Long-Term Health Care

IS GERMAN LONG-TERM CARE INSURANCE A MODEL FOR THE UNITED STATES?

Michaela V. Schunk and Carroll L. Estes

German long-term care insurance, implemented in 1995, significantly extends the coverage of care-related risks. Given the similarities of German and U.S. institutional features, the German social insurance approach has been put forward as a possible model for long-term care in the United States. Using a political economy framework, the authors conducted a policy analysis that compares the main shortfalls of long-term care (LTC) provision in the United States and Germany, examines the responses provided by LTC insurance in Germany, and relates them to broader trends and proposals for change in welfare policy in both countries. German LTC insurance includes a high degree of consumer direction and compensation and protection for informal caregivers; it supports the extension of community-based services. Its shortfalls include the continued split between health and LTC insurance. In both countries, decentralization and institutional and financial fragmentation are some of the characteristics responsible for the failure to promote egalitarian social policy and substantially expand social protection to family- and care-related risks. The German LTC program is a good model for the United States. With a social insurance approach to LTC, costs are spread across the largest possible risk pool. Major goals that can be reached with such a program include establishment of universal entitlements to LTC benefits, consumer choice, and equitability and uniformity.

How comparable are the United States and Germany in the aging of their populations? Germany is demographically older: 15.8 percent of its population is over 65, compared with 12.6 percent in the United States. Much lower fertility rates in Germany are slowing population growth, which is expected to become negative by 2010. Projections of demographic aging in Germany predict a rapid increase in the number and proportion of people over 65 (to 20.5 percent) over the next ten years,

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compared with a more moderate increase from 12.6 to 13.2 percent in the United States (1, 2). Germany will also experience a much more rapid relative growth of the population aged 80 and older than will the United States (Figure 1).

How comparable are the United States and Germany in long-term care (LTC) coverage? Prior to introduction of the LTC insurance program in Germany, both countries excluded LTC from health insurance coverage. Health systems in both countries follow an acute medicine, biomedical model that disadvantages the aged and chronically ill (3). In Germany, until a few years ago, home care was covered only to prevent hospitalization; rehabilitation was aimed at younger workers (4). Institutional similarities between the United States and Germany include the "bifurcation of the welfare system" (5) into "respectable" risks covered by insurance programs (such as pensions) and means-tested and stigmatizing poverty programs.

Long-term care services in Germany, prior to LTC insurance, had to be paid for out-of-pocket until the person became eligible for the poverty program ("social assistance"), much as LTC services are paid for by Medicaid in the United States. Services were directly reimbursed by the social assistance program, and the largest share of expenditure went on institutional care. Then, in what amounted to a significant extension of risks covered by insurance programs, the LTC insurance program was legislated in 1994 and implemented in 1995. This constitutes a major policy change in Germany.

This study draws attention to a number of characteristics of the LTC insurance program in Germany, comments on its implementation, and discusses some of

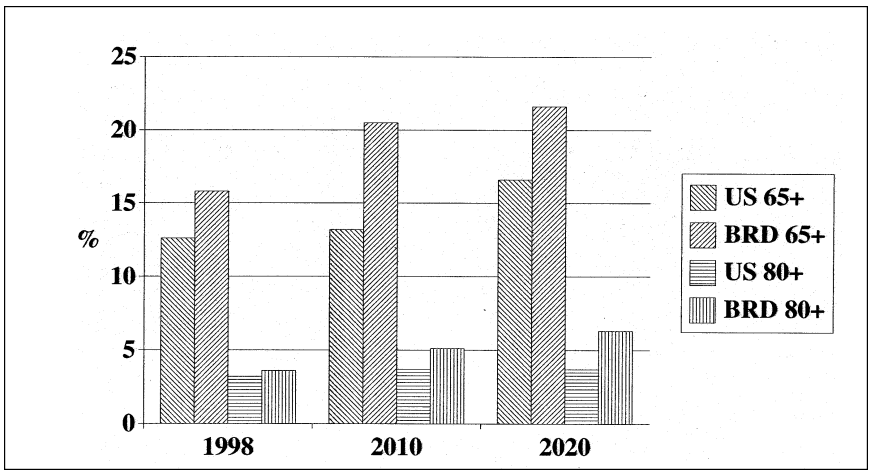

Figure 1. Demographic aging in the United States and Germany (BRD), 1998–2020. *Source:* U.S. Bureau of the Census (1); U.N. Demographic Indicators (2).

its effects—making comparisons with the United States, and drawing upon similarities and differences between the two countries. The argument is structured around six comments on the effects and benefits of the German care insurance as a model for the United States.

1. The German LTC insurance program is a model of a universal, equitable, and accessible program for all people with long-term care needs, regardless of income or age.

Long-term care insurance is a national (federal) program; membership is mandatory for everyone who is a member of a sickness insurance fund, either statutory or private. Thus coverage, like sickness insurance coverage, is nearly universal: about 97 percent of the population is covered. It is financed by monthly contributions, which are 1.7 percent of gross wages, pension income, or unemployment benefit. Employers and pension funds pay 50 percent of the contribution; for unemployed people, the Federal Labor Office pays the full contribution. Employers opposed the introduction of LTC insurance because of their share of the costs; they were compensated by the abolition of one public holiday.

The majority of the insured population (86 percent) is in statutory care insurance funds (Figure 2) (6); entry into these statutory funds is mandatory. As in the sickness insurance program, high-wage earners have the option to leave the

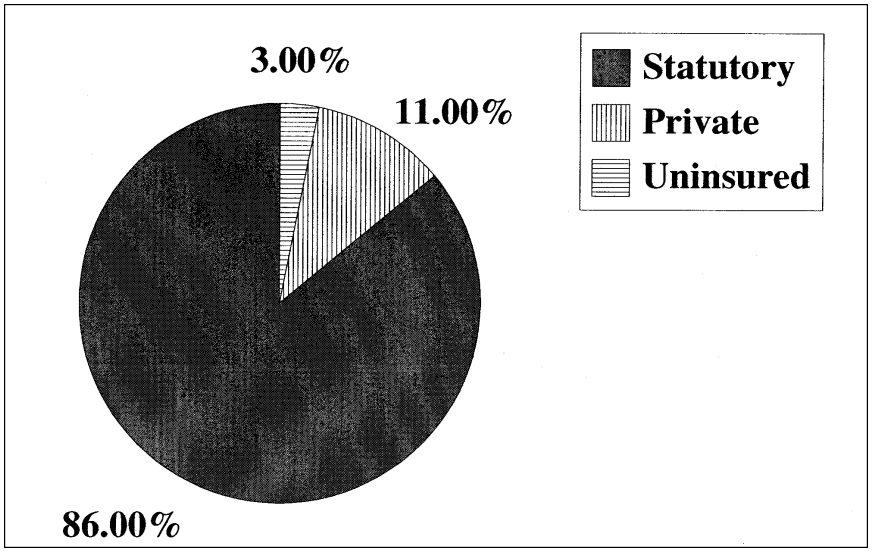

Figure 2. German long-term care insurance program: insured population and beneficiaries, 1998–99. *Source:* Bundesministerium für Gesundheit (6).

statutory funds and join private care insurance instead. Although private insurance funds are highly regulated in the sense that they must offer coverage equivalent to the statutory funds, they have more discretion, for example, in setting contribution rates. However, these rates must not exceed the maximum premium of the statutory plans.

Beneficiaries of the LTC insurance program must pass a "medical assessment" to become eligible. In this assessment, care needs are classified (activities of daily living, ADLs; and instrumental activities of daily living, IADLs) and quantified, and beneficiaries are assigned to one of three levels of care dependency, with three increasing levels of benefits. Everyone with the same level of disability gets the same level of benefit (Table 1) (6, 7). Definitions of care needs and the respective assessment guidelines are set at the federal level; in theory, there should be no variations in the assessment outcomes except those relating to differences in the health status of the population. However, data on variations in assessment outcomes need further analysis.

Early evidence showed a systematic trend in private care insurance funds of assigning higher levels of care dependency and denying benefits to a smaller proportion of applicants than did the statutory care insurance funds (8). This would put the 11 percent of privately insured at the advantage of having a higher likelihood of receiving higher benefits. Recent data show that the gap has narrowed but still persists (Figure 3) (6). This nevertheless indicates that despite "uniform" assessment guidelines, there are discretionary elements in the care dependency assessment.

Table 1

Classification of levels of care dependency in the German LTC insurance program

Disability level	No. of ADL/IADL deficiencies	Frequency of assistance with ADL	Frequency of assistance with IADL
Low (I)	Two or more ADL limitations and need for help with IADL	At least once a day	Several times a week
Medium (II)	Two or more ADL limitations and need for help with IADL	At least three times daily and spread over the day	Several times a week
Severe (III)	Two or more ADL limitations and need for help with IADL	Day and night	Several times a week

Source: Schneider (7).

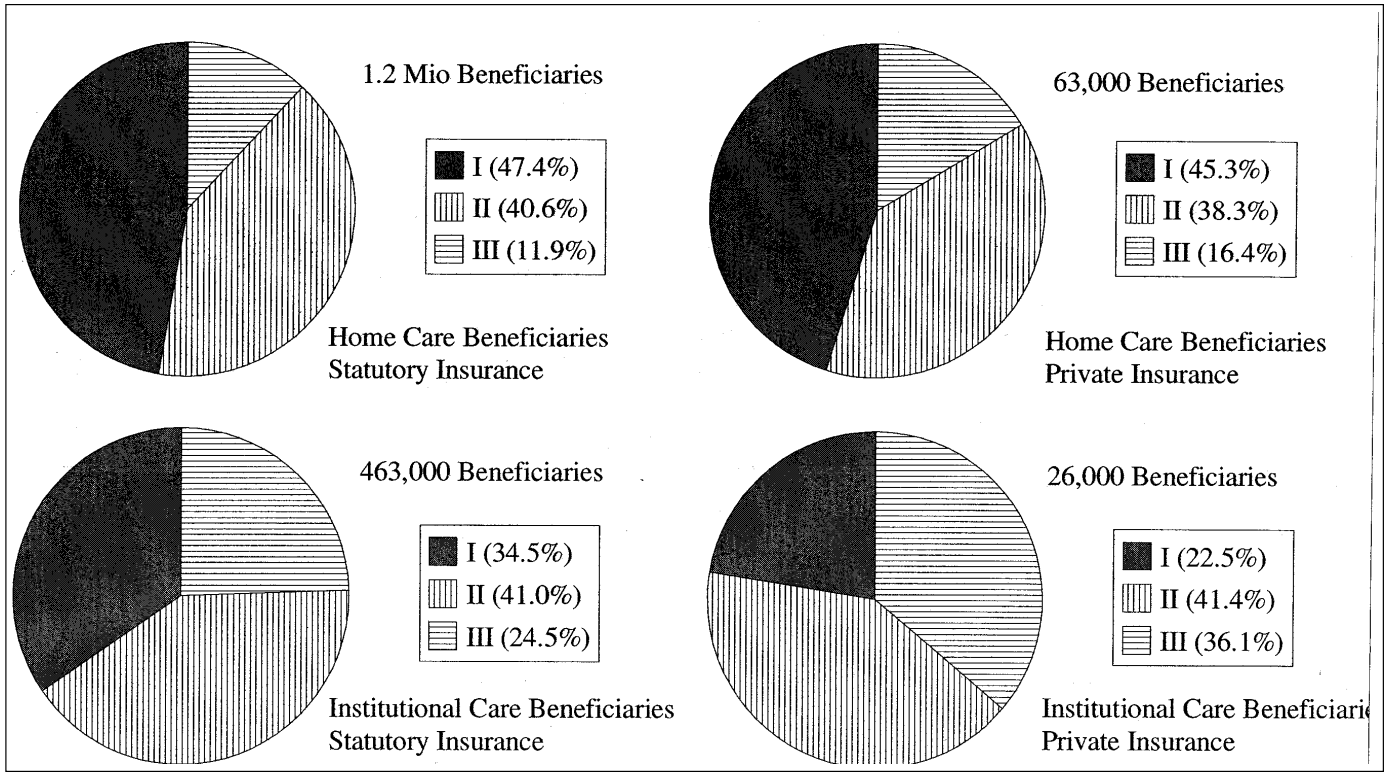

Figure 3. Beneficiaries by level of care dependency in statutory and private care insurance, Germany, 1998–99 (Mio = million). *Source*: Bundesministerium für Gesundheit (6).

Benefits are individual entitlements. There is no financial means test and no discretion in resource allocations (e.g., differences in the availability of informal care). Benefit rates are set at the federal level; they are not indexed to inflation and have not been changed since implementation of the program. Benefits have ceilings and are not intended to cover the full cost of required services. The program is financially very secure—in fact, after four years of operation it is running at a significant surplus (see Table 4).

Three main criticisms of the program are (*a*) the threshold of eligibility for the program is too high; (*b*) the assessment is inadequate for applicants who are cognitively impaired and whose care needs are mainly those of supervision; and (*c*) there are disadvantages in the program for younger disabled persons. The eligibility assessment focuses on the frequency with which assistance is needed for ADL-related personal care needs. As a consequence, people with considerable needs in housework, mobility, and social activities often do not qualify. It has also been said that people with dementia-related illnesses are not receiving equitable assessment ratings compared with people with physical incapacity. And younger disabled people complain that the care insurance program, among other disadvantages, does not allow for the personal assistance model of service provision, which was possible under the social assistance program. On the last two counts—concerning cognitively impaired applicants and the younger disabled—program changes are under way.

2. With a program such as the German LTC insurance, the institutional bias of LTC provision can be reversed. The focus would shift to care in the community.

The LTC insurance benefits are either service benefits or a cash benefit; services include home care in the household, the use of day care or night care facilities, respite care, and institutional care (Table 2). The service "voucher" benefit allows beneficiaries to use the service of their choice. Service providers, as in the U.S. health system, bill the care insurance funds directly for their services. The cash benefit is a monthly payment, at about half the value of the service benefit. It is aimed at beneficiaries who choose to arrange for their care privately. There are no formal restrictions on how the cash is to be used. However, the assumption is that the money is passed on to informal caregivers. Beneficiaries may also select any combination of the service and cash benefits, according to their individual situation, and may revise their decision every six months (Table 3). In 1998, the overwhelming majority (75 percent) of beneficiaries cared for at home chose the cash benefit, 11 percent chose the service voucher, and 14 percent a combination of the two. The decision between cash or service benefit appears to be related to two factors: the severity of care needs and the availability of a stable informal support network (10). The more stable the network (socially and geographically), the more likely is the choice of the cash benefit. Beneficiaries with higher levels of need tend to choose the service benefit or a combination.

Table 2

Benefit types and values for the German LTC insurance program[a]

	Value by level of care, DM (U.S.$)		
	I	II	III
Home care benefits if arranged privately (cash benefit)	400 (222)	800 (444)	1,300 (722)
Home care benefits if provided by approved provider (service benefit)	750 (417)	1,800 (1,000)	2,800 (1,556)
Use of day care or night care facilities, including transportation (counts as proportion of service benefit)	750 (417)	1,800 (1,000)	2,800 (1,556)
Institutional care benefits	2,000 (1,111)	2,500 (1,389)	2,800 (1,556) [up to 3,300 (1,833) in exceptional circumstances]
Respite care (annual benefit)			
For approved provider service (service benefit)	2,800 (1,556)	2,800 (1,556)	2,800 (1,556)
For substitute caregiver (cash benefit)	400 (222)	800 (444)	1,300 (722)
Reimbursement for lost earnings and/or travel expenses of substitute caregiver	Up to 2,800 (1,556)	Up to 2,800 (1,556)	Up to 2,800 (1,556)

Sources: Schunk (9, updated data); Bundesministerium für Gesundheit (6).

[a]Values current in 1999; conversion rate: 1U.S.$ = 1.80 DM (deutsche marks). All except respite care are monthly benefits.

The preference for the cash benefit was even stronger in the very first years of the program, but between 1995 and 1998 there has been a slow increase in the percentage of beneficiaries choosing the service benefit and the combination benefit. This may be early evidence that people are becoming more open to service-supported care at home, perhaps as an alternative to entering institutional care. So far, however, the percentage of beneficiaries in institutional care has been

Table 3

Types of beneficiaries (number and percent) in the German LTC insurance program, 1995–98

Year	Cash benefit	Service benefit	Combined benefit	Day/night care	Respite care (cash)	Respite care (service)	Institutional care
1995	887,403 (83.0%)	82,790 (7.7%)	82,293 (7.7%)	1,777 (0.2%)	10,783 (1.0%)	3,649 (0.3%)	—
1996	943,878 (60.4%)	105,879 (6.8%)	135,305 (8.7%)	3,639 (0.2%)	6,805 (0.4%)	5,731 (0.4%)	360,853 (23.1%)
1997	971,939 (56.3%)	119,428 (6.9%)	157,453 (9.1%)	5,065 (0.3%)	3,716 (0.2%)	5,633 (0.3%)	464,890 (26.8%)
1998	962,669 (53.6%)	133,895 (7.5%)	171,764 (9.6%)	6.774 (0.4%)	4,070 (0.2%)	6,199 (0.3%)	589,293 (28.4%)

Source: Bundesministerium für Gesundheit (6).

relatively stable (25 percent of all beneficiaries) (6). We must keep in mind, though, that the majority of people currently in institutional care entered before the LTC insurance program took effect, and thus it may be too early to measure effects such as a decrease in the usage of institutional care. Future research may show that in a longer perspective, shifts in the continuum of care may occur as a result of the expansion of home care services through LTC insurance.

Contrary to the little evidence on changes in the usage of services, it is clear that the LTC program has brought a significant shift in expenditure on home care benefits. Approximately half of the national expenditure of the LTC program goes into benefits for people cared for at home (Table 4); this expenditure has increased 6.5-fold since the start of the program. This is an impressive achievement, considering the 9:1 ratio in favor of institutional care under the previous means-tested social assistance scheme.

As a consequence of the increased funding through the LTC program, the number of home care agencies and day care facilities has rapidly increased, mainly in the for-profit sector. However, owing to the low take-up of the formal service option, the growth of this sector has been much smaller than expected. There is little empirical information on the determinants of service usage, particularly home care services. The general speculation is that those services may not be sufficiently consumer friendly and that care culture is very family and self-sufficiency oriented (11). For example, critics have noted that services reimbursed

Table 4

Earnings and expenditures of the German LTC insurance program, 1995–98

Item	DM, billions			
	1995	1996	1997	1998
Earnings	**16.44**	**23.55**	**31.18**	**31.30**
Expenditures for benefits, total of items 1–8	8.64	20.05	28.05	29.47
1. Cash benefit	5.94	8.68	8.45	8.38
2. Service benefit	1.35	3.02	3.47	3.89
3. Respite care (cash)	0.26	0.26	0.10	0.11
4. Day/night care	0.02	0.05	0.07	0.09
5. Respite care (service)	0.09	0.17	0.19	0.21
6. Social protection of informal caregivers	0.60	1.81	2.32	2.26
7. Equipment and home adaptations	0.38	0.77	0.65	0.73
8. Institutional care	0.00	5.28	12.80	13.80
Cost of assessment service	0.44	0.47	0.45	0.47
Administrative overhead	0.62	0.71	1.08	1.09
Other expenditures	0.01	0.01	0.02	0.03
Total Expenditures	**9.72**	**21.24**	**29.61**	**31.05**
Liquidity				
Income (earnings minus total expenditures)	6.72	2.30	1.57	0.24
Cash reserves at year end	5.62	7.92	9.49	9.74

Source: Bundesministerium für Gesundheit (6).

by the LTC insurance program are highly segmented and inflexible; gaps in the service spectrum remain, such as the lack of information and care-management services, as well as so-called "soft services" (visiting, social, and recreational services) (9, 12). Arguably, as long as the cash option in its current form continues to be popular, there will be little pressure for additional public expenditure to develop a network of supplementary services.

3. Introduction of the LTC insurance program in Germany represents a significant extension to the social protection of informal caregivers (mainly women).

The extension of expenditure through the care insurance for home care benefits, the cash benefit in particular, has been criticized as inefficient since there is no evidence of savings through the benefit (13). Indeed, the few studies that have looked at how the cash benefit is spent found no evidence that it is directly related to an increase in the amount of informal care (11). The "efficiency" argument is problematic, however, since it questions the value of benefits that bring significant

improvements to the situation of those, mainly women, who perform unpaid care and work within the household. For Germany, as for most other countries, the majority of LTC services are provided through informal care; women, as the main caregivers, experience massive economic and health-related "costs" as a result of this unpaid caregiving. So far, there has been an enormous failure in public policy to provide support to informal care activities and to compensate the women who provide them. A range of benefits in the German LTC insurance program addresses the previous lack of support and recognition of informal care arrangements. Apart from the cash benefit, these include an annual respite care benefit and pension and accident insurance contributions for the informal caregiver.

The policy aim of the cash benefit was to support home care arrangements. Notably, the person who receives the cash benefit is the person with disabilities, not the informal caregiver. According to the care insurance law, how the cash benefit is spent is considered a private decision. Relatively few studies have looked at the precise use of this benefit. However, the few data available indicate that the cash benefit enables families to make small payments to various persons in the informal support network without financial hardship (10, 11). In the majority of cases where the informal caregiver and the care recipient live in the same household, the cash benefit becomes part of the shared household income.

As noted earlier, the cash benefit has only half the value of the service benefit. Both the low level and the distinction between cash and service benefits have been criticized (14). Policymakers argue that the benefit is designed to constitute a recognition, not a payment, of the informal caregiver. Informal care, it is argued, is different from care provided by professional services, and from models in which the disabled person employs and pays "personal assistants." Providers of professional services must undergo licensing and accreditation procedures with the care insurance funds; they also pay taxes and social insurance contributions for their employees. On the contrary, any amount of the cash benefit passed on to informal caregivers is not counted as taxable income; it is also not counted as income for means-tested benefits such as unemployment benefit or social assistance.

Once a year, respite care benefits can be drawn, as either a service or a cash benefit. The value of the service benefit is equivalent to the highest monthly service benefit irrespective of the level of care dependency of the beneficiary; the value of the cash benefit, however, varies with the level of care dependency. Lost earnings or travel expenses of the privately arranged substitute caregiver can be claimed, up to the value of the service benefit.

Importantly, the LTC insurance program also covers monthly pension insurance contributions for informal caregivers who provide care for a minimum of 14 hours per week. The contribution rate is calculated by using a projected wage, depending on the grade of care dependency and the amount of care provided. The scheme has added significantly to secure retirement income for informal caregivers, and it is women who benefit from this. In 1998, pension contributions amounted to about

8 percent of the total expenditure of the program and were paid for about 500,000 informal caregivers; 93.5 percent of these were women (6).

Still, it is difficult to combine employment and caregiving activities, because of the predominantly "private" culture of care and the shortfalls in social service provision in Germany. The argument has been made that because the LTC program includes improvements for caregivers and the cash benefit, women will continually be drawn away from the labor market to provide informal care at home. This must be seen within the framework of social security institutions in Germany, which represent a "system of strongly employment related social insurance with stratifying and status maintaining effects, weak universal rights and underdeveloped public services and infrastructure for children, families and persons in need of care" (15). Against this background, the introduction of caregivers' benefits in the LTC insurance program can only be seen as piecemeal reform, as a limited upgrading but no real extension of social rights for women. Ultimately, the culture of care needs to change toward a model of "shared care," which to a much greater extent combines informal caregiving with the use of collectively provided services to make economic activity and caregiving more compatible.

4. A U.S. LTC program, similar to the German plan, would protect a significant number of people from "spending down" and the catastrophic costs associated with LTC needs. In addition, the LTC expenditures of the Medicaid program would drop significantly.

Before the introduction of LTC insurance in Germany, the percentage of recipients in institutional care who entered the social assistance rolls was approximately 65 to 70 percent in West Germany, and was nearly 100 percent in the eastern part of Germany shortly after unification (dropping to 90 percent over the next few years) (16, 17). These figures match the situation in the United States surprisingly well: between 1991 and 1997, approximately 68 percent of residents in certified nursing facilities were primarily paid for by Medicaid (18).

However, a recent study shows that, despite the German LTC insurance benefits, less than 20 percent of former social assistance recipients in institutional care have been able to leave the social assistance rolls. (The German plan has benefits with ceilings; it does not cover costs of board and lodging and capital cost shares for institutional care.) The ceilings of the care insurance benefit create the greatest difficulty for people with the highest level of care dependency. For people in this category, the care insurance benefit covers a smaller proportion of the costs than does the benefit for those at the other, lower, care dependency levels. Thus, in the sample studied by Rothgang and Vogler (19), 90 percent of people with a high level of care dependency in institutional care still received social assistance payments. However, the total expenditure of social assistance payers (the states and counties in Germany) on LTC costs has dropped by 60 percent since the

introduction of the care insurance scheme. More than 80 percent of these savings have occurred in the group of people who continue to receive some share of social assistance. Though this may seem like a paradox, it is not. Because social assistance only "adds" the remainder of costs, pension income and care insurance benefits now pay for the largest share of LTC costs.

In summary, social assistance payments for care costs still play an important role in Germany, because the LTC insurance benefits have ceilings. It is the social assistance payers (the states and counties) that have benefited hugely through their reduced expenditure. Between 60 and 80 percent of people in institutional care still have to "spend down" and end up on the social assistance rolls. Again, the majority of people in institutional care entered before LTC insurance was implemented. Future data may show that with this program, the percentage of people who are becoming newly poor as a result of their LTC needs is considerably less. However, if we think about an LTC insurance program for the United States, it is important to keep in mind that while it might result in significant savings for Medicaid payers, it may not make such a difference to the situation of persons in need of LTC.

5. If the current fragmented system that splits acute care from LTC could be overcome, then, theoretically, there would be more integrative care provision, significant coordination gains, and emphasis on prevention, rehabilitation, and multidisciplinary approaches to LTC.

Although policy analysts in the United States argue that these benefits should be provided (20, 21), the United States has yet to develop a system that successfully achieves all these benefits, despite many demonstration programs (e.g., social health maintenance organizations). The German care insurance is not a good model for this integration either. The split between health and LTC continues in Germany. Health insurance and LTC insurance are financially and administratively separate programs, although they are run under the same roof of the sickness insurance. Each sickness insurance fund has, so to speak, its own care insurance department. This separation has its origin in the fact that Germany has been battling more or less unsuccessfully to curb health costs and there were substantial fears that LTC costs would make cost containment even more unlikely.

The LTC insurance program has much firmer cost controls than the health sector, mainly through the benefit ceilings (14). It has been described as an experiment in cost containment (5). However, like the health sector, LTC insurance offers free provider choice. Although this choice of provider organization may seem essential for consumer control, gaps in coordination and integration of care at the individual level remain. Patients may get lost (in their pathways through care) in both the health and the LTC sector, because there is little guidance and information. The LTC assessment in particular has been described as too medicalized (22), and the program contains no care management. Professional boundaries in service delivery remain as they were before. One consequence of the

split between the acute health and LTC sectors is that it gives no incentives to expand the availability of rehabilitation or preventive measures for elders. Instead, the separation gives financial incentives to limit one's expenses and shift costs to the other sector.

Since the introduction of LTC insurance, not only has the German system retained the sickness-LTC split, but the program's benefits (with ceilings on the amount beneficiaries receive) have led to the continuing role of the municipalities and counties as payers of the subsidiary means-tested social assistance program—although their expenditures have been reduced significantly. Because of their financial obligations, municipalities and counties have little incentive to work toward improving services and making them more accessible. The LTC program also gives responsibility for capital investment in services to the state. There is a wide variation in funding mechanisms and levels of commitment (8, 23).

As in Germany, LTC service provision in the United States is characterized by a high degree of institutional and financial fragmentation. The introduction of a nationwide and comprehensive LTC program theoretically could reduce this fragmentation; but this may not automatically be the case. The LTC program in Germany introduced one more powerful actor (the care insurance funds) into the already complex policy and administrative networks. Examples of the negative consequences of fragmentation in Germany since the introduction of LTC insurance include additional incentives for cost-shifting between various levels of the state and between sickness and care insurance funds, and duplication and increasing complexity of decision-making (23). This may counteract integration and further "fragment" the delivery of care.

6. A national LTC insurance program, such as the German program, could readily include uniform national quality standards and thus be a powerful tool to improve the quality of care provision.

Yes. But again, the German LTC insurance program is not a good example. It is a mainly financially driven program. Quality improvements potentially increase costs, which act as disincentives for substantive action. The LTC insurance program has given most of the responsibility for quality assurance to the care insurance funds, which are the main financing bodies. Further quality-monitoring responsibilities at the state and municipal levels conflict with financial interests at those same levels of government.

Service costs and reimbursement rates are a matter of collective bargaining in Germany. This process is characterized by large "roundtable negotiations" between payers and providers at the state and federal levels. This is contrary to the situation in the United States, where government (including the states) sets the rates. In Germany, these negotiations are taken out of the political arena and largely dominated by technical and legal experts representing payers and providers' associations. One could speculate whether the procedures in Germany

result in more controls on providers' profit-making compared with those in the United States.

Despite care insurance, the quality/cost dilemmas in Germany and the United States appear very similar: providers are mainly self-interested and profit-oriented, not quality-oriented. Consumer "voice" and "exit" options in the LTC field are generally restricted owing to the nature of the services delivery (24). In addition, social service delivery in Germany has been characterized as having little consumer representation (25). This not only may have led to less responsive service delivery, but may also account for the overall moderate availability of services compared with other (European) countries.

The strong interests of providers and the weakly organized interests of consumers (including significant shortfalls in service access for minorities) in Germany have been suggested as main barriers to quality improvement measures (26). Observers have commented on the increasing bureaucratization and segmentation of care activities in Germany, which seems to run counter to the quality-related aim of integrative service delivery. Furthermore, no funds are earmarked specifically for quality improvement.

The corporatist policy networks in Germany give outside lobbying comparatively less room than does a more pluralist system such as the United States. Perhaps consumer groups in the United States can exert more influence on improving services. But the basic dilemma is similar: providers bargain for cost increases and payers try to keep costs down.

CONCLUSIONS

This article draws attention to some of the advantages and problems of long-term care insurance in Germany. In our assessment, the benefits are worth fighting for. These include entitlement to the LTC benefit, consumer choice among benefit types and providers, and the equitability of the program. Key features of the program, in view of its equitability, are that it is a national program with no variation by place of residence, that all citizens are eligible regardless of age and income, and that the assessment for eligibility is uniform.

For the United States, a similar program would be especially compelling. There is an urgent need to make LTC services available and accessible to all, regardless of income and age. In the United States, LTC benefits are publicly available only to the poor, thus forcing people with care needs into poverty. Because of the way in which LTC is funded, the U.S. system has a strong institutional bias in its care system. Services such as California's In-Home Support Services (IHSS) are accessible only to very poor older people. Moreover, it seems that the U.S. health system takes a particularly harsh stance toward people with LTC needs, given the limitations of the home health benefit under the Medicare program, the significant gaps in coverage, and copayment requirements.

When comparing the current policy in the United States with Germany before the introduction of the LTC insurance program, we find that the means test to qualify for Medicaid is stricter than in Germany under the social assistance program (e.g., asset exemptions are higher in Germany than in California; yet Germany has no spouse resource allowance). Coverage of limited LTC services by the sickness insurance program for acute care in Germany was more generous than Medicare in the United States (e.g., Germany has some limited reimbursement of psycho-geriatric day care and drug coverage, with limited copayments). The United States has much higher out-of-pocket costs under Medicare, and many health needs that are covered in Germany are not covered in the United States.

One of the strongest proposals in the United States for LTC coverage has been to follow a social insurance model (27, 28). The LTC insurance program in Germany follows such a model, with its main contributors being employers and employees. However, retired people and unemployed people also contribute to the program. Critics in Germany have argued that the social insurance model is not adequate for both health and LTC, since LTC benefits (like other health benefits) are not related to previous earnings and contributions and should instead be financed through general taxation (29).

Characteristic of social insurance are the spreading of risk across a huge risk pool and the redistributive elements, irrespective of financing modes; social insurance can be tied either to payroll taxes or to general revenues. The German LTC program embraces such redistributive elements, as does Germany's health insurance system. "These patterns of social balancing and ex ante redistribution reflect the logic of solidarity, and the resulting interpersonal redistribution is a political goal. But the young, healthy, single and high-wage earners must acknowledge that these redistributive mechanisms operate at their expense" (30).

The German program gives everyone with LTC needs an entitlement to coverage of the same share of their LTC costs. This has moved long-term care dependency into the "legitimate" realm of social-insurance-covered risks. Financially, some people benefit more than others (the middle class benefits the most), although some are at a particular disadvantage because of the various cost-containment features (e.g., people just under the care dependency threshold who do not qualify for benefits under the plan).

Among the most attractive features of the LTC insurance program in Germany are the high degree of consumer choice, advances in the recognition and compensation of informal caregivers, and greater spending on community-based care, which has resulted in an (albeit slower than expected) extension of community-based services. Younger disabled persons, on the contrary, have experienced restrictions in the use of the personal assistance model under the German plan. Proposals are under way that would enable disabled people to register with care insurance funds, thus allowing them to claim the higher value service benefit for their reimbursement.

There are several shortcomings in an LTC program such as the German model. Once it is implemented, the "problem" is likely to be regarded as solved, despite remaining shortfalls. This is especially so when the program (as in the German case) has surpluses and is financially "healthy." It becomes politically difficult to address/redress the shortfalls. And it is particularly difficult to address shortfalls that arise from a collision of interests, such as that between financing agencies or between providers and consumers.

A note of caution: many of the shortfalls in services for elders in Germany, persisting despite LTC insurance, may similarly persist in the United States, because they are institutionally determined—delivery and financing of these services are institutionally fragmented in both countries. The context of the debate on LTC in the United States is one of cost containment and high health-related expenditure—a very similar starting point in the two countries. The model character of the German care insurance perhaps lies in its offering a viable shortcut in the face of these (ideologically constructed) cost constraints. However, the ongoing problems of cost-shifting between sickness insurance and LTC insurance in Germany are still a concern; perhaps these problems could be limited if the LTC program were more inclusive. An LTC program in the United States could perhaps include rehabilitation and preventive measures, thus making the LTC provision more inclusive and coordinated and avoiding some of the boundary problems between health and long-term care.

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Direct reprint requests to:

Dr. Carroll L. Estes
Institute for Health and Aging
University of California, San Francisco
3333 California Street
Laurel Heights Campus
San Francisco, CA 94118