



EU-China Social Security Reform Co-operation Project

- Case Study -

- **“Long Term Care Insurance Germany”** -

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Executive summary

The current report has been produced for the higher level manager of the Ministry of Human Recourses and Social Security and presented on the 15th of July. The major findings are that the Chinese population is in needs of support and assistance in terms of elderly care. Reasons therefore are the growing number of elderly people within the next forty years. Family traditional behaviour changes dramatically due to the economical development of the Chinese society which disconnect the younger generation from their parents and grandparents. The report provides as well a comparison between the German long term care insurance and the feasibility to implement the system in China. One of the major conclusions is that the structure of the German system could be implemented very easy but not at the level of costs. Second, the system in China should not change the self-responsibility of the families. The future demand has to be directed into a flexible system which covers the cost for lonely elderly, elderly below the poverty line. The community system has to be strengthened to be able in providing the basic home care or professional care instead of nurses. However, China is facing a big problem and need to focus on the social care for elderly.

1 Introduction of the statutory long term care insurance in Germany

The statutory and private long-term care insurance in Germany will never cover all actual costs today or in the future. Only a private provision through private long term care insurance can close the gap and will become a second pillar.

The long term care reform in Germany came into force at 1 July 2008. The system is administered by the statutory medical insurance funds and provides both capped cash benefits and services to the eligible population. The long term care contribution rate have to be increased from 1.95 today to 3.5 percent until 2030 without a fundamental reform in the field of the statutory long term care insurance system in Germany. However, the contribution rate increased by 0.25 points to 1.95 percent of gross contribution and seems to be continuing to rise in the future. The demographic development and the rising expenses in the long term care sector requires an increase of the contribution rate step by step up to seven percent until the year 2055 according to calculations made by the German Institute for Retirement.

The monthly benefits of the statutory long term care insurance will be gradually increased until 2012. The patient services have been improved since the implementation of the long term care reform but despite the increased donations the coverage of the long term care insurance will not meet the real market costs.

The statutory long term care insurance covered 70,36 million and the private insurance schemes 9,25 million citizens which is around 97% of the total population by the 2007. Around 1,46 million citizen received home care services (ambulant) and 0,71 million citizen nursing home care (inpatient) which is 2,6% of the total population. The long term insurance funds spend around 17,4 billion Euro by the end of 2007 and the surplus reached around 3,2 billion Euro.

2 Entitlement and Benefit package of the statutory long term care insurance

Insured population is entitled for benefits from the statutory care insurance in case of a physical or mental illness or disability which is expected for at least six months and cannot cope with the everyday life without assistance. The using care covers four areas:

- **Personal hygiene:** Washing the body, cleaning the teeth, combing the hair and using the toilet
- **Feeding:** Preparing food and feeding
- **Mobility:** help to stand up and/or walk to bed, dressing and undressing, monitoring, visiting a doctor, etc.
- **Household:** shopping, cooking, cleaning, doing the laundry

The Long Term Care Insurance is covering **Nursery Care** as well, for example:

- Changes of bandages
- Injections (Insulin)
- Wound treatment
- Administer medicines

Furthermore the private caregiver, mostly family members (around 440.000 by the end of 2006), will be insured at the pension insurance and the long term care insurance pays the premiums (in total 0,9 billion Euro by the end of 2006). In addition specific remedies and home care devices have to be covered by the long term care insurance.

3 The different levels of care, benefit in kind and cash

The levels of nursery care are differentiated into three levels according to the needs to the patient:

Level I (substantial needs of care): The patient needs required assistance for at least 90 minutes per day which includes basic care for at least 45 minutes (personal hygiene, nutrition, mobility). It also requires that the patient needs support several times per week in household.

Level II (higher needs of care): The patient needs at least nursery care three times a day in total three hours and includes two hours of basic care. The patient also needs several times a week help in their household.

Level III (the heaviest needs of care): Patients are dependent to full time assistance or around the clock. The daily assistance should be necessary for at least five hours, with at least the basic care of four hours. Moreover, the person status requires several times a week help in the household.

Hardship case: Patient, which needs help for at least six hours a day in the basic care (of which at least three times during the night). As required the basic care should be provided by several nurses.

Financial benefits and benefits in kind are to be increased until 2012. According to the principle “home care over facility based care”, home care benefits will be increased to a higher degree than facility based care benefits. From 2015 on, benefits will be adjusted to the current pricing trend every three years. Also, benefits for the disabled and for patients with mental diseases are to be increased substantially: from current 460 Euros per year to 2400 Euros per year. Moreover, eligibility for day care for the disabled and patients with mental diseases is to be expanded.

Level of Care ¹	Since the 1. July 08 (Euro/Month)	from 2010 (Euro/Month)	from 2012 (Euro/Month)
stationary care in a nursery home			
I	1023	1023	1023
II	1279	1279	1279
III	1470	1510	1550
in hardship cases			
	1750	1825	1918
professional nursery home care (benefit in kind)			
I	420	450	450
II	980	1040	1100
III	1470	1510	1550
in hardship cases			
	1918	1918	1918
home care through care taker or family members (cash benefit)			
I	215	225	235
II	420	430	440
III	675	685	700

¹ Ministry of Health Germany

4 Prerequisites and administrative procedures of the statutory long term care insurance

The patient or their empowered person must submit an application form to the statutory or private long term care insurance to initiate the payments. As prerequisites the applicant has to pay in minimum 2 years of premiums within the past ten years or was covered as a family member. The patient must assure that they are permanent or unable to live without external help for at least for the next six months.

The Medical Service of the Health Insurance (MDK) verifies the status of the patient from the statutory long term care insurance through an examination and the private insurance patients' will be certified by the company "Medicproof" through visits at home. The professional evaluators determine to which extent home and nursery care (personal hygiene, nutrition, mobility) and financial assistance is needed. The decision has to be made within five weeks in a written format which has been introduced in order to reduce service waiting lists.

It is of important that the patient receive services and financial support only if the long term insurance set up a formal act and if the examination certifies that the patient is not in needs of medical services which mean the applicant cannot request any payments from the insurance schemes. In the year 2007 29,2% of the applicants could not receive any services through the long term care insurance after the examination of the Medical Service of the Health Insurance (MDK). In the outpatient care were 32.2 percent of applications and in institutional care have been 15,1% rejected. The insured persons have the right to appeal against the formal act within four weeks and they will be re-evaluated. Around 40% of those cases have been revised by 2007 and the patient got services out of the long term care insurance.

5 Reform activities in the long term

care insurance

Local long term care support centres are to be established for every 20,000 citizens. Ideally, all actors involved in long term care, which is the statutory medical insurance fund, private long term care insurers, municipality, social welfare bodies and local long term care providers should be represented in these centrally located, easy-to-reach, barrier free centres. They are to be managed by the funds and provide information on available care services, facilities and providers, as well as support with paper work and decisions to beneficiaries and their families. This is supposed to facilitate organizations of care – ranging from meals on wheels, help with activities of daily living to medical care – and cooperation between involved actors. Citizens no longer need to seek assistance from a variety of providers at different locations – as is the case today – but will be offered advice, direction and available care according to the one-stop shopping principle.

Long term care coordinators (case managers) working in the local support centres are to pro-actively support and advice beneficiary and their families. Specifically, they are to set up individual care plans, coordinate with providers and arrange for services to be delivered to beneficiaries. Every beneficiary would be entitled to this kind of support. This is supposed to make more attractive and easier accessible, and thus to decrease demand for facility based institutional care.

Improving quality of care that all actors involved, in long term care jointly develop mandatory care standards and care institutions are to be examined every three years including to publish the result.

Rehabilitation of patients in care institutions will be rewarded for improving the health status of their residents. If the health status of patients improves to such a degree that they can be downgraded in their care, nursing homes will receive a one-time bonus of 1536 Euros.

The insurance funds, states and other stakeholders are supposed to better integrate voluntary service providers into community long term care provision. Volunteers are to receive greater support through professional networks and trainings. Furthermore the insurance will be allowed to advertise private Long term care insurance contracts to their insured. As in private health insurance, the insurance reserves for old age are portable in case of change of insurer.

6 Financial gap in the statutory long term care insurance Germany

The monthly benefit of the statutory nursing care insurance will be gradually increased until 2012. Nevertheless, the benefits will not be enough to cover the estimated total costs of needed nursery care. For example: A professional nurse provides care for a patient which has been categorized in group II and all those services costs around 2592 Euro but the long term care insurance pays only 980 Euro per month. Many insured persons have to cover the gap with their total income (pensions), private property/assets or through their families. However the states promotes or encourages all citizens born 1958 onwards to sign additional private insurance contracts and deduct up to 184 Euro from the tax.

Financial gap between the insurance expenditure and services

Level of nursery care	Insurance pay 2008 monthly	Total cost of Services/Month	Gap per Month
stationary care in a nursery home			
I	1023	1855	832
II	1279	2280	1001
III	1470	2706	1236
professional home care			
I	420	810	390
II	980	2592	1612
III	1470	3360	1890
home care through family members/care taker			
I	215		
II	420		

III	675		
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7 Relevant demographic factors and forecast Germany

Demographic forecast Germany by 2030

The official statistics and their forecast predict an increase of elderly population (60 years above) of around 8 million people between 2005 to 2030 from 20,5 to 28,5 million people. This is 25% of the total population by 2005 and around 36% by 2030 (total population 80 million citizens by 2030).

The life expectancy will be for a

- Newborn boy 75,9 years
- Newborn girl 81,5 years
- 60 years male 20,0 years
- 60 years female 24,1 years

Risk and trend for the Long Term Care Insurance Germany

The risk probability of the age group <60 years will be 0,7%, 60 to 80 years 4,2% and above 80 years 28,4% of the total population. Therefore the "Ruerup Commission" – Long term care commission is forecasting the future demand of Long Term Care as follows (number of population):

- 2007 2,03 Mio.
- 2010 2,13 Mio.
- 2020 2,64 Mio.
- 2030 3,09 Mio.

Empirical formula and calculation

10.000 patients in home care costs per year around 70 million Euro, 10.000 patient in nursery home care per year around 154 million Euros and in specific handicapped

homes around 31 million Euro per year.

8 Lessons learned in the Long term

Care Insurance Germany

Lesson 1: Calculation and payments of the flat rate benefits

Challenges faced in caring for older and disabled persons in Germany should include the inflations rates, price raise, and in general, a more service interventions for older persons through the providers.

The initial law fixed the flat rates without considering the inflations rates, price raise for example maintenance or that more services have to be provided in order to guarantee a proper quality of basic and professional home care. The system faced after 1996 till the end of 2007 a dramatic change in the additional co-payments of the families caring or financing their older or disabled relatives. As a result the quality of services worsens during the last decade and many patient and family members complaint about the situation. The government reacted in increasing the flat rates till 2012 (see chapter no. 3) but still the families and the society faces the financial gap (see chapter no. 6).

Lesson 2: Guarantee the quality of services

For example Berlin, 26,000 people lived in 336 nursing facilities in the year of 1998 but 18 of them has been closed. The Medical Service of the Health Insurance (MDK) certified serious grievances in the institutions:

- lack of care by the nurse,
- incompetent staff,
- and bad hygienic status of the patients and as well the facility.

In the light of that the agency found out that 75 percent of the residents had no

response by professional and 40 percent of the residents do not received enough quantities of liquids. Even mash food wash provided instead of solid food was providing in case of residents who could eat normal. Often entertainment has not been provided.

The sample shows dramatically the problem of the financial situation and pressure on facilities which leads into a lower quality of care. Furthermore there was no regular quality care check by the purchaser of services. The German government identified the problem and set up major activities on improving the quality significant (see chapter no.3). Within that the purchaser and provider have to agree on the future quality and standards of services.

Lesson 3: Integration and coordination between the different level service delivery and payers

By the end of 2008, the ambulant institutions reached 236,162 service providers and 573,545 facility-based home care stations. The patients and their family members faced the problem that they have to choose between the different providers in not knowing their quality. On top of that the insured have to coordinate the activities of providers together with the services from the doctor, the long term care insurance, the social welfare institutions and other providers for example physiotherapists or other professionals. The institutional burden for the family were very high and created a lot of problems for them and therefore the government decided that the long term insurance gaining an active role in this process in coordinating the activities for all the insured population.

Lesson 4: Encourage actors to provide rehabilitation

The initial law provided only basic home care and professional care through nurses and it was never foreseen that the residents, patients, disabled or elderly could be trained in certain skill to participate in the live. The institutions will be encouraged to provide for example geriatric services like mobility training, physiotherapy, etc. The reform rewards the initiatives (see chapter no. 3).

9 Relevance for the Chinese population

Why the Chinese population does need professionalized Social- and Long-term care in the future?

Cultural changes erosion the family based tradition of the Chinese population

Challenges faced in caring for older persons in China include the erosion of traditional family care practices, spiraling medical care costs, and in general, a low priority accorded to program's and interventions for older persons.

The dramatic increase of western style consumption and the western work style changes the value and culture of families in China in particular. The younger urban population has been disconnected from their families through studying at the university and working in the prosperous cities. All those generation faces the big pressure to finance their lifestyle in a big city and the ability to assist their family members in the home towns is minimal. They are not any longer able or may not have the willingness to provide substantial help to their elderly family members. Millions of migrants are detached of their families and they are not able to follow the family tradition in taking care of their elderly.

Ageing society China

China's elderly population is expected to reach its peak of 437 million by 2051 and the twenty years starting from 2030 will be a crucial period for the problem of aging in China.

A report recently released by China National Committee on Aging shows that the next 25 years from now on means both a key preparation period for coping with the problem and a strategic opportunity.

China has become an aging society since 1999. By the end of 2004, people over 60 years old had reached 143 million, accounting for 10.97 percent of the nation's total population. So far, China is the world's largest aging population country, taking up one fifth of the world's total.

Li Bengong, a high-ranking official with National Aging Committee pointed out that the aging process in China could be divided into three phases.

The first phase from 2001 to 2020 features the fast aging process. The annual increase of senior citizens stands at 5.96 million, and the total aging population by 2020 will reach 248 million, with an aging growth rate of 17.17 percent.

From 2021 to 2050, accelerated aging will be witnessed. Considering those who were born in baby boom in the 1960s and 1970s, the increase of aging population is expected to hit 6.2 million annually. The aging growth rate will be over 30 percent.

The most severe aging problem will come from 2051 to 2100. Till then, the aging population will reach its peak of 437 million.

The aging growth rate will become stable at around 31 percent after this and people over 80 years old will reach between 80 million to 90 million.

Health care system structure China

By the end of 2006, China has in total 308,969 healthcare institutions, 60,037 of which are hospitals and health centres, 264 of which are Sanatoriums, 212,243 of which are clinics, 3,021 of which are Outpatient Department & Clinics, 3,003 of which are Maternal & Child Health Centres, 1,402 of which are Specialized Disease, Prevention & Treatment Institutes, 3548 of which are Centre for Disease Control, 248 of which are research institutions and 28,224 falls into other categories.

However, the health care system as well the social security system does not provide and support a specific institutional home care system, special trained professional or a benefit package. It is unknown how many patients are hospitalized not needing any acute treatment but demanding only professional care by a nurse.

Conclusion

The population and institution are not ready and prepared for the future task of social and long term care under the future challenges in China. In the near future the government has to cope with the problem in training professional for community care, basic home care and may have to establish professional home care institution to cover the elderly and disabled population. Additional financial investments are necessary in order to establish a minimum protection.

10 Considerations based on the Chinese situation

Is the German system suitable for the Chinese reality?

The German system is very complicated and expensive and therefore not suitable for the Chinese reality. However, the structure as an insurance system fits into the Chinese context and the categorisation of patients into the different grades of disability opens more chances for the Chinese population to obtain decent services if they will be established in accordance to the German system. Nevertheless the reality in china requires a different implementation which we consider as feasible for the future system development.

What need the Chinese government to consider if it wants to cover the growing group of elderly citizens and maybe include the younger disabled generation?

Step 1: Keeping the family based tradition of the Chinese population and the community based structure to provide basic home care

The French and German system still provides a good idea of basic home care. The basic home care in China could at least cover the minimum

- **Personal hygiene:** Washing the body, cleaning the teeth, combing the hair and using the toilet
- **Feeding:** Preparing food and feeding
- **Mobility:** help to stand up and/or walk to bed, dressing and undressing, monitoring, visiting a doctor, etc.
- **Household:** shopping, cooking, cleaning, doing the laundry

The basic home care should be provided through the families at first and in case there is no family member available (dislocation) or disabled the services might be provided through community helper. The idea of traditional responsibilities of families should be kept for all above mentioned service because the financial demand towards the public sector will be too high. Only in specific cases, for example population below the poverty line and disability of family members, the public sector should sponsor the services needed.

Step 2: Establishing community nurses to cover the basic medical needs within the community

Professional trained community nurses needs to assist the families in training the members on for example:

- Changes of bandages
- Injections (Insulin)
- Wound treatment
- Administer medicines

The training will encourage the families and/or community helpers to do the minimum medical assistance by themselves which reduces the costs as well. Only in heavier cases the nurses should get involved which has to be defined. At this level starts the point where the government might consider their participation and payments through public community nurse programs. However, this level might require co-payments by the families in order to reduce the public costs.

Step 3: Establishing community based centres to provide home care and professional nurses

Elderly persons and disabled persons without family needs defined the help of the public sector and therefore it is necessary to develop specific community based

centre's which reduces the cost for the government. The pensions or the assets of that group should be used to pay a part of the maintenance of the facility and the personnel.

Step 4: Establishing specialized centres to provide home care and professional nurses including specific devices

For heaviest cases it is necessary to establish specific centre's including professional nurses in order to reduce the usage of hospital beds. All those people are often using nurses and doctors services in hospitals in order to be covered in terms of professional care, which sometimes includes the misuse of medical insurance funds.

Step 5: Financing system of the future demand in China

First of all, the four level approaches guarantee the traditional family values and encourage the system to use the community because the majority of population do not want to move to other areas. Second, the financial envelope could be shared between the government and the families which still will be enormous in the future.

However the government have to think about if they would like to establish a national home care system which is funded by tax or an insurance system which is funded by contribution collection.

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