Care services for the elderly in Germany: infrastructure, access and utilisation from the perspective of different user groups

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Zusammenfassung

In dem Discussion-paper wird die Entwicklung der ambulanten, stationären und semi-stationären Pflegeinfrastruktur seit der Einführung der Pflegeversicherung analysiert und mit einer Darstellung niedrig-schwelliger Angebote auf lokaler Ebene ergänzt. Zugänglichkeit und Inanspruchnahme der vorhandenen Dienstleistungsangebote werden aus der Perspektive unterschiedlicher Gruppen älterer Menschen betrachtet. Die Ergebnisse basieren auf einer Analyse von Statistiken und Berichten sowie auf Interviews mit Experten/innen.

Die Untersuchung bestätigt die Expansion ambulanter Pflegedienste seit Einführung der Pflegeversicherung sowie die Modernisierung und zunehmende Diversifikation stationärer Wohnformen seit den 1980er Jahren. Der steigende Anteil von Empfängern/innen von Pflegeversicherungsleistungen die in Pflegeheimen versorgt werden, verweist auf Probleme der Versorgung älterer Menschen in der häuslichen Pflege. Dies betrifft den Ausbau und die inhaltliche Konzeption der semi-stationären Angebote. Hinzu kommen das zu geringe Angebot und die regionalen Disparitäten im Bereich niedrig-schwelliger Dienste, die älteren Menschen die Teilnahme an sozialen- und Freizeitaktivitäten ermöglichen sowie pflegende Angehörige entlasten sollen. Als Lösungsmöglichkeiten werden die Einrichtung eigenständiger Kurzzeitpflegeeinrichtungen einschließlich der Etablierung einer Übergangspflege nach einem Krankenhausaufenthalt, die Förderung und Finanzierung niedrig-schwelliger Angebote und die Einrichtung spezifischer Angebote für ältere Menschen mit dementiellen Erkrankungen bzw. für deren pflegende Angehörigen diskutiert.

Die Inanspruchnahme unterschiedlicher Leistungen der Pflegeversicherung weist deutliche Einflüsse nach Geschlecht, sozialer Schichtzugehörigkeit, Ethnizität und Wohnsituation auf. Dazu gehört die Auswahl konkreter Leistungen, die Rolle der informellen Pflege im Rahmen der Familie aber auch die Möglichkeit durch die Pflegeversicherung nicht-abgesicherte Pflegebedarfe mit eigenen, privaten Mitteln zu ergänzen. Weiterhin werden deutliche regio-nale Einflüsse in der Versorgungssituation älterer Menschen erkennbar.

Abstract

The discussion paper analyses the development of the home-based, semi-residential and residential care infrastructure since the introduction of the long-term care insurance. The presentation is supplemented with a review of local area low-threshold offers. The accessibility and claims on available service offerings are discussed from the perspective of different groups of elderly people. The results are based on the analysis of statistics and reports as well as interviews with experts.

The research confirms the expansion of home-based care services since the introduction of the long-term-care insurance as well as the modernisation and increasing diversification of residential care facilities that had already begun in the 1980s. The increasing number of nursing-home admissions points to problems in the care of the elderly in their homes. The expansion and conceptual approach regarding the semi-residential offers has been revealed as one deficit. In addition, there are not enough offers and a marked regional disparity in the low-threshold service area that could supplement care arrangements in the area of social- and leisure activities and also unburden family members. As solutions are discussed the establishment of transitional care services after discharge from hospital, the promotion and financing of care offers in the area of social and leisure activities and the implementation of specific offers for elderly people with dementia respectively for their family carers.

The claims which are made for specific care insurance benefits show the clear influence of gender, social status, ethnicity and living conditions. This applies not only to the choice of the actual offers and the role of informal care within the family framework but also to the possibility of complementing care needs that are not covered by care insurance benefits with private means. Furthermore, there are regional influences that are also predominant in the care situation of the elderly.

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Introduction: Approach of the study

As one pillar of the social insurance system in Germany, the long-term care insurance is at the centre of the political debate on the future of the welfare state. The issues which are raised attain to the current and the expected future financing problems due to demographic changes. In contrast, the strengths and weaknesses of the insurance in securing the long-term care provision are neglected within the debate. The development of the care infrastructure and the care situation for different groups of elderly people in Germany is analysed in the research presented in the discussion-paper. The evaluation explores different types of care-services established mainly within the framework of the long-term care insurance. In addition, it also includes services provided by different actors on the local level and housing possibilities, which are aimed at supplementing the care offers of the insurance. The different services are investigated according to the figures and characteristics of the providers, the organisation and service offers, access, number and characteristics of users as well as the mode of financing and the costs for users and the situation for the staff. The evaluation enables to assess the development of the care infrastructure, the strengths and weaknesses of the care services related to different groups of elderly and thus demonstrating the achievements of the long-term care insurance. By comparing the financing developments of the social long term care insurance and private long-term care insurance, the prospects of the introduction of a citizen-insurance is discussed in the conclusion.

Established on a federal level, long-term care insurance is bone fide law for the Federal Republic, but its implementation is on the level of the Länder (Bundesländer) and oriented on their specific conditions. In order to attain an overview of the implementation, Brandenburg was selected as an example for the new Länder, for the old Länder Baden-Wurttemberg, and Berlin, which is both a Land and a large city. The availability of statistics on a federal level and the congruence of key features in the Länder, allows the illustration of the situation as a whole in the Federal Republic. The discrepancies between the Länder are used to elaborate the statements.

The investigation is being carried out within the framework of the EU-Project “Care for the Aged at Risk of Marginalization” (CARMA), where in a comparison between seven EU-

member states, respectively EU-candidate states, the care infrastructure is analysed and compared.[1] In the first part of the report the demographic development, the pension system, the economic situation of the elderly as well as the development and characteristics of the long-term care insurance are presented. This part is aimed at describing the context of the development of the care infrastructure, the social situation of the care receivers and the expected demographic change. In the second part the findings of the analysis of the care infrastructure and the care situation of different groups of users are discussed. Statistics, reports, materials and research results form the background of the analysis. In addition, 19 acknowledged experts were interviewed on the federal, the Länder and the local area levels to reveal in-depth information on this process and illustrate status quo (see appendix table A1).

1. Context

1.1 Demographic situation

At the end of 2001, Germany's population was approx. 82.44 million with 14.06 million people over 65 years (17.07%). 7.32 million or 8.9% of the population were foreigners (i.e. non German citizenship status) with a proportion of 5.25% or approx. 384,000 people over 65 years (Federal Statistical Office 2002a).

The demographic development in Germany is characterised by an ever increasing process of population ageing. This is due to a decline of the birth rate since the 1970s, and an increase in the average life expectancy. Since the 1970s in the former territory of the Federal Republic, the birth rate has not achieved the level of 2.10 children per 1000 women, which would be necessary to maintain the level of the population. Since the beginning of the 1990s, the birth rate is just below 1.400 children per 1000 women where it is expected to remain. In the new

[1] Partners from the following countries are participating in the project: Austria, Belgium, Estonia, Germany, Italy, Northern Ireland and Norway. Funding from the European Commission is gratefully acknowledged.

Länder the birth rate with 1.200 children per 1000 women is even lower but it has recovered during the 1990s and is estimated to reach the same level as the western part in 2010. (Federal Statistical Office 2003a).

The development of life expectancy reflects gender differentials. The life expectancy of boys is estimated to increase from 74.8 years in 1998-2000 to 81.1 years in 2050 and for girls from 80.8 to 86.6 according the 10th co-ordinated population prognosis (Federal Statistical Office 2003a).[2]. In addition, the prognosis assumes a rise in the further life expectancy of a 60 year old man by 4.5 years to 23.7 years in 2050 and for women of the same age by 4.7 years to 28.2 years. Due to the gender differences in life expectancy, in 1999 two-thirds of the elderly over 75 years were women (Federal Statistical Office 2002b). The assumed life expectancy in combination with the low birth rates is expected to result in a decline of the total population by more than 10 million by 2050, with the number and proportion of people over 65 years rising to 21.4 % in 2020 (Naegele/Walker 2002). The number of people over 80 years is assumed to rise from 3.4 million in 2000 to 5.8 million in 2020 (Kruse et al. 2003).

Household size and family structure determine to a great extent the availability of informal care resources. In 2001, the proportion of one-person-households in the whole population amounted to approx. 36.5% and the proportion of two-person households to a further 33.5% of all households.(Federal Statistical Office 2003b).

Table 1: Household size by age group and sex in 1998 (%)

	Women	Men	Women	Men	Women	Men
Age group	70-74	70-74	75-79	75-79	80+	80+
Households						
1-person households	45.1	13.9	60.7	18.6	71.5	32.7
2-person households	48.4	75.8	33.0	73.9	17.6	59.4
Households with 3 or more persons	6.5	10.2	6.3	7.5	10.9	7.9

Source: Kruse et al. (2003 :17)

[2] The prognosis contains different models for the future development, which are developed on the basis of defined suppositions. The statements in the report are full of uncertainties.

Household size and family structure show a clear gender profile for the aged. In 1998, 71.5% of the women over 80 years lived in a single household compared to only 32.7% of the men (see table 1). Detailed analysis on the living-situation of migrants revealed differences especially with elderly women. Only 50.4% of female migrants over 80 years lived in a single household, 20.2% with their partners and a further 22.7% with relatives (Zeman 2002).

1.2 Pension system and the economic situation of the elderly

The pension system in Germany includes different components, which vary according to their mode of financing, social group, level of benefits and the degree of voluntary involvement. Schmähl (2002:7) describes the German pension system as a three tier system consisting of:

- Mandatory basic schemes as the first tier
- Supplementary occupational schemes as second tier and
- Additional private old-age provision as third tier

Several different mandatory pension schemes exist for different groups of the population. The most important system, the mandatory statutory (social) pension scheme covers more than 80% of the population. This statutory (social) pension is financed as a pay as you go system with equal contributions from employees and employers up to a certain limit of the gross earnings and is subsidised by federal government taxes. In 2004, the overall contribution rate was 19.5%. The pension benefit payments are earnings-related and are calculated on the basis of all earnings during a working life. On the death of a partner widows and widowers are entitled to a pension of 60% of the partner's pension payments.[3] Since the 1980s, mothers and fathers bringing up children under the age of three or people who look after persons in need of care for a defined time-period have compulsory insurance. Further social insurance schemes have been introduced for specific groups of the population, e.g. for farmers and several other groups of professionals (e.g. lawyers). The pensions of civil servants are financed by public

[3] The law has been changed to emphasise the family-status instead of marital-status as the basis for calculation: If both partners were younger than 40 years in 2001, they will be entitled to only 55% of the deceased partner's pension payments in widows/widower's pension benefit, supplemented by a so-called child-component for married couples with children.

taxes and are calculated on the basis of an individual's latest gross earnings and the number of years employed.

The occupational schemes supplement as a second tier the statutory (social) pension scheme. While in the public sector, in principle, both white and blue collar workers are covered by a occupational pension scheme, this holds true for only about 50% of the employees in the private sector. Here the access to a company based insurance increases with the size of the firm, e.g. in firms with more than 5000 employees, nearly 90% of the workforce participate in an occupational pension scheme. Despite a great variety of pension arrangements in the private sector, they usually have two common features: They are financed by the employer and are based on capital-funding.

The private insurance schemes, the additional third tier of the German pension system, consist of very different types of funds and insurance, which can be used as a source of income in old age. The German government grants tax deductions and allowances to encourage savings in private funds. Federal statistics show, however, that the possibility of availing oneself of this third type depends on an individual's net income situation. In 2001, only 23% of persons older than 14 years with a net-income of below 511 € held a private life- or pension insurance contract, compared to 54% of persons with average incomes (1534 € to 3068 €) and 65% of persons with a monthly net income more than 3068 Euros (Federal Statistical Office 2002c)

On the background of the prognosticated demographic developments, some pension reforms have been introduced to reduce the expected growth of pension expenditure. The latest reform in 2001 is characterised by a shift in some of the objectives and measures in an effort to achieve its realisation (Schmähl 2002, Naegele/Walker 2002):

- The introduction of a compensation factor aims at reducing the level of pension benefits and adapting the system to the demographic development. The replacement rate of a standard pensioner (45 earning points/years) will decrease from 70% (at present) of the average net earnings of the individual pensioner to 64%. This will lead to considerably lower pension benefits. The effects will be reinforced by the fact that only a small proportion of the elderly will receive benefits on the standard level. Today, due to the

policies of early retirement and career breaks, about 50% of all men and 95% of all women receive pension benefits below the standard level.

- The individuals themselves are required to compensate the loss of income voluntarily by signing capital-funded private old age insurances or by firm-based arrangements respectively. The government supports the development by subsidizing contributions if the arrangements fulfil certain criteria. The shift in the system is intended to promote private insurances and thus create a new mix between the public pay-as-you-go system and a private capital-funded system.
- A universal pension scheme based on residential status or citizenship has not been introduced in Germany to provide a minimum living-standard and thus prevent poverty. With the pension reform of 2001, persons over 65 years are entitled to a means-tested transfer payment, which is automatically provided as a supplement to pension benefits and aims at guaranteeing elderly people a minimum income on the social assistance level. In contrast, to the social assistance payments based on the principle of subsidiary, children up to a yearly income of 100.000 € are no longer made responsible for the economic support of their parents.

The poverty rate has declined since the 1970s when poverty among the elderly was quite widespread. The poverty rate of approx. 5% among the elderly in 2000, is below the average level of the population at a whole (Federal Statistical Office 2002b).[4]

Table 2: Personal net income of people 65 years old and more by sex in 2001 (%) [5]

Former territory of the Federal Republic of Germany

DM	-1000	-1800	-2500	-3500	-4500	4500-
Male	3.85	15.85	33.10	27.53	9.71	10.80
Female	27.68	30.49	22.97	11.63	4.13	3.12

[4] The poverty line is defined as a household income below 50% of the average income of a comparable household.

[5] Personal net income is defined as the personal income of one member of the household. In addition to the pension payments it includes all further types of incomes, which may be granted, e.g. housing allowances, social assistance benefits. For the calculation of the personal net income the additional income, calculated on the basis of the household, is divided equally between the members of the household.

New Länder and East Berlin

DM	-1000	-1800	-2500	-3500	-4500	4500-
Male	1.18	31.83	48.28	16.16	1.77	0.49
Female	15.48	46.22	28.43	6.58	1.60	0.60

Source: Federal Statistical Office (2001a)

Despite the general positive trend, the economic situation of the elderly is very heterogeneous (see table 2). The earnings- and working life related social insurance pension payments privilege workers with long and continuous periods of employment and put women with career breaks and blue-collar workers without vocational qualification often at a disadvantage. The more equal distribution of income in the new Länder is due to the wage structure in the former German Democratic Republic (GDR). Furthermore, the continuous labour market participation of the women in the former GDR resulted in a smaller proportion of women with very low pension payments. In the process of re-unification, the contributions paid towards the statutory social pension scheme in the former GDR were accepted as a basis for the calculation of pension payments. The significance of the statutory social pension scheme differs in the two parts of the country. Whereas in the new Länder more than 90% of the pensions are financed by the statutory social pension scheme, the rate is only about 60% in the former territory of the Federal Republic. (Federal Ministry of Labour and Social Affairs 2001). In both of the parts of Germany, the future trend towards a rise in the number of discontinuous working-careers will result in a even more heterogeneous income structure and increase the risk of poverty in old age.

1.3 Long-term care insurance

Social long-term care insurance (Social Statutes XI – SGB XI) was introduced in two steps in 1995/96 as an independent branch of the social security system. For non-members of the Statutory Health Insurance Scheme, a compulsory care insurance was set up within the

framework of private health insurances[6] Until the introduction of the insurance, the need for care was defined mainly as the private responsibility of the family and the elderly were usually cared for by relatives. However, two life situations had already been recognized as a social risk and regulated by welfare state interventions. With the Health Reform Law of 1989, the costs for respite care for the informal carers could be refunded and with the Reform in 1991, a limited group of very frail people were entitled to cash or in kind service by the Statutory Health Insurance Scheme (Social Statutes V- SGB V). Under the Federal Social Assistance Act (BSHG) 1961, payments for home-based and residential care were covered by the tax-based welfare system if the elderly could not meet the costs. In particular, the high costs of residential care left a high proportion of the elderly dependent on social benefits or strengthened their dependence on their children. In 1991, the municipalities, which are responsible for financing social benefits in Germany, used about one third of their total social assistance expenditure to cover the costs of long-term care (Ostner 1998).

The long-term care insurance was drawn up according to the following basic principles and corresponding objectives:

- Orientation towards basic daily activities and basic needs.

The prerequisite for benefits is the necessity for a frequent and significant level of help or assistance in daily activities (housekeeping and personal care i.e. mobility, eating and personal hygiene) that has to have existed at least for six months. On the basis of a predefined assessment procedure, the claimants are assigned to three different levels (assessment levels I, II, III) characterised by an increasing severity of dependency and need of help. The level of need is analysed according to three categories, i.e. number of daily activities where assistance is needed, the frequency of assistance during one day and night and the necessary time used for the assistance (see table 3). An example for assessment level I would be a care-dependent person who needs assistance with two activities at least once a day within the area of personal care, e.g. personal hygiene in the morning and eating lunch and in addition with the house-

[6] Within the framework of the Statutory Health Insurance about 90% of the population is insured by a wide range of different insurance funds. The private health insurances cover about 9% of the population. These are mostly white-collar workers above a certain earning limit, self-employed professionals and state officials.

Table 3: Assessment levels long-term care insurance and corresponding benefits

Assessment Levels			
Need of care	I *Considerable*	II *Substantial*	III *Most substantial*
Within the range of Personal care	Two daily activities	Daily activity	Daily activity
	Once per day	Three times a day	Round the clock
Housekeeping	Several times a week		
Time	90 min/ day	3 hours/day	5 hours/day
Within share: Personal care	45 min.	2 hours	4 hours
BENEFITS (€)			
	I	II	III
Cash	205	410	665
Professional Services (home-based)	384	921	1432/1918
Residential Care	1023	1279	1432/1688

Notes:

The benefits granted in assessment level III for professional home-based services and residential services are extended in the case of an extraordinary high need of care.

If the care recipients choose a combination of cash and professional services, the proportion of the cash benefits will be complemented with professional services for the remaining percentage (up to 100%).

Source: SGB XI

keeping several times a week. The minimum time needed for the assistance is defined with 90 minutes a day, 45 minutes of which must be used for the assistance with personal care (see table 3).

The benefits are classified in defined amounts of payments related to the three dependency levels and fixed by the law. The payments differ in regard to whether the elderly prefer cash to pay the carers themselves, accept professional services, choose a combination of cash and professional services or decide to be cared for in a nursing home (see table 3). The level of payment guarantees only a basic care provision and is intended to be supplemented either by unpaid informal care, by the purchase of further services by the elderly and their relatives themselves or by welfare state benefits after means-testing. The insurance benefits are aimed at reducing but not abolishing the risk for the elderly in need of care of becoming dependent on social assistance benefits. Moreover, the reduction is aimed at relieving the social assistance expenditure on the local level. The contribution rate to the insurance with 1.7% of the gross earnings paid both by employers and employees is defined by law.

- Priority of domestic care as well as prevention and rehabilitation

In view of the requests of most of the elderly, the premise of cost-efficiency and the prognosticated demographic changes, the construction of the law aims at supporting domestic, respectively home-based care. Informal care within the family framework and wider social networks, which forms a precondition for successful home-based care, is to be strengthened. Cash, but also the care infrastructure aims at supporting informal care within the family framework. The need for long-term care is to be avoided and the time period of dependency shortened through prevention and rehabilitation measures.

- Establishment of a market segment for high-quality care services

Due to the emphasis put on the informal care until the beginning of the 1990s, the quantitative expansion of professional care services and the level of professionalism in this sector in Germany were low compared to other European countries. The money provided by the insurance for the elderly was expected to give impulses for a quantitative and qualitative development of the care infrastructure. The opening-up of the market for private providers should further this development. Simultaneously, efforts have been made to improve the qualification level of the carers and the performance of quality standards in daily practice.

- Responsibility for the implementation.

The law must be implemented on the level of the individual Land. It defines the common responsibility of the government of the Land, the municipalities, the care insurance funds including the medical department of the health insurance funds (MDK), and the service providers and their host organisations for the development and maintenance of a quantitatively sufficient, coordinated and efficient care infrastructure. The governments of the Länder are responsible by law and its guidelines for the further regulation of the mode of cooperation between the specified actors and must act as mediators in case of conflict.

2. Inventory: Care structures and care services

2.1 Care structures

Since its introduction, the long-term care insurance forms the basis for the funding of services in case of care dependency and is supplemented after a means-test by welfare state benefits and some additional services delivered by actors on the local level. The shift of the eligibility criteria to benefits in case of care dependency from a means-tested (welfare) principle to a (compulsory) insurance principle aimed at broadening the range of potential benefit receivers. In contrast, the restrictive definition of care-dependency limits the benefits to severe care dependent people. In 2001, approx. 1.9 million people received different types of benefits through social long-term care insurance and further 111,000 through private compulsory long term care insurance (VDAK 2003a, PKV 2003). Figures reveal an increase in the number of beneficiaries since the introduction of long-term care insurance in 1995/96. In 1994, a mere 563 000 care-dependent people received payments for different types of care according to the Federal Social Assistance Act (BSHG) after a means-test (Eisen/Mager 1999)

According to Naegele/Walker (2002) about 2 to 2.5 million people are in need of basic nursing care in Germany. They assume that about 80% of care dependent people are covered by the insurances. In 2001, about 22% of the population over 75 years were receiving some type of care insurance benefit (Federal Statistical Office 2003c) In addition, between 1.5 and 2 million predominantly older people need some form of assistance with housekeeping. The figures reflect not only unmet needs but also the so-called grey market, especially in the case of individually paid household services not covered by the insurance. Research findings in this area reveal that a high proportion of people over 65 years who live in a single household, buy housekeeping services (Hank 1998).

Table 4:
Benefit recipients according to the types of benefits provided by social long-term care insurance (%)

Year	*Type of benefit*				
	Cash	Services	Combination cash/service	Short-term – Semi-residential Care	Residential Care
1997	56.27	6.91	9.12	0.83	26.84
2001	49.98	8.34	10.48	1.44	29.71

Source: VDAK (2003a)

Since the introduction of long-term care insurance, most people in need of care are cared for at home, with a clear majority preference for cash benefits rather than professional services (see table 4). Evers (1997) explains the latter as corresponding to the specific culture of caring, which existed even before the introduction of insurance. The benefits are used to secure arrangements allowing the elderly to pay – at least nominally – relatives or neighbours and to buy paid domestic services on the so-called grey market. Despite an overall stable picture, the comparison of the figures for 1997 and 2001 show a tendency towards professionalized services with an increase of the different types of paid formal services and residential care. In a detailed analysis Simon (2003) shows that the increase is partly due to the utilization of professionalized services already in case of a lower level of care-

dependency. Professionalized home-based care is more often used by benefit recipients assigned to assessment level 1. Furthermore, there is an increase of nursing home admissions, especially, for benefit recipients assigned to the assessment levels 1 and 2. According to Simon (2003) the development may indicate a decline of the care resources within the family framework. How the care services are provided and used is analysed in the following. In addition their strength and weaknesses is discussed from the perspective of different user groups.

2.2 Home-based care

2.2.1 Development of the infrastructure

With the introduction of long-term care insurance in 1995, the number of home-based care providers increased significantly from previously approx. 6,000 to approx. 11,000 with the figures stabilising since the end of the 1990s. In 2003, some 12,696 service providers delivered services within the range of the long-term care insurance (VDAK 2003b). Typically, the providers are organised as economically independent units, whereas only a very small proportion (6.35%) are linked to different types of housing arrangements for the elderly, e.g. sheltered housing (6.34%) or to a nursing home (3.76%) (Federal Statistical Office 2003c). The interviewed experts rate the quantitative supply and demand for care services as generally balanced in all regions, with a slight over supply in the over populated areas.

Prior to the new care legislation the six non-profit welfare organisations were the main providers of public-funded social services, which were privileged as service provider vis-à-vis the public and for profit providers. The regulations of long-term care insurance promoted the entrance to the market of for-profit providers, competition between for-profit and non-profit providers on equal terms and the withdrawal of the public providers. The entrance to the „care market“ is regulated in each individual Land. When the legally defined conditions are met, in particular the proof that the provider has a qualified carer in charge, the applicants receive a licence by the care insurance fund enabling them to provide care services and be reimbursed

within the framework of the care insurance. Any existing offer of care provision is not taken into consideration here, because the principle of an open market entrance must be guaranteed. The care insurance fund is only then obliged to take action, i.e. adequate and concerted action with further actors like the Länder, the municipalities and care providers, when there is a low availability of care services.

Table 5: Basic information: Service Providers in 2001

Providers	Market share %	Range, Länder in 1999 %	Number of Users, Average	*Further services delivered %*	
				SGB V	BSHG
For-profit	51.85	20.7-74.9	30	96.35	64.70
Non-profit	46.22	24.2-74.4	53	97.16	73.84
Public	1.93	0.0-6.7	42	96.07	54.41

Notes:
Range Länder: The market share of the different service providers varies widely between the Länder. The column shows the lowest and highest market share respectively of the services which a single type of provider-for-profit, non-profit and public-has in one individual Land.
Further services delivered: Proportion of service providers, which not only delivers services financed by the long-term care insurance (SGB XI) but also services financed by the Statutory Health Insurance (SGB V) and the Federal Act of Social Assistance (BSHG)

Sources:
Federal Statistical Office (2001b, 2003c): Pflegestatistik (Care statistic) (1999, 2001):

The rise in the number of service providers is due predominantly to the expansion of private providers onto the newly established market area (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2001, Federal Statistical Office 2003c). In 2001, in Germany more for-profit than non-profit providers were established on the market. (see table 5). The comparison of the different Länder shows that the share of private providers is above the average in the city states of Hamburg, Berlin and Bremen (61.9 to 74.9%) and often, too, in the new Länder. According to experts interviewed in Berlin, the success of private providers is due to their time-flexibility in providing 24 hours care services and their orientation towards specific target groups, e.g. minorities. While providers usually offer services in the

evenings and even at weekends only some – mainly private - providers offer care services on a 24 hour basis. In Brandenburg, as an example for the new Länder, private providers have established themselves mainly in the rural areas where many former district nurses started their own private service provision.

Table 6:

Number of benefit recipients in home-based services by host organisation (%), 2001

	Total	For-profit	Non-profit	Public
1- 10	10.4	14.0	6.3	10.8
11- 15	9.2	12.5	5.6	6.9
16- 20	10.0	13.7	6.0	7.8
21- 25	10.0	12.7	7.1	9.8
26- 35	15.9	17.8	13.6	18.1
36- 50	17.7	15.9	19.5	20.1
51- 70	12.8	8.2	17.8	14.7
71-100	8.3	3.6	13.7	6.4
100-150;	4.0	1.4	7.0	4.4
151-	1.7	0.2	3.3	1.0

Source: Federal Statistical Office (2003c): Pflegestatistik (Care statistic) 2001

The picture changes, if the number of the clients is taken into consideration. 55.5% of the private providers serve up to 35 users with an average number of 30, while 64.6% of the non-profit providers serve between 26 and 100 users with an average of 53. As a result the non-profit organisations provide care to 63% of the benefit recipients within the framework of the long-term care insurance.

In addition to the contracts within the framework of the long-term-care insurance, approx. 97% of the service providers held further contracts in the area of specialist nursing care funded by the Statutory Health Insurance Scheme (SGB V) and 69% had contracts with the public authorities to offer care services funded according to the Federal Social Assistance Act (BSHG) (see table 5). Hence, the individual facilities offer an all-round service that includes basic nursing care and domestic services, all funded by the long-term care insurance or according the Federal Social Assistance Act (BSHG) and specialist nursing care. The majority

of private care providers started their business within the range of long-term care insurance and extended their services to include specialist nursing care after they had established themselves on the market. On a practical basis, the provision of specialist nursing care can be used as a market-strategy to attract users, who after hospital discharge and a short time-period of specialist nursing may often need an additional period of basic long term care.

2.2.2 Services: Approach, costs and users

Tasks in the area of specialist nursing care are performed to comply with the needs prescribed by a physician and are financed by the health insurance funds. Basic nursing care and domestic services offered by the providers are determined to a large extent by the definition of care needs and corresponding funding possibilities of the long-term care insurance. It defines care dependency as the need of help or assistance in a range of daily activities in four predefined areas “mobility, eating, personal hygiene and housekeeping” (see table 3). Within this range, different care packages consisting of precisely defined care activities and their costs have been specified on the level of the individual Länder (Selected examples in two Länder see table 7)**.**

Table 7: Examples of Care packages: Definition and costs

Personal hygiene (Basic)	***Eating***	***Accompanying Service***	***Cleaning of the home (Basic)***
TASKS			
Dressing	Preparation	Dressing	Living area
Oral hygiene	Assistance/Eating	Assistance/	Bathroom
Doing hair/shaving	Hygiene	Leaving/Returning to the home	Emptying bins
Washing	After-Preparation	Accompanying	
COSTS			
Brandenburg			
7 €	8-9 €	19-22€	14-15€
Berlin:			
8 €	10 €	24 €	11 €

Sources: Care insurance funds in Berlin and Brandenburg

The users may choose any combination of care packages suited best to their own situation. The costs are funded by the insurance within the limits set up by the budgets according to the different levels of care dependency (Assessment level I: 384 €; II: 921€ and III: 1432 €, see table 3). Care recipients buy services mainly in the area of basic nursing care, which is evident in the carers` field of activity, which shows that in 2001, 66% worked in the basic care area and approx. 18% in the area of domestic services (Federal Statistical Office 2003c). It is estimated that the share of professional services in home-based care as a whole, is approx. 13%, and in households with professional services approx. 35% (German Parliament 2002).[7] The demand for professional services shows a marked social profile. Benefit recipients in the upper strata in society chose services instead of cash benefits more often than recipients in the lower strata (Blinkert/Klie 1999). Even, minorities are underrepresented among the users of professional services (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2001). The issue of cultural differences and the necessity to develop services to suit the cultural habits and needs of the latter are emphasised in the political debate. In Berlin, where there's a comparably high proportion of minorities, for-profit providers have established services oriented towards the needs of different groups of minorities.

According to the principles of the insurance only basic needs are covered. The users are required to supplement the provided care services by informal care services or by purchasing further professional services which can be funded on the basis of the Federal Social Assistance Act (BSHG) after a means-test. The expectations of insurance designers that the benefits recipients purchase further professional services have rarely been met. Most of the elderly or their relatives choose a range of care packages within the limit of the budget. The interviewed experts claim that the explanation for this is the absence of a culture of buying domestic services or care services within private households, with the exception of upper-middle class households and the competition of the so-called grey market, which offers less expensive services. A representative German survey found that the economic situation is

[7] The estimation is based on the findings of a study carried out in Baden-Wurttemberg. The study analysed both care arrangements of elderly receiving services and elderly receiving cash payments. The definition of services only includes formal services purchased from service providers or on the regular labour market. Services bought on the so-called grey market are excluded.

decisive for the purchase of services in private households. In 2001, an average 17% of over 64 years olds bought such services. This applies to 11% of elderly with an individual income 500-750€, and increases to approx. 43% to 46% for elderly with an individual income of more than 2000 € per month. The latter group makes up about 9% of the elderly population (SOEP 2001)[8].

Since the introduction of the long-term care insurance the number of care dependants receiving care services paid under the Federal Social Assistance Act (BSHG) has declined significantly and is now below 5% (Federal Statistical Office 2001c). The figure reflects an ambivalent development. One success of the insurance is the reduction of the dependency on social assistance in home-based care. However, the figure underestimates the real need of welfare benefits. There are still elderly people who feel that a claim for social assistance to buy additional care services is like a stigma, or they fear that according to the subsidiary principle their children are economically responsible and have to pay back the money. Many providers have difficulties in convincing the elderly or their relatives to claim for social assistance benefits to buy additional care packages. Because of the limited demand of the users even within the range of the defined care packages, additional care offers have only rarely been developed, e.g. in the area of social care and communicative or leisure activities or health promotion.

The shaping of the care packages towards assistance in the performance of daily activities presupposes a stable network of informal carers who provide the additional services, organise daily life and integrate the different services. The care packages support informal carers with basic activities, but if a more complete service arrangement is necessary, e.g. in case of people with increasing care dependency and living alone, difficulties arise in creating an adequate care arrangement on the basis of the insurance. Hence, only 31.9% of women assigned to assessment level III are living in a single household compared to approx. 60% of women assigned to level I and II. Gender differences can also be observed with only 11.6% of men assigned to assessment level III living in a single household, compared to 24.5% of men assigned to assessment level I (Federal Statistical Office 2002d).

[8] In the figures, the care or domestic services provided within the range of the long term care insurance

2.3 Semi-residential care facilities

Under the terms of the law for long-term care insurance, day care and short-term care services must be established to support domestic care. Despite a generous funding of the investment costs by the governments of the Länder, offers of short-term care as well as day care facilities are still limited. In 2001, while approx. 1,44 million benefit recipients were living at home, the Pflegestatistik (Care Statistic) report that 23,332 places in nursing homes were used for short-term care, (3.46 % of which were in residential care), further 15,522 places were available in day care facilities (2.30% of all places in residential care) and 543 places for night care (0,07% of all places in residential care) (Federal Statistical Office 2003c)

2.3.1 Day care

Day care services are defined as semi-residential facilities meant as a link between domestic and residential care. They are usually offered by home-based service providers or in conjunction with residential care facilities. A precondition for the demand of day care services is, that care is secured in the morning time, the evening, during the night and even at the weekend. Informal carers, who often look after their relatives on a 24/7 basis, find the part-time relief from their duties through the day-care facilities as an incentive to continue caring for their relatives. The care dependant can facilitate of the necessary care offers in suitable facilities without having to move out of their own homes. Besides the relief and care function, the day-care is aimed at encouraging and activating the care dependants by giving them the opportunity to communicate and socialise. Travel to and from the facilities, as well as meals are included.

The majority of day care facility users are over 80 years old, a high proportion of whom are either assigned to assessment level I or II within the range of the long term care insurance. Many of the day centres are used mostly by people with dementia. The integrative care of physically and mentally disabled people has proved difficult and presents a challenge to the

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can be included.

personnel. Hence, there is a rise in the number of facilities specializing in the care of people with dementia (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2002).

The difficulties in establishing more widespread offers of day care, despite the fact that it supports informal carers and may prevent the admission to a nursing home, are explained in the following:

- Costs

Day care costs can be financed within the framework of long-term care insurance, but the costs are not completely covered. Day care is regarded as a part of the professional service package and can only be funded within the limitations defined by the insurance for professional services. This also applies to the costs for any further home-based service. Alternatively, there is the possibility to combine day care costs with cash to the limits of the budget of professional services[9]. The high costs of carrying out day care compared to the insurance benefits, allows the care dependants only a limited utilization of the services (see table 8). Continual and regular visits to day-centres, however, are especially important for people with dementia.

- Too far away and too little flexibility

As a general rule, a distance with max. 30 minutes driving time to a day centre is regarded as adequate. The limited expansion of the facilities often poses too long a journey for some of the care dependants. Furthermore, the day centres are described as too inflexible, especially in regard to the individual and changing needs of the care dependants.

- Information and counselling

While service providers for home-based care are typically well-known, information on offers in semi-residential care is less widespread. In particular, the elderly themselves and their relatives, who are in need of support, e.g. those with a high level of care dependency, those cared for within the family framework or those less integrated in social networks and the people of the lower classes, are shown to have the least information (Federal Ministry for

[9] The same procedure is used to finance night care services.

Family Affairs, Senior Citizens, Women and Youth 2002). The existing counselling services are not oriented enough towards tendering advice on the service offers.

Table 8:

Nursing rates (€) per person according to different types of care in Germany 2001

	Day care	Short-term/ Respite care
	Day/month	*Day/month*
Assess. Level 1	34/1037	48/1464
Assess. Level 2	40/1220	58/1769
Assess. Level 3	45/1373	69/2105
Average 1-3	40/1220	58/1769
Hotel costs	10/ 305	19/ 580

Source: Federal Statistical Office (2003c): Pflegestatistik (Care statistic) 2001

2.3.2 Short-term care

Short-term care services are offered either integrated in nursing homes, where some beds are used for short-term care or established as independent units, almost always linked to nursing homes. In 2003, 4,550 providers offering mainly integrated beds in nursing homes for short-term care were registered by the care insurance funds. The number of such independent facilities for the whole of Germany cannot be given because there are no separate figures for some Länder.[10] The figures for the Länder that have available statistics show that 825 of the 3,050 registered providers are independent (VDAK 2003b).

Short-term care is defined as a limited time period in a residential home, when permanent admission to a nursing home or a hospital is not warranted. The long-term care insurance

[10] There are no figures available for Lower Saxony, Baden-Wurttemberg, Schleswig-Holstein and the district of Northrhine.

makes a clear distinction between respite care, which aims at enabling the informal family carers who are temporarily prevented, either through their own illness or because they want to take a vacation or have a rest, from carrying out the care. Short-term care is also temporarily available for care dependants who cannot be adequately cared for in their own homes after their discharge from hospital or because of a crisis in the care arrangements (see below). In both cases, the care insurance finances a maximum of four weeks per annum with costs up to 1432 €, independent of the assessment level.[11] However, depending on the assessment level, the real costs can be much higher and the balance must be paid either by the dependants or their relatives or can be funded after means-testing according the Federal Act of Social Assistance (BSHG). This means that care dependants assigned to Assessment Level III must pay the balance of 917 € per month, including hotel costs (see table 8). The high costs are quoted as one reason for the poor demand for short-term care. The information deficit on the availability of short-term, respectively, respite care services is stated as a further reason for the hesitant demand for the services (Blinkert/Klie 1999). The typical users are as a rule over 80 years old, and on the assessment level III, despite the high balance payments. Compared to the benefit recipients of the long-term care insurance, elderly people with psycho-social problems, e.g. dementia and the recipients of social assistance benefits, are underrepresented in the short-term care facilities.

Besides the quantitative development of the services, the conceptual approach of the short-term care is criticized for not reaching the goal of preventing admissions to long-term care facilities or re-admissions to hospital. The following representative research project sums up the situation of the different user groups in short-term care (Hartman et. al. 2001; Hartman 2002 see table 9).

In about 50% of the cases, the facilities are used for respite care while the informal family carers are on vacations and the elderly usually returning to their previous living and caring situation. For the other users, the stay is meant as a time of decision, to ascertain whether the home-based care arrangement can still be upheld or whether the admission to a nursing home

[11] Respite care services can even be carried out by neighbours, etc, who receive the same benefits. If close relatives like children, grandchildren, brothers and sisters replace the informal carer, the long-term care insurance finances the defined cash-benefits according to the assessment level (Ass.level I: 205€, II 410€, III 665 €, (see table 3)

Table 9: Characteristics of different user-groups in short-term care

	Respite care	**Hospital dismissal**	**Crisis in informal care**
Proportion of the users, approx	50%	20%	20%
Assessment level, average	1.70	1.03	1.41
Reason for admission	Vacation (80%)	Re-definition	Re-definition
Caring situation before	Living with their children	Directly after hospital dismissal (56%), living in a single-household (27%)	Living in a single-household (42%), with a partner (30%)
Caring situation afterwards	No changes (90%)	Nursing-home (55%), no changes (32%), hospital (10%)	Nursing-home (42%), no changes (36%)

Source: Hartman et al. (2001: 29)

is unavoidable. After their discharge from hospital, the elderly use the period of short-term care for convalescence and to make the necessary arrangements for the organisation and selection of the different types of care adapted to their new situation. The term “care arrangements in a crisis” refers to situations where the informal carers experience a high level of physical and psycho-social strain or even suffer from an acute illness themselves. The research findings show that the elderly of the last two groups receive more care services, especially specialist nursing care, but also shows a deficit concerning rehabilitative care and social or communicative activities. However, a high proportion of these user groups were admitted to nursing homes permanently at the end of short-term care measures. In order to reduce the admissions to nursing-homes, the researchers recommend the establishment of independent units with specific care services adapted to the situation of the elderly and their informal carers, including rehabilitative measures or intensive counselling. However, the establishment of independent units with specific service offers will ultimately lead to a rise in the cost of the services, which at present are already not covered by the insurance benefits. This will impede the demand for services by the potential users and make the establishment of service facilities unprofitable from the perspective of the providers.

2.4 Supplementary services in the local area

Despite the general responsibility of the individual Land for the development of a service infrastructure within the framework of long-term care insurance, the different services must be co-ordinated and supplemented with further services offers on a local level. According to the law and its guidelines, the municipalities must support the development of services in two areas to foster independence of the elderly and their participation in society:

- Supplementary, low-threshold services are designed to enhance the chances for the elderly to live independently as long as possible even in case of care dependency or need of assistance, i.e. meals on wheels, accompanying and visiting services, emergency call service for the elderly living on their own and different forms of counselling services.
- Within the framework of the elderly assistance system, senior clubs, communication centres for older people, etc. have been established to strengthen the social integration of the elderly.

The development of suitable offers on the local level is defined as optional for the municipalities and the mode of implementation can be suited to the circumstances and the needs of the individual municipalities. As a rule, state, non-profit and private institutions and providers are included when an infrastructure is established. The co-operation and co-ordination of the service provisions are often impeded by parallel offers. There is no comprehensive research that would give an overview of the different services on the local level. In principal, it can be stated that the range of services differs from one Land to another and even from one city to another and shows a service deficit in rural and economically weak areas (Naegele/Walker 2002). In Brandenburg, Berlin and Baden-Wurttemberg mechanisms of complementary financing were introduced by the government of the Länder and on the local level to establish supplementary care services. The longer time-horizon for developing the measures in Berlin and Baden-Wurttemberg enabled the development of a wide range of care services. In Brandenburg, however, the establishment of an infrastructure has been impeded due to the insecure financing structure and a high proportion of time-limited and un-coordinated measures for active labour market policies.

The most important offers are shown and their development is evaluated in the following:

- Meals on wheels

Meals on wheels provide a warm meal to elderly people, who are no longer capable of preparing it themselves. The service is offered by a wide range of private and non-profit providers. Often, a comprehensive offer is established and the users can choose between various diets and levels even up to exclusive and expensive meals. The municipality can subsidise the costs for people with a low income, close to the defined social assistance limit. In Berlin, for example, a person with a low income may choose any meal that costs up to 6 € and would only have to pay ca. 2 € per meal.

- Visiting- and accompanying services

Visiting- and accompanying services aim towards furthering the social integration of elderly people and supporting them in their leisure activities, thus preventing social isolation. In addition, even different transport services are available. These services are organised by public authorities, parishes, and associations. They are often rendered by voluntary workers who are recruited and supported by organisations. Measures for active labour market policies are a further possibility of establishing such services. The latter is possible in regions with a high unemployment rate, particularly in the new Länder and Berlin where many offers have been made possible this way. The expected cuts in public expenditure for active labour market policies will lead presumably to a decline in the supply of offers. The offers are usually free of charge for the users. Further opportunities are made available through associations that were founded for this specific reason. They are sometimes subsidised by the state and participants pay a small nominal fee annually giving them approximately an hour care service every week, which they can use to have somebody accompany them to a doctor or for leisure activities.

- Emergency call systems

The service is meant to give elderly people living alone a feeling of security when they have acute health problems, e.g. if they need to get help quickly in the case of a stroke or an accident. The costs for the technical equipment are covered by the long-term care insurance. The services are provided by various organisations. In Berlin, the service is offered by non-

profit organisations for a monthly fee of 30 €, which can be paid for by public funds within the framework of the Federal Social Assistance Act (BSHG).

- Counselling

Counselling services on the local area level are organised by a wide range of different actors, like care insurance funds, public service, non-profit organisations and service providers. The often uncoordinated counselling services are criticised by the experts for the fragmented and sometimes ambivalent information as well as for the difficulties establishing continuous case management services. Those seeking advice are mainly interested in information related to different providers of home-based and residential care, in possibilities and prerequisites for further welfare state benefits and assistance in the course of admission to a nursing-home. In addition, the experts at the insurance funds offer legal advice in conflicts with service providers. The elderly or their relatives, however, are only seldom interested in an intensive counselling or case-management. Moreover, the informal carers receiving cash benefits are obliged to accept a continuous counselling by the professional services to assure the quality of the care. The professional carers must even assess the existing care arrangements and propose necessary changes.

- Senior clubs

Within the context of elderly assistance systems, welfare associations, churches or self-help groups autonomously define the objectives, the themes and the organisation of the measures. The result is a very heterogeneous structure of services and offers, which are provided in a co-operation of professionals and volunteers. Offers in the elderly assistance system like senior clubs often reach only certain groups. During the lifetime developed forms of participation have proved to be decisive for the activities in old age (Baltes et al. 1999). Elderly people who are open-minded and have participated in different cultural and sporting activities during the course of their life, find access to the different offers more easily. In particular women, who have reared children, engage themselves in similar activities in volunteer work in the social area, e.g. visiting services. In contrast to the scarcity of opportunities for minorities within the existing elderly assistance system, elderly migrants contribute as volunteers to the development of their own organisations where their culture-specific competence is acknowledged (Zeman 2002).

- Additional health aids

The long-term care insurance and the health insurance cover the costs for technical equipment, like wheelchairs, walkers, special beds, emergency call systems or material goods like padding for beds and bandages if they are necessary to maintain or facilitate domestic care or foster an independent way of living. Within the framework of the long-term care insurance, experts in the medical department of the health insurance assess the necessity for the health aids. The care insurance provides up to 34 € per month for material goods. Benefit recipients must make a payment of 10% at maximum 25 € for the costs of technical equipment. Larger equipment like wheelchairs is usually loaned out by specific service centres or medical suppliers, which hold contracts with the care insurance funds.

2.5 Housing

Corresponding to the aspirations of the majority of the older generation, the government policy in Germany aims at enabling elderly people to live an independent life as long as possible in their own homes. To accomplish this principle, concepts for different forms of living for elderly people have been developed to deal with all aspects of the heterogeneity of this group in society. The most important approach is seen as the adaptation of the homes of the elderly to suit the changes in their physical conditions. Both this and the replenishment to suit an elderly person's needs could lead to the goal of ensuring that they have enough room to move around in their own homes, feel more secure and have more comfortable utilisation of their kitchens and bathrooms. Typical modernisation measures are: creating barrier-free living space, revamping bathrooms and kitchens and making it easier access buildings and apartments. On the local area level, intense counselling services are offered to find a solution to suit the needs of the individual elderly people. Within the framework of the long-term care insurance, grants can be awarded for the adaptation of an individual's living environment, dependent on the income of the care dependent and the cost of the measure. The grant may not exceed 2557 € for any individual measure.

Furthermore, a variety of special housing arrangements have been created. Flats adapted to the specific needs of the elderly have been built within regular housing projects to ensure that different generations can live together under one roof. The flats don't usually offer any further advantages besides the adaptation to these needs, but there are specific forms of sheltered housing for people who need more security and care. This type of housing has lifts and well-built pathways to and from the houses and a care system that includes an emergency call system, day-care as well as counselling services with a social worker. In publicly subsidized housing arrangements the rents are comparable to those of other public subsidized flats and when necessary, welfare state benefits can be granted up to a certain limit after means-testing. The interviewed experts made a positive evaluation of the adapted housing projects, but they criticized the imbalance between the high prices and the actual care service as well as the shortage of opportunities for the elderly to communicate and socialise. Due to the fact that any further services mean extra bills, the costs rise as the care dependency grows, often resulting in the admission of the care dependent into a nursing home.

The development of sheltered housing varies from one Land to the next. Baden-Wurttemberg, seen as the first-in in this area, has about 25,000 housing units to date. In 1996, they had an average of 1.4% units for elderly people compared to the federal average of 0.4% In contrast to the care services, accommodation costs for sheltered housing are determined by the market and not regulated by the care insurance funds or by the state. Despite the possibility of receiving housing-allowances there is a reported lack of sheltered housing facilities for elderly people with lower incomes (Ministry of Social Affairs Baden-Wurttemberg 2001). Since the middle of the nineties in Brandenburg, there have been plans for 3,068 places in sheltered housing parallel to the modernisation of nursing-homes. But up to the present day, a mere 1,718 places have been built, usually combined with nursing home facilities (Ministry of Labour, Social Affairs, Health and Women Brandenburg 1999, 2002). The lack of interest of the rural people for this form of housing and the higher than expected need for nursing-home care are said to have led to this development. In Berlin, sheltered housing is seen as one possible form and the housing policy there aims at a wide variety of housing forms for elderly people, which are integrated into regular housing projects (Ministry of Labour, Social Affairs and Women Berlin 2001)

2.6 Residential care

Compared to the service providers in home-based care, residential care facilities have expanded and improved in the former territory of the Federal Republic of Germany since the 1980s and in the new Länder since the 1990s. Significant changes can be observed in relation to the quality of housing and comfort of the home, the diversity of special housing arrangements for the elderly (nursing homes form only one element), the market-share of different host organisations with an increasing proportion of for-profit providers, the costs of residential care for the users and the characteristics of the residents.

2.6.1 Development of the infrastructure

In Germany in 2003, some 9,323 institutions provide residential care showing a steady increase since the introduction of the long-term care insurance (VDAK 2003b). With the introduction of the latter, the governments of the Länder were obliged to invest half of the savings made through the reduction of social assistance costs to expand and modernise the number of long-term care places in nursing homes. However, in most of the Länder in the western part of the country, the goal of investing half of the savings in the care infrastructure has not been achieved (Roth 2003).

In his analysis of the development since the introduction, Roth (2003) found an increase from 3.24 in 1994 to 4.29 in 1999 of the places in nursing homes per 100 of the population over 64 years, with considerable differences between the Länder. In 1994, the range was between a mere 2.60 available places in North Rhine Westfalia to 5.30 in Hamburg. Besides the increases, in 1999, the differences between the Länder were also reduced showing 3.58 in Thuringia and 6.05 in Schleswig Holstein (see table 10). The adjustment can be explained with the significant differences in relation to the promotion of the investments of the governments of the Länder .

Table 10: Residential care places per 100 inhabitants older than 64 years by Länder (%)

	1994	**1999**
Baden-Wurttemberg	3.10	4.03
Bavaria	2.70	4.25
Berlin		4.92
Brandenburg	4.06	
Bremen	3.30	3.89
Hamburg	5.30	4.76
Hesse	2.90	3.81
Mecklenburg-Vorpommern	4.93	
Lower Saxony	3.80	4.69
North Rhine Westfalia	2.60	4.47
Rhineland-Palatinate	2.90	3.69
Saarland	3.60	3.91
Saxony		0.83
Saxony-Anhalt		3.94
Schleswig-Holstein	5.10	6.05
Thuringia		3.58
Total	3.24	4.29

Source: Roth (2003:75)

Despite the inroad of private providers onto the market, most nursing homes are still run by non-profit organisations. The share of the private nursing homes is particularly low in the new Länder where the infrastructure of small private old age or nursing homes has not been developed. Furthermore, after re-unification, the non-profit welfare organisations, which were already active in the former German Democratic Republic took over the public old age and nursing homes. The organisation of nursing homes can be distinguished according to the provider. 35% of the non-profit provider compared to 23% of the for-profit providers are linked to housing developments for the elderly, like sheltered housing or an old age home (see table 11). Even the size of the facilities differs according to the provider and reflects the share of small nursing homes run by for-profit providers. The majority of the private nursing-homes serve up to 50 care dependent people, whereas the majority of the non-profit providers serves between 50 and 100 or over 100 care dependent people (see table 12).

Since the 1980s in the former territory of the Republic of Germany, the modernisation of residential homes to defined minimum standards resulted in a rise in the comfort of the homes and in the corresponding quality of life, e.g. in 2001, 46.8% of the elderly were living in a

Table 11: Basic information: Nursing homes in 2001

Providers	Market share	Range Länder in 1999	Average Number of users	Integrated/ facility
For-profit	35.9%	13.3-63.2%	50	23.22
Non-profit	56.0%	30.2-76.6%	73	35.43
Public	8.1%	1.3-15.9%	84	38.72

Notes:
Range Länder:
The market share of the different service providers varies widely between the Länder . The column shows the lowest and highest market share respectively of the services which a single type of provider -for-profit, non-profit, public- has in one of the Länder.
Integrated facility:
Nursing home with further service facilities e.g. sheltered housing, home-based care service

Sources:
Federal Statistical Office (2001b, 2003c): Pflegestatistik (Care statistic) 1999, 2001

Table 12: Number of benefit recipients (%)according to host organisation 2001

Number Recipients	Share in (%)			
	Total	For-Profit	Non-Profit	Public
1- 10	6.6	9.7	5.0	3.7
11- 20	11.0	15.6	8.9	5.6
21- 30	9.5	15.9	5.9	5.9
31- 40	8.6	11.7	6.8	8.0
41- 50	8.5	10.1	7.3	9.7
51- 60	7.9	7.6	8.2	7.5
61- 80	15.6	11.3	18.1	17.5
81-100	12.5	6.9	16.2	12.6
101-150	14.4	7.9	18.3	16.2
151-200	3.6	2.4	3.6	9.1
201-300	1.5	0.9	1.5	3.1
301-	0.2	0.0	0.2	1.2

Source:
Federal Statistical Office (2003c): Pflegestatistik (Care Statistic) 2001

single room and a further 47.5% in a double room (Federal Statistical Office 2003c). Parallel to the modernisation of residential home buildings, a range of special housing arrangements for the elderly were also introduced and established. The basic idea was to establish integrated

care service facilities covering the whole spectrum of residential care (i.e. residential care, short-term care, day and night care), special housing arrangements (e.g. sheltered housings), home-based care and counselling services, to offer a continuum of different care services and hence overcome the dichotomy between residential and home-based care. In total, in Germany in 2001, 31.33 % of the residential homes were linked to different types of further care services (Federal Statistical Office 2003c).

As an example for the development in the former territory of the Republic of Germany, in Baden-Wurttemberg the increase of nursing-home places during the 1990s was due to a general restructuring of places in old age homes. There, the number of places dropped from 25,000 to 5,000 in the 1990s and parallel to a significant increase in the number of accommodation units in sheltered housing arrangements for the elderly (Ministry of Social Affairs Baden-Wurttemberg 2001). At the beginning of the 1990s in Brandenburg, one of the new Länder, only 3 of 258 old age or nursing homes met the minimum legal standards for residential home buildings. To adjust the existing infrastructure to the required standards, the German federal government introduced an investment programme with a total of 6.4 billion DM until 2002 for the new Länder. In Brandenburg, about 14,000 places in residential homes have since been built or modernised on the basis of the investment programme in accordance with the Care Plan of the Land (Landespflegeplan) and a further 4,300 places were built by private investors without any public funding. Similar to Baden-Wurttemberg, integrated service facilities have been planned and implemented, e.g. nursing homes, day and night care, short term care and sheltered housing (Ministry of Labour, Social Affairs, Health and Women Brandenburg 1999, 2002).

2.6.2 Services: Approach, costs and users

With the changed conditions of the nursing homes, the establishment of different forms of housing arrangements and the demographic development, there were also considerable changes with regard to residents' age of entry and life expectancy. The average age of entry e.g. in Baden-Wurttemberg in 2000, was 82 years and the average length of stay 2.5 to 2.8 years (Ministry of Social Affairs Baden-Wurttemberg 2001). While 29.6% of all long-term

care insurance benefit recipients are cared for in a nursing home, this proportion increases for elderly people over 85 years to 41.5% (see table 14).The admission to a nursing home is closely linked to the level of care dependency, e.g. about 46% of the care dependent people assigned to assessment level III are living in nursing homes (see table 14).

Table 14:

Benefit recipients in residential care according to assessment level and age group in % 2001

Total	Assessment Level			Age Group			
	I	II	III	I	II	III	IV
29.62	20.0	34.9	46.4	22.9	27.9	32.4	41.5

Notes:
Total: Share of all benefit recipients
Age group in years
I = 70-75, II= 75-80, III= 80-85, IV= 85-

Source:
Federal Statistical Office (2003c): Pflegestatistik (Care Statistic) 2001

The residents in nursing homes are typically women (78.7% in 2001) reflecting a stable gender pattern since the introduction of the insurance. Both men and women lived mostly in a single household before admission to the homes (men 81.3% and women 95.4%) (Federal Statistical Office 2003c, Federal Statistical Office 2002d, Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2002). The position in the social strata further influences admission to a nursing home. The insurance fund AOK (Allgemeine Ortskrankenkasse), which insures mainly blue-collar workers, quotes that 8.6% (men: 4.10%; women 10.26%) of their members over 75 years as living in nursing-homes compared to 6.4% (men: 3.24%; women 8.61%) in private health insurance, whose members are mainly from the upper strata (PKV 2003, AOK 2003).

Simultaneous with the increasing age of the residents, their symptoms have shifted from somatic to geronto-psychiatric illnesses, among the latter mainly dementia. It is estimated that about 60% of all residents in nursing-homes are suffering from dementia illness. On a policy level, care concepts and approaches have been developed ranging from separate living areas, like the establishment of special care units, to different levels of integrative concepts and the introduction and implementation of model projects. However, to date there are no sufficient

evaluation studies on the outcomes and prerequisites for the different concepts (Ministry of Social Affairs Baden-Wurttemberg 2001) In particular, there is a gap between different concepts and their implementation in the infrastructure as a whole. In Brandenburg, e.g. about 5% of the nursing homes have established separate living areas for dementia patients or forms of segregated day care facilities and furthermore, some homes have implemented specific care concepts (Ministry of Labour, Social Affairs, Health and Women Brandenburg 1999). In 2003, research into nursing homes facilities in Berlin found that only about 25% are sufficiently qualified to deal competently with dementia (Dillmann 2003).

The expected rising proportion of migrants among the elderly led on a political level to the development of different concepts of minority care (Ministry of Social Affairs Baden-Wurttemberg 2001). For the year 2003, statistics on nursing homes in Berlin show only a minor representation of elderly migrants despite their assumed higher degree of care dependency due to their living- and working conditions (Dillmann 2003). The findings are explained by the assumption that the relatives look after the elderly family members (Zeman 2002). On a long term basis, the concepts of nursing homes will have to be adapted to the specific culture, i.e. to the specific needs of migrants. The interviewed experts in Berlin report on the difficulties of establishing specific concepts. The heterogeneity of the groups of migrants requires the adaptation of concepts to very specific values, needs etc., but the low demand at present makes the requested comprehensive offers unprofitable. This refers to a basic problem in residential care, where most concepts are orientated towards groups of elderly and not towards the individual resident and rarely allow an individualised form of care.

One main objective of long-term care insurance was the reduction of dependency on social assistance benefits in the case of admission to a nursing home (see section 1.3). The benefits of the insurance in case of residential care come close to the rate for nursing care on the assessment levels I and II, but the difference increases for assessment level III (see table 13). In addition to the nursing rates, the residents must pay hotel costs and- if not publicly subsidized - the investment costs. If the residents are not able, or no longer able to cover the overall costs themselves, they can be supplemented by social welfare benefits. Statistics show a significant decline in the dependency on social welfare benefits since the introduction of the insurance, but in 2001 about 32% of the long-term care benefit recipients were still dependent

on supplementary financing under the Federal Act of Social Assistance (BSHG). Furthermore, the statistics reveal considerable differences in the individual Länder, ranging for example from approx. 18% in Brandenburg, 32% in Baden-Wurttemberg and 46% in Berlin (Federal Statistical Office 2001c). The figures overestimate the proportion of residents in nursing homes receiving supplementary social assistance benefits in addition to insurance benefits. The social assistance statistics do not distinguish between elderly people receiving additional payments and the small group of elderly not qualified for benefits under the terms of the care insurance.[12] In Berlin, where separate statistics are available, the proportion of care insurance recipients receiving supplementary welfare benefits is 38.1% for 2003 (Dillmann 2003). The lower nursing rates and hotel costs and the lower share of investment costs paid by the residents in the new Länder as well as the more equal pension payments (see tables 2 and 13) are the main reasons for the differences between the individual Länder.

Table 13:

Nursing rates, hotel costs in residential care per person and month and care insurance benefits in 2001

	Germany	Baden –Wurttemberg	Berlin	Brandenburg
Assess. Level 1	1,190	1,373	1,312	1,007
Assess. Level 2	1,586	1,678	1,830	1,251
Assess. Level 3	2,013	2,135	2,196	1,780
Average 1-3	1,586	1,708	1,769	1,342
Hotel costs	580	549	488	458
	Benefits*	*Germany only		
Assess. Level 1	1,023			
Assess. Level 2	1,279			
Assess. Level 3	1,432			

Sources:
Federal Statistical Office (2003c): Pflegestatistik (Care Statistic) 2001,
Statistical Office Baden-Wurttemberg (2003): Pflegestatistik (Care Statistic) 2001
Statistical Office Brandenburg (2003): Pflegestatistik (Care Statistic) 2001
Statistical Office Berlin (2003): Pflegestatistik (Care Statistic) 2001
SGB XI

[12] When care dependency is not severe enough to be assigned an assessment level of care insurance, but the management of daily life activities necessitates the admission to a nursing home, the costs of the measure are funded under the Federal Act of Social Assistance (BSHG) after a means test.

2.7 Staff

The employment opportunities in the area increased corresponding to the described expansion of home-based and residential care providers. In home-based care services, the number of employees rose from 65,300 in 1996 to 190,000 in 2001 and in residential care from 205,756 in 1996 to 475,000 in 2001, followed however, by a rise in part-time employment in residential care from 39.11% in 1986 to 54.0% in 2001 and in home-based care from 54.21% in 1996 to 69.7% in 2001 (Schölkopf 1998, Federal Statistical Office 2003c). With the expansion of services within the framework of the insurance, the issue of quality of care in home-based and residential care advanced into the centre of the debate (see e.g. Roth 2001, 2002; Igle et al 2002). As a starting point for the improvement of the services the new-regulation of vocational training for elderly carers and the further development of daily activities and nursing processes were emphasised.

2.7.1 Vocational training programmes

In contrast to the vocational training of nurses, where in 1985 a standardised training programme was established on a Federal level, the vocational training programmes for elderly carers were organised on the level of the Länder. The state-specific regulations led to a wide range of different vocational training programmes. The entrance requirements for the programmes differed according the minimum age, educational attainment level or whether the vocational training was defined as a further training or a basic training programme. The curricula of the training programmes, particularly the proportion of main subjects, reflect different standards, e.g. lessons related to basic nursing care cover between 12% and 63% of the training programme (Oelke/Menke 2002).

In an effort to standardise the vocational training and to improve its quality, a new Federal law for elderly carer training “Act of Training Staff in Elderly Care” came into effect in October 2002, despite the resistance, especially of the Bavarian government and is now gradually been implemented by the individual Länder. The new law standardised the vocational training on a comparatively high level, e.g. regarding the entrance requirements

and the duration with a compulsory three years training programme. The law was further intended to equalize the level of vocational training of the nurses and elderly carers and hence create a more equal position in the working-place. Moreover, within the law, even basic requirements were defined for the vocational training of the elderly carer assistant.

The interviewed experts judge the new vocational training programme as an important step forward and highlight the improved level of training and the future possibility of a more equal position, even up to equal wages for elderly carers and nurses. They view the new vocational training programme as a first step in developing an integrated two-step training curricula in the future. In the first phase, both nurses and elderly carers take part in common training, which is followed in the second phase by separate specialist training. In day to day practice, the elderly carers need more competences in regard to symptoms and nursing care and the nurses an improved competence in regard to the issue of social consequences related to different syndromes.

2.7.2 Employees: Vocational training and working-situation

According to the long-term care insurance law (SGB XI), care services must be provided in cooperation with, and under the guidance of a nurse or elderly carer in charge, further paid carers and informal carers. Hence, it was planned that in the home-based service, qualified nursing staff were to be active mainly in key areas like management, coordination, quality assurance, while the basic nursing care and the domestic services are provided by nurse assistants, auxiliaries or even volunteers. The vocational qualification patterns in home-based care, however, show a high proportion of qualified nursing staff, e.g. 32.7% of employees are nurses and further 14.9% elderly carers (see table 15). The high proportion of nurses can be explained by the fact that almost all providers delivering services funded by the long-term care insurance, also hold contracts within the framework of the statutory health insurance where the regulations require that only nurses perform specialised nursing care. In respect to the objectives of the long-term care insurance, the high proportion of nurses is criticized as a reason for the neglect of social aspects in day to day practice. The elderly carers are regarded as better able to manage both the daily life and the social consequences of care dependency and illness.

Under the law regulating residential care, (nursing) homes must have a proportion of about 50% qualified staff in the area of nursing. The quantitative dominance of elderly carers compared to nurses (20% to 10%) is judged positively by the interviewed experts, who highlight the valuable non-hospital character of the homes (see table 15). However, the proportion of nurses and elderly carers have to be adapted according to the characteristic and needs of the residents of the individual nursing homes. In big cities in Germany or in prosperous Länder like Baden-Wurttemberg, there is a shortage of qualified nursing staff, which impedes the fulfilment of the legally required qualification criteria for staff in care (see table 15). On the basis of well-developed rehabilitation measures, the physical and psychological conditions for elderly with dementia or after a stroke are aimed to be improved in residential care. The providers obtain no additional financing for the employment of therapist, i.e. they have to reduce the corresponding number of nursing staff to pay the wages. In home-based care, the therapists are only linked to the providers and deliver as self-employed different forms of therapeutic treatment on the basis of a prescription of a physician and financed by the health insurance. Social workers are mainly active within the area of counselling of the care dependent elderly and their relatives or are responsible for development and implementation of quality management approaches.

Despite the high proportion of qualified staff, about 50% of staff in residential homes and 30% in home-based services are still assistances or auxiliaries (see table 15) The interviewed experts complain about the low level of further training for these groups in both the residential care and home-based care areas. Most of the programmes for further training address the qualified staff or the nurses/elderly carers in charge. The experts outline that the auxiliaries or assistants perform the daily tasks with the elderly and need not only expertise in nursing but also gerontological competences. Even domestic workers who are involved in daily management tasks should be able to acquire an understanding, especially of elderly with dementia problems.

The hierarchical distribution of labour with the strong position of the nurse/elderly carer in charge and the labour market position of the different groups of carers are reflected in the wage development and the flexibility of working-time. The for-profit providers only rarely orientate their wages on the wage-settlements made on the labour market for this area.

Table 15:

Staff of home-based care providers and in residential homes by vocational qualification, sex and working-time (%), 2001

	Home-based care providers			Residential homes		
Vocational Qualification	*Proportion of staff*	*Proportion of women*	*Proportion of full-time*	*Proportion of staff*	*Proportion of women*	*Proportion of full-time*
Elderly carer	14.9	87.3	44.3	20.3	85.6	65.8
Elderly carer assistant	2.3	91.6	32.5	3.1	91.2	51.0
Nurse/university/ university of applied science	0.3	60.2	62.4	0.2	65.9	65.6
Nurse (vocational training)	32.7	89.8	38.9	10.4	89.6	56.4
Nurse assistant	5.0	91.4	30.5	4.3	90.3	50.1
Social worker	0.8	78.5	38.5	1.2	76.5	51.3
Therapists	0,2	84.0	26.8	0.8	85.8	45.8
Further health occupations	4.2	87.4	30.8	1.2	83.1	48.0
Further caring occupations	11.2	94.3	21.1	7.0	92.5	46.1
Domestic workers (with vocational training)	2.9	97.9	20.0	4.7	86.9	52.0
Workers with further vocational training	18.0	82.2	19.2	24.1	78.0	38.6
Workers without vocational training	10.0	62.7	12.9	21.8	83.1	27.2
Total:		*86,0*	*30.3*		*84.5*	*46.0*

Notes:
Further caring occupations: e.g. family carers; Further health occupations :i.e different occupations within the field of health care with the exception of physicians

Source:
Federal Statistical Office (2003c): Pflegestatistik (Care Statistic) 2001

Instead, they prefer a wage structure, which gives higher than settlement defined wages to the managerial staff and lower wages to the other carers. Meanwhile, even the non-profit providers are discussing changes in their wage policies and establishing new regulations, which may ultimately lead to lower wages and lower personnel costs, e.g. the abolition of a rise in wages every second year, wages linked to age or marital status, or the reduction of bonuses for weekends- or night work. The changes may result in lower wages for carers performing the daily activities and the older carer assistants, especially.

A similar trend can be observed in the development of working-hours, where since the introduction of the long-term insurance a sharp increase in part-time work can be detected for residential care from 39.11% in 1996 to 54.0% in 2001 and home-based care from 54.2% in 1996 to 69.7% in 2001 (Schölkopf 1998, Federal Statistical Office 2003c). From the perspective of the employers, part-time work allows working-time flexibility and in consequence, the adaptation of staff to the changing demands for care within a daily routine. In home-based care, the availability and access to full-time positions are limited for both qualified and assistant nursing staff as well as auxiliaries. Due to the shortage of qualified carers in residential care, qualified carers can decide themselves, whether they prefer full-time or part-time employment but in the case of carer assistants or auxiliaries were no shortage exists, carers usually have to accept the working hours offered. This may explain the higher share of part-time employees in assistant or auxiliary positions.

2.7.3 Voluntary work, active labour market policy and the grey market

The employment possibilities which have been increased by the insurance are embedded in measures of active labour market policies, remuneration and voluntary work as well as services purchased on the so-called grey market in areas not funded by the insurance, e.g. social or leisure activities or in domestic services (SOEP 2001; Evers et al 2002). Household- or care services purchased on the so-called grey market are usually carried out under precarious conditions by female migrants or older German women (Gather et al 2002).

The role of voluntary work and the situation of the voluntary worker is more ambivalent. The interviewed experts agree on the significance of voluntary work complementary to the service

offers and not as a substitute for regular nursing activities. The offers of social activities are limited due to increasing nursing needs, in particular in nursing homes. In 2001, only 3.5% of the employees in nursing homes were predominantly active in the area of social or leisure activities (Federal Statistical Office 2003c). On the basis of research in the area of voluntary work, experts assume that there is a great potential of volunteers that can be attracted to the social area (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2000). In practice though, the experience in nursing homes shows that voluntary work with elderly, care-dependent people often with dementia presupposes a specific interest in this area. The attraction of volunteers is improved when the nursing homes are linked to a parish or an organisation active in the area of elderly care. In addition, professional staff in the institutions must develop strategies to find and attract potential volunteers. In day to day practice, the co-operation of professionals and volunteers, which is still described as difficult, requires a clear distribution of work tasks, supervision and counselling of the volunteers and acknowledgement of their work. In how far voluntary work is judged as positive or negative depends not only on the area of voluntary work but also on the specific living-conditions of the volunteers themselves. With a secure income situation, volunteers employed in a well-paid labour market positions or pensioners with a reasonable income can commit themselves to the activity. The transition to regular employment, however, seems difficult for most of the volunteers, because the structures of the activities revealed in the area indicate principal changes on the labour market and in employment possibilities (Evers et al. 2002).

2.8 Further development of care services

The development of the care infrastructure paints an ambivalent picture. Since the introduction of the long-term care insurance, the providers in home-based care and facilities in residential care have significantly expanded. In contrast, measures which could support domestic care, like semi-residential and short-term care facilities have not been sufficiently established. Moreover, on a local level supplementary care services or offers organised within the elderly assistance framework are defined voluntarily, heterogeneous and differ in range

and coverage from one region to another**.** Despite the guiding principle of the long-term care insurance “domestic care before residential care” the proportion of elderly being admitted to nursing homes is increasing steadily. Due to the demographic changes, the rising proportion of the elderly persons over 80 years, will probably also increase the number of nursing-home admissions in the future. The results point to three main problem areas, where according to the interviewed experts new measures must be implemented to enhance domestic care and to forestall the expected demand for nursing home places.

- A trend for the elderly people’s transition from hospitals into nursing homes can be observed. The present organisation and concepts of short-term care are not adapted to the specific demands of these groups, i.e. the provision of a time-period for convalescence with the necessary rehabilitative measures, intensive case-management and the support with the organisation of domestic care arrangements. As an instrument on a political level, the introduction of a financing mechanism for a transitional short-term care offer, characterised by an extension of the funded time-period to eight instead of four weeks and an adaptation to the needs is presently being discussed.

- Dementia is one of the main reasons for the admission to a nursing-home. The elderly suffering from dementia pose a challenge to their families and the institutions. The provision of domestic care for dementia-effected elderly persons includes a wide range of care tasks, i.e. general supervision and attention, social and emotional support and the assistance in daily activities. The result is often an overburdening caring-situation leading to health problems for the carers themselves, intensified further due to the informal carer’s hesitation to ask for support. Moreover, the orientation of the long-term care insurance towards the performance of basic daily activities and the neglect of the further care tasks puts the carers at a disadvantage. The Complementary Nursing Act in 2002 was drawn up to relieve the informal carers and simultaneously give more space to create new elements in the care infrastructure. According to the new law, patients suffering from dementia or their relatives also receive up to 460 € per annum to alleviate their burden. The amount of the benefit has been criticised because it offers only limited purchasing power for care services with a consequence of only limited unburdening effects. The availability within this budget should further enable the carer or the elderly to gain more experiences with

purchasing care services such as day-care or short-term care services as well as specific caring services with a home-based care providers and payable low-threshold offerings. Low-threshold services are characterised by a co-operation of professionals and volunteers with specific training opportunities and supervision to meet the criteria defined by the law. Within this area self-help groups, associations, etc. are encouraged to develop offers, which are reimbursable. The economic promotion of model projects by the Länder, the local level and the care insurance advocates support for the establishment of new elements within the care infrastructure.

The implementation of the new law and the establishment of the new services are proceeding slowly. The Länder have only rarely introduced the necessary regulation frameworks for the licensing of services and the promotion of model projects. At the beginning of 2003, only some of the Länder had acknowledged low-threshold offerings or only a few applications have been submitted. The offers and applications relate mainly to different forms of care to relieve the informal carers. In particular, the implementation of the required quality assurance measures, the demand for professional supervision and training and the bureaucratic procedure of licensing deter the associations or self-help groups. In Brandenburg, where some services have already been licensed, the government of the Land gives economic support to the Alzheimer association, which offers training courses and supervision for volunteers in the different projects. The interviewed experts emphasise the necessity to open up the service sector for self-help groups, etc. and the co-operation of professionals and volunteers. But they reckon that the incentive is too low to establish a widespread offer of new elements within the care infrastructure.

- The orientation of the long-term care insurance towards basic daily activities presupposes family support or a stable social network. This impedes the development of more comprehensive care-arrangements, e.g. for elderly living alone with an increasing level of care dependency. Some experts see the solution in the extension of the range of care package funded by the insurance to include even social or leisure activities and in the simultaneous introduction of fixed personal budgets on the present level of payment to prevent further cost increases. The development of intensive case management services is devised to support the elderly in the establishment of their individual care arrangements. However, the additional costs of non-funded care packages have to be paid by the elderly

themselves or by their relatives or to be funded on the basis of the Federal Social Assistance Act (BSHG). Elderly women with a low income, living on their own, who are particularly in need of such extended service offers, the possibilities of purchasing additional services are limited. It is proposed that volunteers be recruited to establish affordable services. The volunteers will co-operate with professionals in home-based care services to provide social, leisure and housekeeping services.

A research project conducted in 2002/2003 on care providers in Baden-Wurttemberg in the area of personnel policy found that in 75 of the 143 participating home-based care providers, on average 18 volunteers were actively involved especially in the area of housekeeping (57 providers) and social and leisure activities (59 providers). In 123 of the 138 participating nursing homes, an average of 23 volunteers were active mainly (96 nursing homes) in visiting- and accompanying services (Equal 2003). The findings show the main possibilities of voluntary activities in specific areas of service delivery. On the local level, there are no expectations for an expansion of the municipalities' paid social services, which contribute to the care infrastructure. In the present situation of high public deficits the interviewed experts emphasise the risk of a reduction of services or outsourcing to non-profit organisations as well as their own personal efforts to maintain the status quo. In contrast to welfare state benefits delivered under the Federal Social Assistance Act (BSHG), the provision of these offers are voluntary for the municipalities.

3. Conclusion

Before the introduction of long-term care insurance, care dependency was viewed mainly as a private matter for the elderly and their families and had only limited societal support. Long-term care insurance broadened the access of the care dependent elderly and their relatives to different types of support and achieved a relatively high level of coverage in case of care dependency. Despite the fact that most benefit recipients prefer cash to services, the rising purchasing power and the opening up of the market, with a marked inroad for for-profit

providers, has led to an expansion especially in home-based care and has supported the expansion and restructuring of residential care facilities, corresponding to the changing demands. Home-based care providers typically supply services, which include specialist nursing care, basic nursing care and domestic services.

A detailed analysis of the development illustrates specific difficulties in the service provision and the utilisation of the services by user groups. Key features of the care services are their fragmented organisation and the efforts being made to bring about changes. This applies to the dualism of residential care services and hospital treatment on one hand, and on the other the domestic care, home-based services and their corresponding support systems, e.g. day care, short-term care and a wide range of supplementary services. As structural solutions are emphasised the establishment of different forms of multi-level service provisions e.g. including residential care, day care, short term care and home-based care facilities as well as affordable low-threshold offers and the introduction of transitional periods. On an individual level, case management services should support the establishment and adaptation of a care arrangement suited to individual and their changing care needs. The restructurings measures are aimed at reducing the increase of residential care admissions, despite the presumed demographic changes.

The goal of the long-term care insurance is to offer basic security in case of care dependency, which can be supplemented by welfare state benefits after means-testing, on equal terms for the whole population. The principle of equality is shown by the standardized benefits for all recipients, by the standardized costs of care packages and nursing rates for the members of both the social and private compulsory care insurance, which is not otherwise the case within the framework of the social and private health insurances. The funding of additional costs for residential care by the welfare state in approx. 90% to 95% of the existing nursing-homes is aimed at guaranteeing a free choice of nursing homes for care dependants. However, the independent providers of nursing-homes have still the right to choose their residents. Despite efforts to create an equal care situation in the country as a whole, differences in user costs, different levels of dependency on social assistance benefits for elderly living in nursing homes as well as the differences in the infrastructure on the local level reveal regional disparities in access to services and in the care situation for the elderly.

Furthermore, the analysis of the care situation, has shown significant differences in the utilization of service offers by user groups according to their social position, gender, ethnicity and living situations. Members of the lower strata in society are overrepresented in regard to cash benefits and residential care and in contrast to this, members of the upper strata use home-based care services more often. Furthermore, there are significant differences in the proportion of benefit recipients. While 22% of the members of the “blue-collar insurance”, Allgemeine Ortskrankenkasse (AOK), over 75 years, receive some type of benefits, this applies to only 14% within private insurance. One explanation can be found in the different age structures of the members in both insurances. In the AOK 57.2% of the over 75 year old members are older than 80 compared to 52.2% of members of the private insurances.(AOK 2003; PKV 2003). Existing care needs may form the main explanation for the discrepancy. In many cases, care dependency is the result of the development and manifestation of a chronic disease and further functional reductions, which impede the maintenance of basic activities in old age (Baltes et al. 1999; German Parliament 2002). Members of lower strata are effected earlier in life by multiple and chronic disease and more frequently than persons from the higher strata (AC 2001, 2002). This is reflected in the proportion of benefit recipients.

In addition, members of the private insurances over 75 years are assigned more often to assessment level II and III in case of home-based care and assessment level III in residential care (AOK 2003; PKV 2003). The government report on the development of the long-term care insurance suggests, as an explanation for the difference, a more generous assessment of needs within the framework of the private care insurances (Federal Ministry for Health 2001). The explanation is supported by an analysis of Simon (2003), who proved the problems of validity of the assessments and the tendency to adapt the assignments to the strained economic situation of the social care insurance. A further possible explanation may be the different access to private, informal support systems. Elderly people with a higher income buy informal household services more often, which they can use as a service offer in the case of a lower level of care dependency as well as to supplement professional services and thus postpone the admission into a nursing home (SOEP 2001).

Migrants are viewed in socio-gerontological research as a particularly vulnerable group. Their often bad health status due to their poor living- and working conditions and the specific

negative effect of migration presupposes that they are at a higher risk for the development of care dependency. The under-representation of minorities in professionalized home-based services and residential care can be explained by the higher significance of informal family care and the difficulties to adapt the existing care services to their cultural habits.

The utilisation of services shows a marked gender profile 69% of all recipients are women - reflecting gender differentials in old age. Women are not only in the majority among the elderly over 80 years, they live alone in a single household more often than men and receive lower pension payments. Furthermore, women over 80 years experience more often than their male counterparts restrictions in the performance of daily activities and an increase in care dependency (Naegele/Walker 2002; Federal Statistical Office 2003c). This leads not only to a higher total proportion of insurance benefits, but also to a higher risk due to the cumulative effects and ultimate admission to a nursing home. Service provision has to be extended to the specific situation of women and made available to women with lower pension payments.

At present, the long-term care insurance, like pension schemes and statutory health insurance, are at the centre of an intense political debate in Germany. The issue of the deficits of the long-term care insurance in the last four years and the expected cost increases due to demographic changes form the background of the debate. Even the abolishment of the social care insurance and the introduction of either a tax-based system or a private insurance have been presented as solutions. The Rürup-Committee in Germany dealing with these issues, proposed to maintain the social care insurance but to adapt its shaping to the present problems and foreseeable developments. Economic incentives are aimed at strengthening the principle of domestic before residential care. Recipients assigned to assessment levels I and II should receive the same amount of benefits in residential care as for home-based services with 400 € for Ass-level I and 1000 € for Ass-Level II. This would mean an increase in benefits in home-based services but a significant decline in residential care. The analysis and findings presented in this report support the necessity of strengthening the purchasing power in home-based care. But on the other hand, the dependency on social assistance payments within residential care will be enhanced.

Furthermore, the Rürup-Committee proposed that the benefits defined by law (SGB XI) should be adapted to the changing costs from 2005 on, to secure at least the current level of purchasing power. The committee suggests that pensioners should pay 3.2% of premiums from 2010 on to finance the expected increase in insurance benefit costs and to stabilise the insurance contributions made by employees and employers on the current level of 1.7%. The higher premiums for pensioners are justified by the fact that they have only contributed to the insurance since 1995, in contrast to the younger generation who will pay contributions during their whole working life. At present, elderly people often receive reasonable pension payments but in future this can change due to the lower level of statutory pension payments and the more discontinuous working-careers. How this regulation will effect the living-situation of the future pensioners will have to be assessed.

The establishment of a “Bürgerversicherung”, i.e. an insurance which covers the members of both the private- and social insurance funds within one common insurance fund is being presently discussed for the area of health care. A comparison of the financial development of the social long-term care insurance and the private long-term care insurance even supports the solution for this pillar of social insurance (see table A2 in the appendix). Since the introduction of the long-term care insurance the private long-term care insurance funds utilise approx. 25% of the income for the expenditure and leaving a stable, yearly surplus of approx. 1.4 - 1.5 Billion €. Despite a reduction in the insurance contributions, especially for the younger members, the reserve which is aimed to be used for ageing provision totalled 10.24 Billion € in 2002. The low level of expenditure is due to the small proportion of benefit recipients among the older members but also to the favourable age structure. In 2001, for example 15.34% of the members of the AOK were older than 75 years, compared to 5.44% of the members of the private long-term care insurance (AOK 2003; PKV 2003). In the course of the introduction of the long-term care insurance many older members of the private insurances changed their membership to the social long-term care insurance because the level of insurance contributions was lower. This is no longer possible. The different financial developments of both of the insurances show, however, that the establishment of a citizens` insurance would at least in the long run ease the financing problems of the social long-term care insurance.

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Appendix

Table A 1: Organisations/ (Governmental) Institutions of the 19 Interviewpartners

	Federal Level	Brandenburg	Berlin	Baden-Wurttemberg
Host organisation/ Service provider	4 experts	1 expert Brandenburg	-Berlin	1 expert
Government official		1 expert	1 expert	1 expert
Care insurance fund	2 experts	1 expert	1 expert	1 expert
Medical department of health insurance		1 expert Brandenburg	- Berlin	1 expert
Local level: district and municipality		1 expert	1 expert	1 expert

Table A 2:

Financial development of the social- and private compulsory long-term care insurance

Social long-term care insurance (In Billion €)

	1995	1996	1997	1998	1999	2000	2001	2002
Income (Contributions etc.)	8.41	12.04	15.94	16.00	16.32	16.55	16.81	16.98
Expenditure	4.97	10.86	15.14	15.88	16.35	16.67	16.87	17.36

Reserves in 2002 : 4.93 Billion €

Private long-term care insurance (In Billion €)

	1995	1996	1997	1998	1999	2000	2001	2002
Income (Contributions etc.)		1.66	2.10	2.10	1.93	2.01	1.96	1.99
Expenditure		0.29	0.44	0.44	0.45	0.47	0.49	0.50

Reserves in 2002 : 10.24 Billion €
Sources:
Federal Ministry of Health and Social Security (2003)
PKV (1997-2003)