungen an eine Pflegereform. Ergebnisse einer Repräsentativbefragung. *WiDO-monitor* 8, (2), 1-8.

Appendix:

Table 1: Care dependency levels: Definition and corresponding benefits

Care dependency levels			
Need of care	**I** ***Considerable***	**II** ***Substantial***	**III** ***Most substantial***
Number of activities: Within the range of personal care (bodily care, mobility, nutrition)	Two daily activities	Daily activity	Daily activity
Frequency Wthin the range of personal care	Once per day	Three times/day	Round the clock
Plus housekeeping	Several times a week		
Time (total)	90 min/ day	3 hours/day	5 hours/day
Share within: Personal care: minimum time	45 min.	2 hours	4 hours
Benefits			
Need of care	**I** ***Considerable***	**II** ***Substantial***	**III** ***Most substantial***
Cash payments: (per month, p.m.)			
July 2008	215.00 €	420.00 €	675.00 €
January 2010	225.00 €	430.00 €	685.00 €
January 2012	235.00 €	440.00 €	700.00 €
Care services (home based): (p. m.)			
July 2008	420.00 €	980.00 €	1470.00 €
January 2010	440.00 €	1040.00 €	1510.00 €
January 2012	450.00 €	1100.00 €	1550.00 €
(extraordinary high need of care 2008-2012)			(1918.00 €)

Sources: SGB XI; MDK Bayern (2008)

Table 1 continuing

Benefits			
Need of care	**I** ***Considerable***	**II** ***Substantial***	**III** ***Most substantial***
Care services(institutionalised) (p.m.)			
July 2008	1023.00 €	127.,00 €	1470.00 € (1750.00) €
January 2010	No increase	No increase	1510,00 € (1825,00 €)
January 2012	No increase	No increase	1550.00 € (1918.00 €)
(extraordinary high need of care)			
Respite care (informal care)			
Up to four weeks a year			
July 2008	215.00 €	420.00 €	675.00 €
January 2010	225.00 €	430.00 €	685.00 €
January 2012	235.00 €	440.00 €	700.00 €
Short-term care or Respite care (institutions)			
Up to four weeks a year			
July 2008	1470,00 €	1470.00 €	1470.00 €
January 2010	1510.00 €	1510.00 €	1510.00 €
January 2012	1550.00 €	1550.00 €	1550.00 €
Complementary Nursing Act			
Benefits (p.m.)			
High need of supervision, e.g. due to dementia illness			
July 2008: basic rate	100.00 €	100.00 €	100.00 €
July 2008: extraordinary rate	200.00 €	200.00 €	200.00 €

Sources: SGB XI; MDK Bayern (2008)

Table 2: Residential care services: Care rates, hotel costs and investment costs in € on average in 2007

Federal State	**Care rate: Level I**	**Care rate: Level II**	**Care rate: Level III**	**Hotel costs**	**Investment costs**
Baden-Württemberg	1459	1854	2371	608	Not available
Bavaria	1520	1885	2158	517	284.54
Berlin	1398	1946	2310	486	Not available
Brandenburg	1125	1398	1885	486	Not available
Bremen	1064	1702	2128	638	Not available
Hamburg	1246	1794	2341	699	Not available
Hesse	1307	1763	2280	517	405.53
Mecklenburg-Western Pomerania	1094	1429	1854	456	Not available
Lower Saxony	1246	1611	2006	486	462.38
North Rhine-Westfalia	1277	1794	2341	790	Not available
Rhineland-Palatinate	1216	1581	2189	638	Not available
Saarland	1186	1642	2189	608	Not available
Saxony	1034	1338	1824	456	Not available
Saxony-Anhalt	1125	1490	1763	486	Not available
Schleswig-Holstein	1368	1733	2098	638	421.65
Thuringia	1003	1368	1794	547	Not available
Germany	**1307**	**1733**	**2158**	**608**	**322.24**

Source: Rothgang et al, 2009
Explanation: In case investment, e.g. building of facility is not publicly subsidized, the residents can be obliged to pay investment costs

Table 3: Home-based care services: Prices selected care packages in € on average in 2007

Federal State	Bodily care (Comprehensive)	Nutritional support	Preparation warm meal	Support: Leaving/Returning to the flat
Baden-Württemberg	21.33	Not available	20.90	Not available
Bavaria (for-profit)	24.51	12.41	13.38	3.51
Bavaria (non-profit)	26.31	12.43	14.73	3.52
Berlin	27.83	11.97	12.92	3.40
Brandenburg	19.80	8.48	7.51	2.71
Bremen	18.92	10.51	11.35	2.97
Hamburg	20.60	11.45	12.36	4.49
Hesse	32.16	13.87	Not available	6.22
Mecklenburg-Western Pomerania	18.43	10.25	11.06	2.92
Lower Saxony	22.83	13.12	Not available	3.57
North Rhine-Westfalia	18.59	11.22	7.39	Not available
Rhineland-Palatinate	24.06	13.38	13.21	3.24
Saarland	22.44	10.20	12.24	2.86
Saxony	16.25	9.03	9.75	2.53
Saxony-Anhalt	16.74	9.30	10.04	2.98
Schleswig-Holstein	20.96	12,72	12.83	5.45
Thuringia	15.75	8.75	9.45	2.45
Germany	**21.61**	**11.19**	**11.97**	**3.52**

Source: Rothgang et al., 2009

Table 4: Financial Development of the social- and private LTCI and Long-term Care Assistance (SGB XII)

Social long-term care insurance (In Billion €)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Revenue	8.41	12.04	15.94	16.00	16.32	16.54	16.81	16.98	16.86	16.87	17.49	18.49	18.02	19.77	21.31
Expenditure	4.97	10.86	15.14	15.88	16.35	16.67	16.87	17.36	17.56	17.69	17.86	18.03	18.34	19.14	20.33

Source: http://www.bmg.bund.de/pflege/pflegeversicherung/zahlen-und-fakten-zur-pflegeversicherung.html

Private long-term care insurance (In Billion €)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Revenue		1.66	2.10	2.10	1.97	2.01	1.96	1.99	1.85	1.87	1.87	1.87	1.88	1.97	2.07
Expenditure		0.29	0.44	0.44	0.46	0.47	0.49	0.50	0.52	0.53	0.55	0.56	0.58	0.62	0.67

Sources:
Private Health Care Insurances (PKV). 2003. *Zur Versorgung der Versicherten im Rahmen der Pflegeversicherung*. Unveröffentlichte Statistik. Köln, (Figures1995-1998)
Private Health Care Insurances (PKV). 2010. *Zahlenbericht der privaten Krankenversicherung 2009/2010*. Köln, Verband privater Krankenversicherung. (Figures1999-2009)

Long-term Care Assistance (Hilfe zur Pflege) (SGB XII)
Expenditure and number of beneficiaries

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Expenditure (in million euro)	9.062	8.934	7.100	3.500	3.001	2.901	2.876	2.905	2.943	3.005	3.142	3.152	3.120	3.217	3.262
Beneficiaries (in thousand)	563	574	426	328	289	310	324	332	313	323	328	344	366	372	397

Source: Federal Statistical Office (2010). *Statistik der Sozialhilfe. Hilfe zur Pflege*. Wiesbaden, Statistisches Bundesamt.

Institutet för Framtidsstudier – Arbetsrapporter: Tidigare utgivning
Institute for Futures Studies – Working Paper Series: Backlist

2000/1–2009/21, see www.framtidsstudier.se.

- 2010/1: Meagher, Gabrielle & Marta Szebehely. *Private financing of elder care in Sweden. Arguments for and against*
- 2010/2: Niedomysl, Thomas & Jan Amcoff. *Is there a hidden potential for rural population growth in Sweden?*
- 2010/3: Gartell, Marie. *The College-to Work Transition during the 1990s. Evidence from Sweden*
- 2010/4: Esser, Ingrid & Tommy Ferrarini. *Family Policy, Perceived Stress and Work-Family Conflict. A Comparative Analysis of Women in 20 Welfare States*
- 2010/5: Baroni, Elisa. *Effects of Sharing Parental Leave on Pensioners' Poverty and Gender Inequality in Old Age. A Simulation in IFSIM*
- 2010/6: Korpi, Martin & Ayse Abbasoğlu Ösgören. *Does Immigration Hurt Low Income Workers? Immigration and Real Wage Income below the 50th Percentile*, *Sweden 1993-2003*
- 2010/7: Montanari, Ingalill & Kenneth Nelson. *Health Care Developments in EU Member States. Regressing Trends and Institutional Similarity?*
- 2010/8: Kumlin, Johanna. *Har kvinnor och män blivit mer jämnt fördelade över yrken, organisationer och arbetsplatser i Sverige under perioden 1990-2003?*
- 2010/9: Minas, Renate. *(Re)centralizing tendencies within Health Care Services. Implementation of a new idea?*
- 2010/10: Mkandawire, Thandika*. On Tax Efforts and Colonial Heritage in Africa*
- 2010/11: Kuivalainen Susan & Kenneth Nelson. *The Nordic welfare model in a European perspective*
- 2010/12: Strömblad, Per & Bo Bengtsson. *Political Participation of Ethnic Associations. Exploring the Importance of Organisational Level Differences in Resources, Motivation and Recruitment Networks*
- 2010/13: Alm, Susanne, Olof Bäckman, Anna Gavanas & Johanna Kumlin. *Utsatthetens olika ansikten. Begreppsöversikt och analys*
- 2010/14: Lundqvist, Torbjörn. *Visioner om IKT i arbetslivet. Från distansarbete till arbete när som helst och var som helst?*
- 2010/15: Johansson, Peter. *Sociala rättigheter och migration. Det svenska pensionssystemet i internationella situationer 1946-1993*
- 2011/1: Pelling, Lisa, Charlotta Hedberg & Bo Malmberg, Bo. *Remittances from Sweden. An exploration of Swedish survey data*
- 2011/2: Lindh, Thomas & Ying Hong. *Swedish fertility swings and public expenditure for children*
- 2011/3: Boguslaw, Julia & Eskil Wadensjö. *Humanisterna och den svenska arbetsmarknaden. Underlag till Humanisterna och framtidssamhället: Tre studier och en workshop om humanioras framtid Kulturhuset, Stockholm, den 24 mars 2011*

- 2011/4: Geschwind, Lars & Miriam Terrell. *Vilka var humanisterna? Underlag till Humanisterna och framtidssamhället: Tre studier och en workshop om humanioras framtid Kulturhuset,Stockholm, den 24 mars 2011*
- 2011/5: Stenlås, Niklas. *Vilka blir humanisterna? Underlag till Humanisterna och framtidssamhället: Tre studier och en workshop om humanioras framtid Kulturhuset, Stockholm, den 24 mars 2011*
- 2011/6: Hallberg, Daniel. *Is Early Retirement Encouraged by the Employer? Labor-Demand Effects of Age-Related Collective Fees*
- 2011/7: Avdic, Daniel & Marie Gartell. *The study pace among college students before and after a student aid reform: some Swedish results*
- 2011/8: Bäckman, Olof, Vibeke Jakobsen, Thomas Lorentzen, Eva Österbacka & Espen Dahl. *Dropping out in Scandinavia Social Exclusion and Labour Market Attachment among Upper Secondary School Dropouts in Denmark, Finland, Norway and Sweden*
- 2011/9: Gavanas, Anna & Alexander Darin Mattsson. *Bland Rolexklockor och smutsiga trosor. Om skattereduktioner och segmentering på den svenska hushållstjänstemarknaden*
- 2011/10: Adman, Per & Per Strömblad. *Utopia becoming dystopia? Analyzing political trust among immigrants in Sweden*
- 2011/11: Johansson, Peter. *Den politiska momsdebatten i Sverige efter 1990. Ett bidrag till studiet av skattereformers politiska hållbarhet*
- 2011/12: Daniel Hallberg, Thomas Lindh & Jovan Žamac. *Study achievement for students with kids*

ISSN: 1652-120X
ISBN: 978-91-85619-91-7