Current Problems and Challenges in Germany's Long-term Care System

Meeting of the European Confederation of Care Home Organisations (E.C.H.O.)

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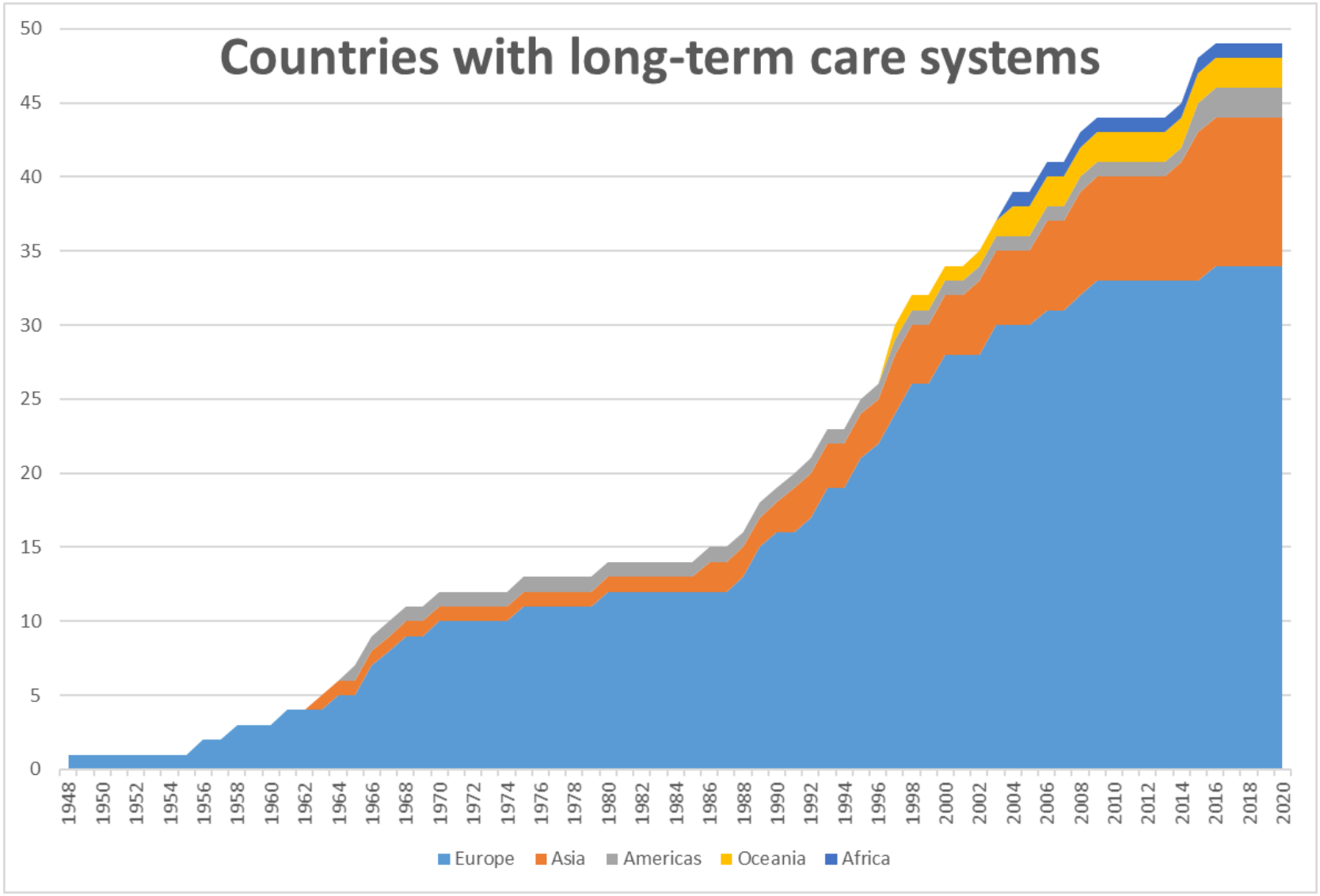
A. Background: Financing and Providing Long-term care in Germany

B. A New Staffing Scheme for Nursing Homes in Germany

C. Limiting co-payments for nursing home residents in Germany

- Up to now about 50 countries in the world have a long-term care (LTC) system, most of them introduced after 1980.

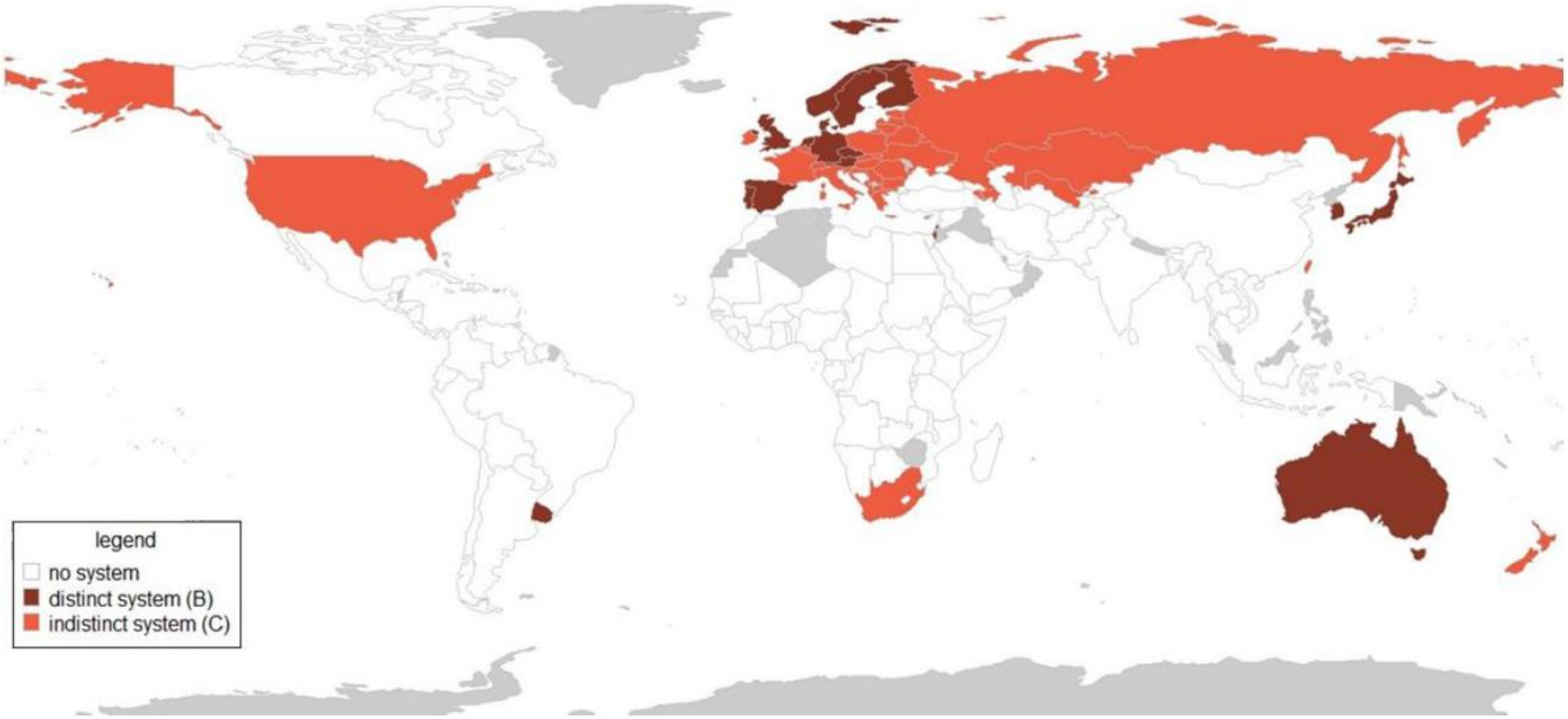
I. Germany compared to other countries



- Up to now about 50 countries in the world have a long-term care (LTC) system, most of them introduced after 1980.

- About 20 countries have a distinct LTC system.

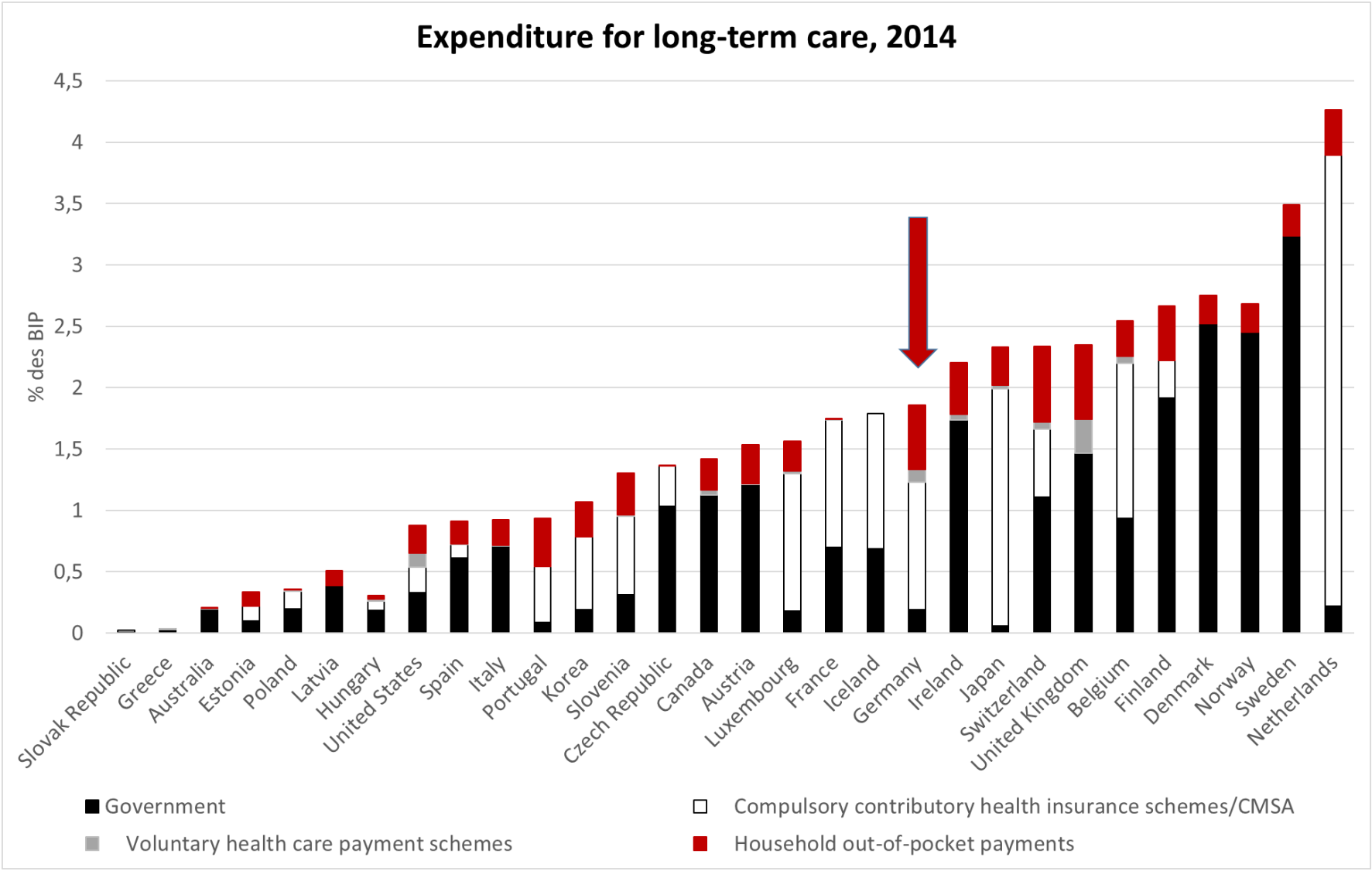
Countries with a long-term care system



Source: Own presentation, based on data from the HLTCS (version 06.09.2021). Data is available in Table 9, Appendix A.

Note: Countries for which data about the existence of an LTC system is missing are highlighted grey. These are all countries which had less than 500,000 inhabitants in 2017 as they are not included in the dataset and 18 further countries for which the (non-)existence of an LTC system could (as of yet) not been determined. These are: Algeria, Bahrain, East Timor, Iraq, Jordan, Kosovo, Kuwait, Malaysia, Moldova, Montenegro, Nepal, North Korea, Oman, Papua New Guinea, Philippines, Qatar, Tunisia, Zimbabwe.

- Up to now about 50 countries in the world have a long-term care (LTC) system, most of them introduced after 1980.
- About 20 countries have a distinct LTC system.
- Along with the Netherlands, Luxembourg, Japan, Korea, and Israel, Germany has a Social Insurance Scheme at the heart of its system.
- Compared to other OECD countries Germany's spending on LTC is slightly above average.


Expenditure for long-term care, 2014
% des BIP
4,5
4
3,5
3
2,5
2
1,5
1
0,5
0
Slovak Republic
Greece
Australia
Estonia
Poland
Latvia
Hungary
United States
Spain
Italy
Portugal
Korea
Slovenia
Czech Republic
Canada
Austria
Luxembourg
France
Iceland
Germany
Ireland
Japan
Switzerland
United Kingdom
Belgium
Finland
Denmark
Norway
Sweden
Netherlands
Government
Compulsory contributory health insurance schemes/CMSA
Voluntary health care payment schemes
Household out-of-pocket payments

- Coverage
  - The whole population is covered in two branches: social health insurance (90%), mandatory private insurance (10%).
  - Risk structure of private insurance is much favourable with respect to age, sex, care probabilities and income.
- Financing
  - PAYGO (social LTCI) and funded system (private mandatoy LTCI)
  - S-LTCI: Contributions levied on labour income, pensions etc., but not on rents and income from capital
- Degrees of dependency:
  - In 2017, five care grades replaced three 3 levels of care.
  - Benefits are related to care levels/degrees.
  - Since 2017: equalisation mechanism in nursing homes: all residents bear the same amount of private co-payment.

- Benefits:
  - All benefits are capped or lump-sums. Until 2008 no adjustments at all, in nursing homes: first adjustment (for care level I and II) in 2008. Still no formula-based regularly adjustment
    → decreasing purchasing power of LTC benefits
  - Home care:
    - Cash benefits
    - In-kind benefits (including respite care, short term care, day care etc.)
    - Pension benefits
    - Nursing aides. etc.
  - Nursing home care:
    - No benefits for room and board, investment and training costs, which have to be payed by users
    - Lump sum for costs of nursing care – which leaves a considerable amount uncovered

Pflegebedürftige 2019 nach Versorgungsart

4,1 Millionen Pflegebedürftige insgesamt

zu Hause versorgt:
3,31 Millionen (80 %)

in Heimen vollstationär versorgt:
818 000 (20 %)

durch Angehörige:
2,12 Millionen Pflege-bedürftige (Pflegegrad 2 bis 5)

zusammen mit/ durch ambulante Dienste:
983 000 Pflege-bedürftige (Pflegegrad 1 bis 5)

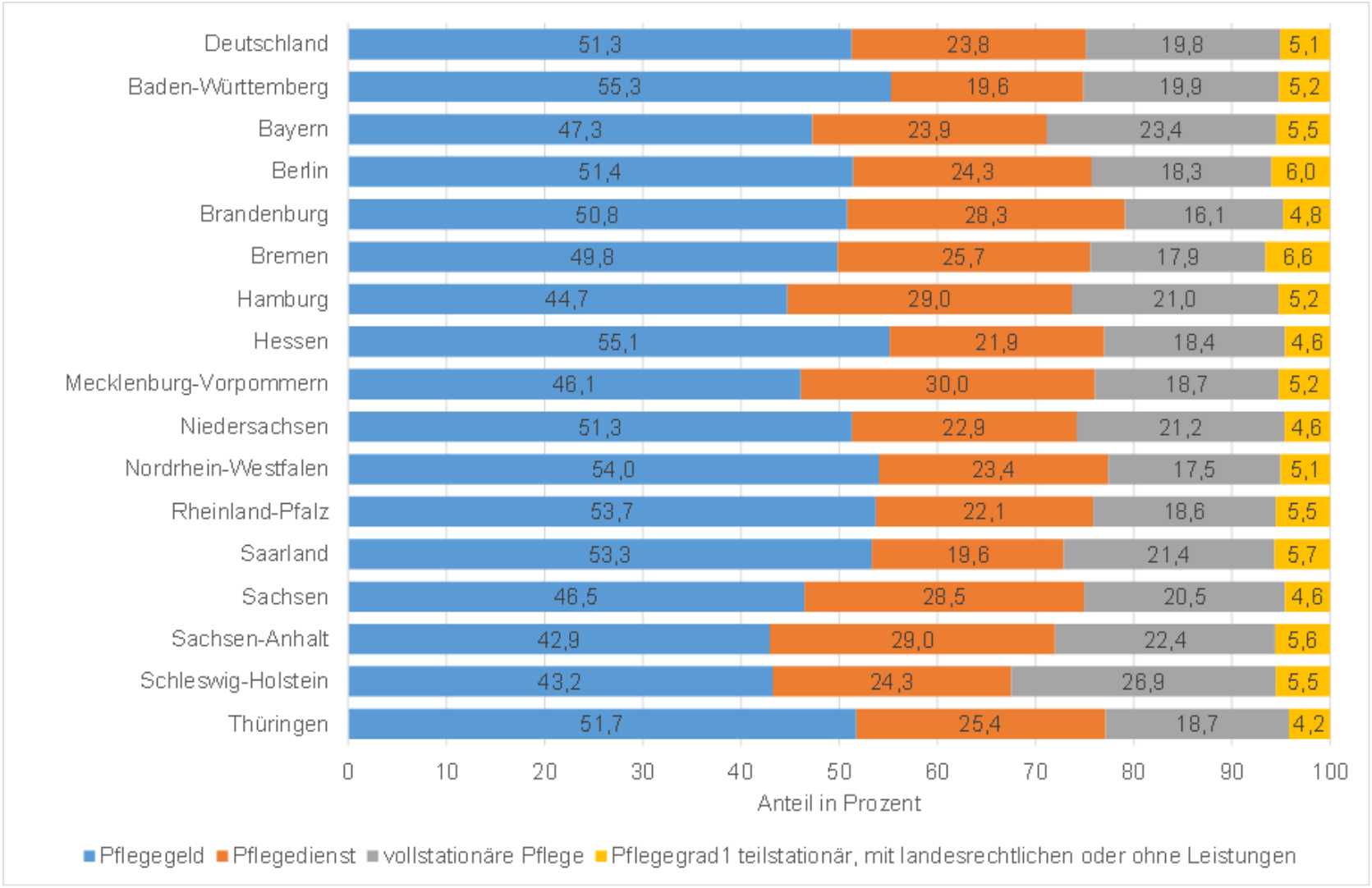
im Pflegegrad 1 (mit ausschließlich landesrechtlichen bzw. ohne Leistungen der Heime und Dienste):
208 000 Pflege-bedürftige
Auch durch Angehörige versorgt.

durch 14 700 ambulante Dienste mit 421 600 Beschäftigten

in 15 400 Pflegeheimen [1] mit 796 500 Beschäftigten

1 Einschl. teilstationärer Pflegeheime.

III. Utilisation of Services



Source: BARMER Pflegereport 2020

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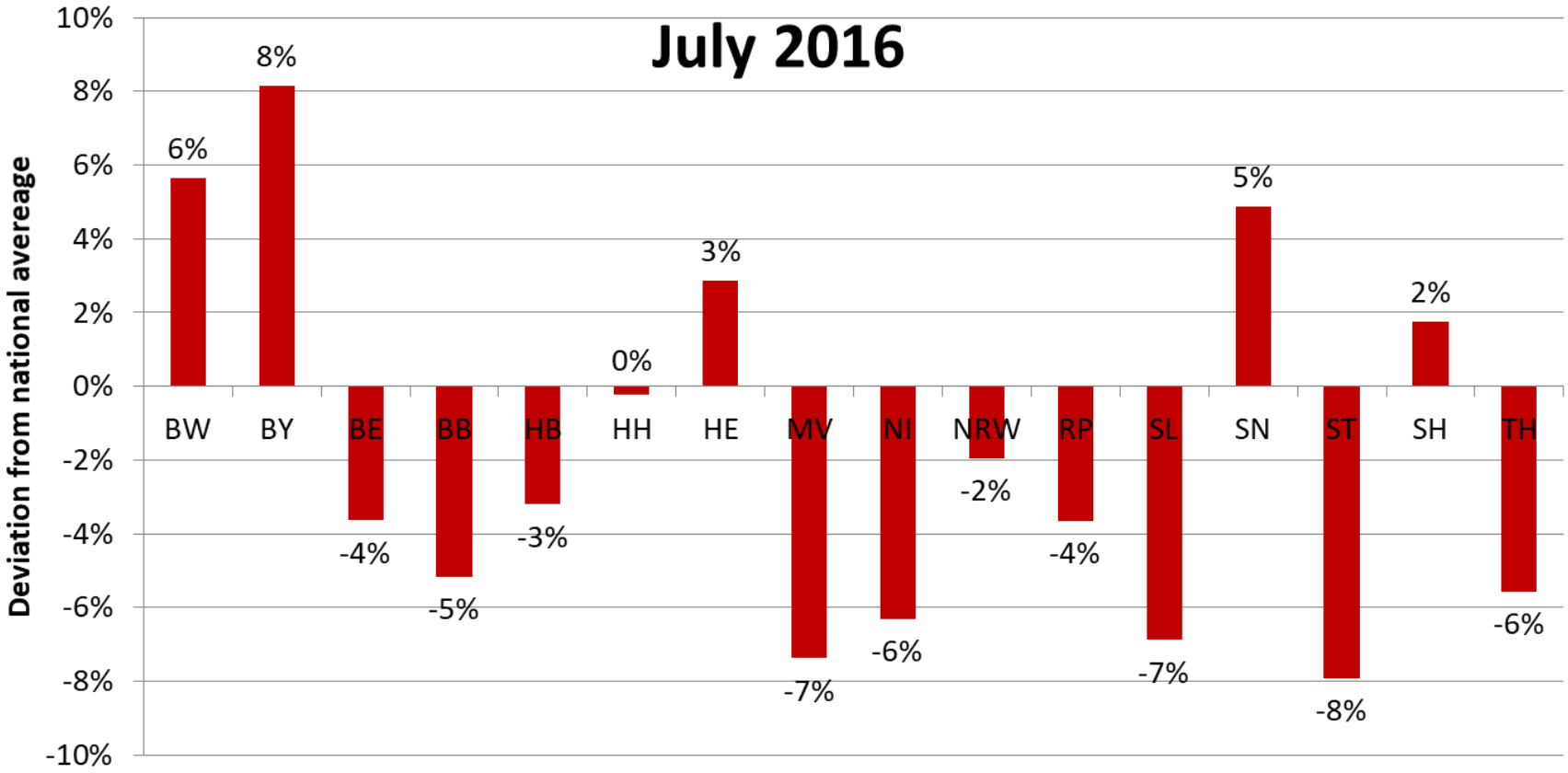
1. Staffing patterns have hitherto differed considerably between federal states → without any rationale



1. Staffing patterns have hitherto differed considerably between federal states without any rationale

2. Staffing patterns have generally been seen as too low.
   - Geriatric nurses complained about understaffing and subsequent working conditions (DGB 2018: 7f.)
   - In a survey half of all geriatric nurses admitted that understaffing led to deficits in the quality of care (DGB 2018: 16f.)
   - Nursing is one of the professions with the highest rates of sick leave (Isfort et al. 2018: 2f.) and invalidity pensions (Rothgang / Müller 2020).
   - Working conditions are the most important single reason why geriatric nurses leave their job (Hasselhorn et al. 2005).

1. Staffing patterns differed considerably between federal states without any rationale

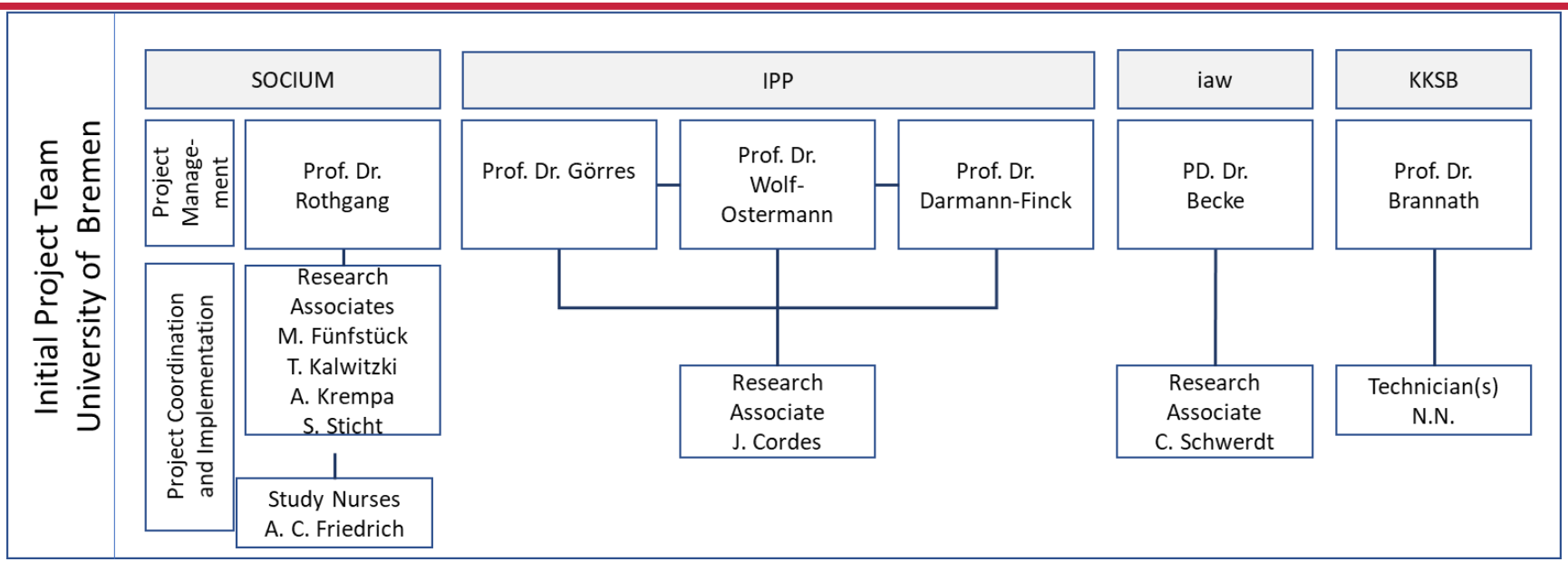
2. Staffing patterns were generally seen as too low.

3. In 2015, the Second Long-term Care Strengthening Act was passed, requiring the Development of a new Staffing Scheme
   - The University of Bremen filed a bid for the tender and was commissioned to develop an instrument.
   - From 2017 to 2020 the staffing scheme was developed, and the final report was accepted in September 2020.

In what follows I will

- describe the methods applied in developing the new staffing scheme,
- present what follows from the new scheme for Germany, i.e. changes in the number of staff as well as their qualification mix
- report the state of implementation, and
- discuss the applicability of the instrument to other countries.

III.1 Project team



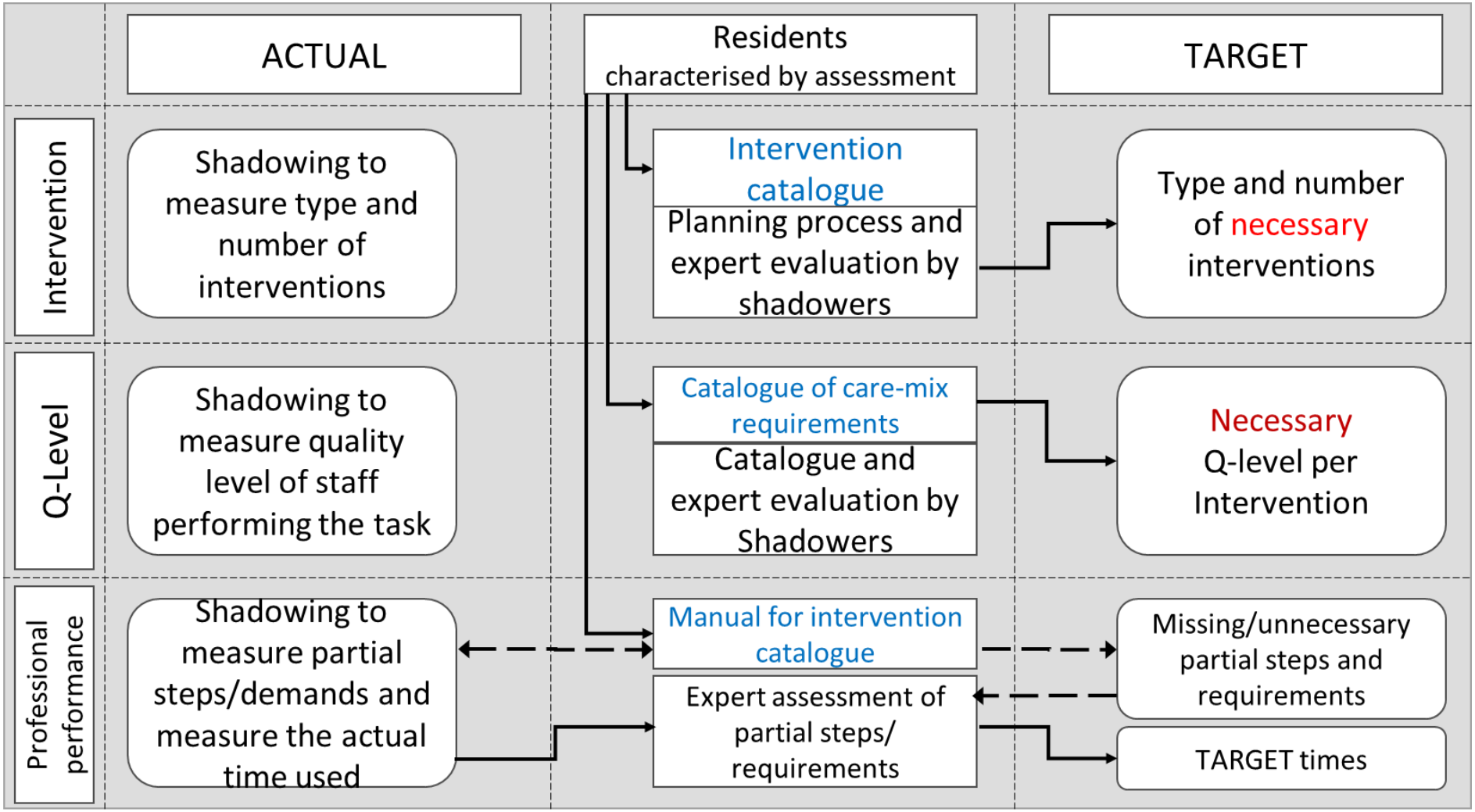
- **Project director:** Prof. Heinz Rothgang
- **Nursing science:** Prof. Stefan Görres, Prof. Karin Wolf-Ostermann, Prof. Ingrid Darmann-Finck, Prof. Andreas Büscher, Dr. Claudia Stolle-Wahl
- **Labour studies:** PD Dr. Guido Becke, Cora Schwerdt
- **Registered nurses with academic degrees:** Mathias Fünfstück, Agata Krempa, Sarah Sticht, Janet Cordes
- **Gerontology:** Thomas Kalwitzki; **Social Sciences**: Lukas Matzner
- **Statistics:** Prof. Werner Brannath, Dr. Stephan Kloepp
- **Study nurses**: 242 registered nurses, half of them each from LTC funds and services providers

1. Step: Developing an instrument to guide observation
   → Catalogue of interventions

2. Step: Definition of state of the art description of interventions and necessary qualification level (registered nurses, nurse assistants, helpers)
   → Manual for catalogue of interventions
   → Catalogue of care-mix requirements

3. Step: Shadowing of all nurses on a ward with respect to what does (positive) and should happen (normative)

4. Step: Calculation of necessary amount of care-giving by adjusting the observed time volumes with respect to number of interventions, time for each intervention and qualification level of nurses


ACTUAL
Residents
characterised by assessment
TARGET
Intervention
Shadowing to measure type and number of interventions
Intervention catalogue
Planning process and expert evaluation by shadowers
Type and number of necessary interventions
Q-Level
Shadowing to measure quality level of staff performing the task
Catalogue of care-mix requirements
Catalogue and expert evaluation by Shadowers
Necessary Q-level per Intervention
Professional performance
Shadowing to measure partial steps/demands and measure the actual time used
Manual for intervention catalogue
Expert assessment of partial steps/ requirements
Missing/unnecessary partial steps and requirements
TARGET times

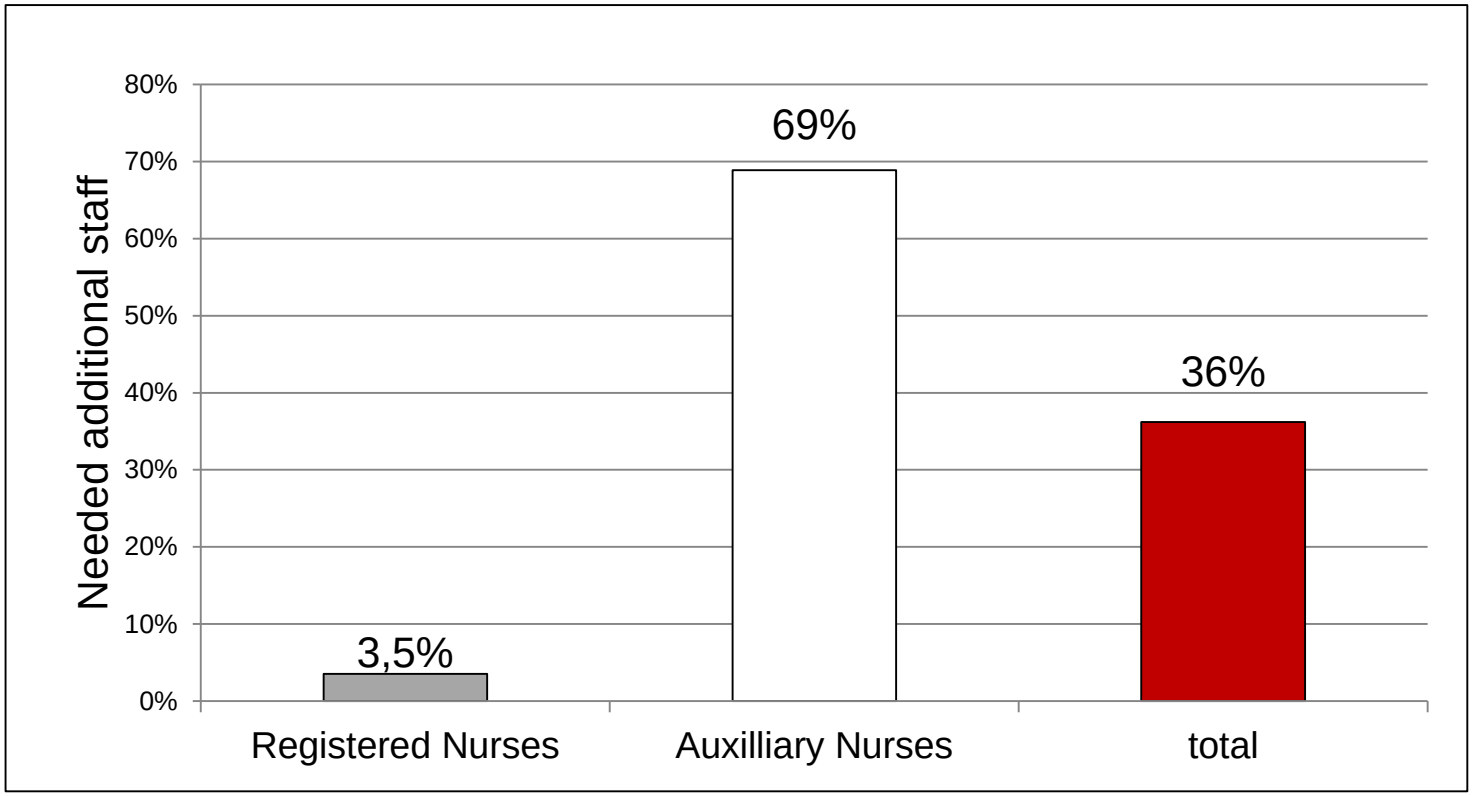
- Observations on
  - which interventions were conducted,
  - how much time was taken,
  - whether the intervention was necessary,
  - whether the intervention was performed according to the state of the art
  - how much additional time is necessary if state-of-the-art nursing is conducted.

POSITIVE

NORMATIVE

- Data base:
  - 130,656 interventions, on
  - 1,380 nursing home residents, in
  - 62 wards, in
  - 15 out of 16 federal states

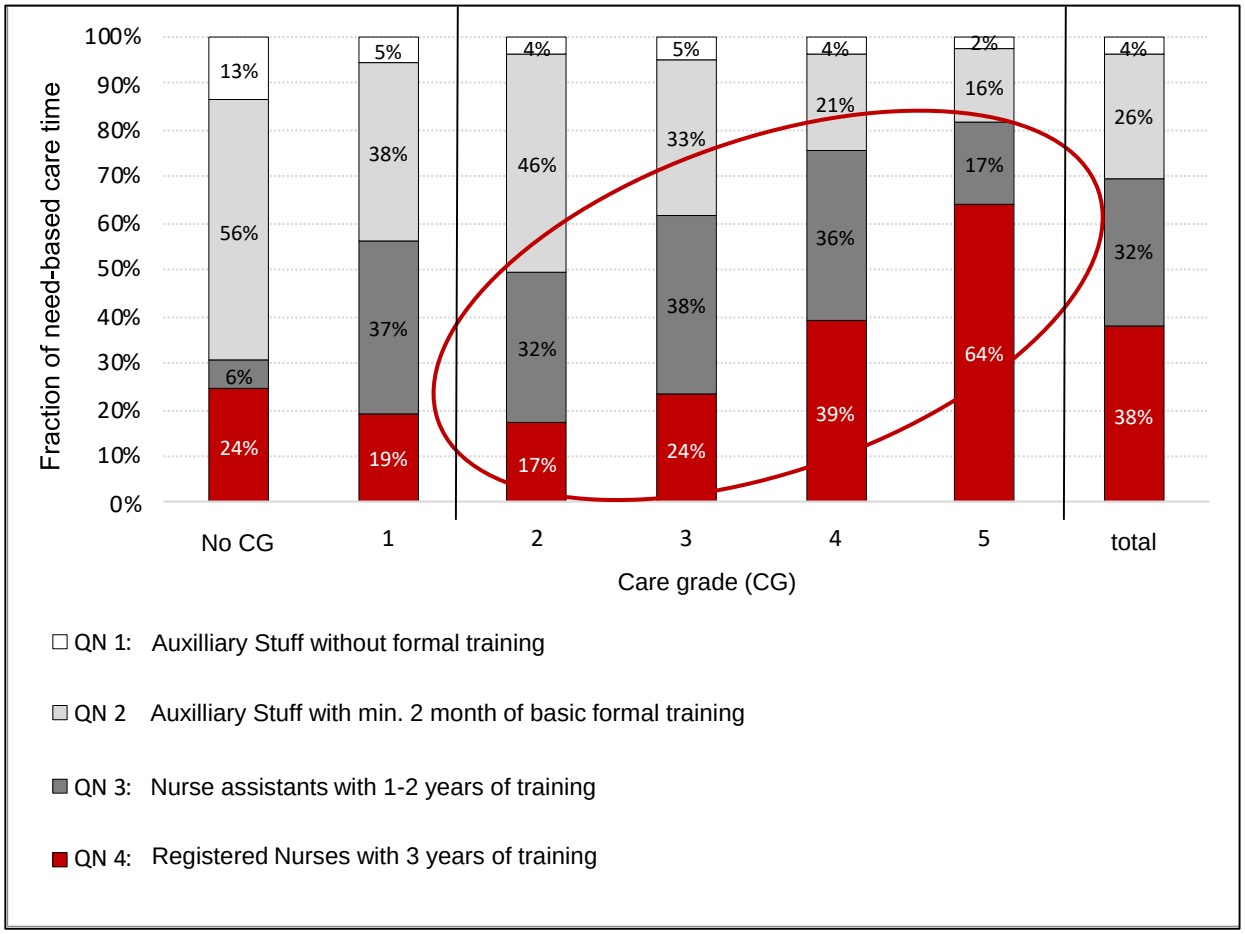
- The study reveals a considerable need for additional nursing staff, particularly nurse assistants.



Source: Rothgang und das PeBeM-Team 2020

- The study reveals a considerable need for additional nursing staff, particularly nurse assistants.
- Nursing homes with a higher case-mix need a higher care-mix.

Care-mix according to case-mix of residents



Quelle: Rothgang und das PeBeM-Team 2020

- The study reveals a considerable need for additional nursing staff, particularly nurse assistants.
- Nursing homes with a higher case-mix need a higher care-mix.

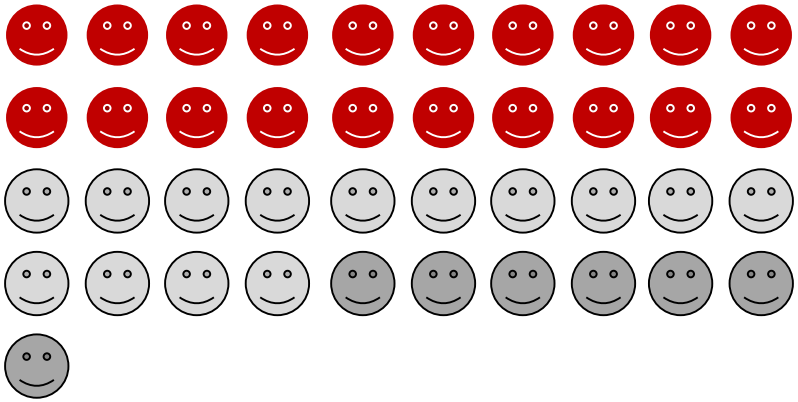
- The current quota of 50% registered (geriatric) nurses will be replaced by an individual care-mix according to the respective case-mix.

- On average the result is:
  - 38% of time for registered nurses and
  - 32% of time for nurse assistants with 1-2 years training (according to federal law).

IV.3 Results: Effects for an (average) nursing home

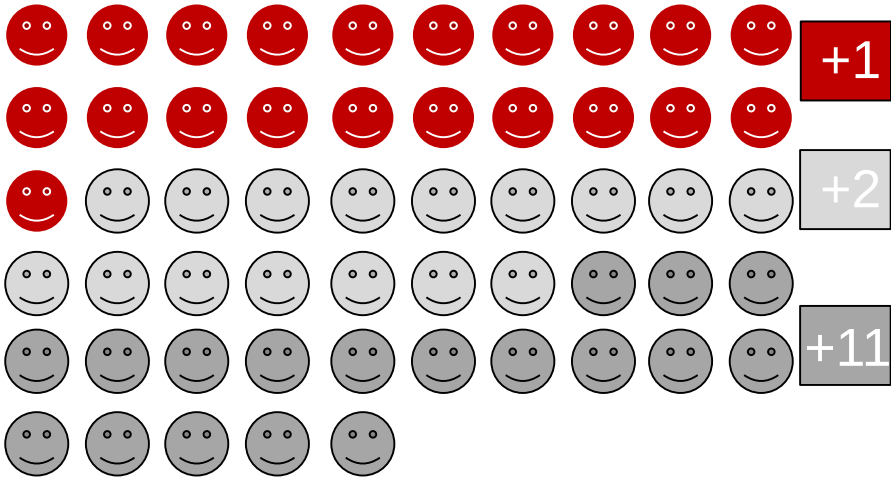
Nursing home with 100 residents and average case-mix

Currently: 41 FTE



41

Need: 55 FTE



55

Registered nurses (qualification level 4)

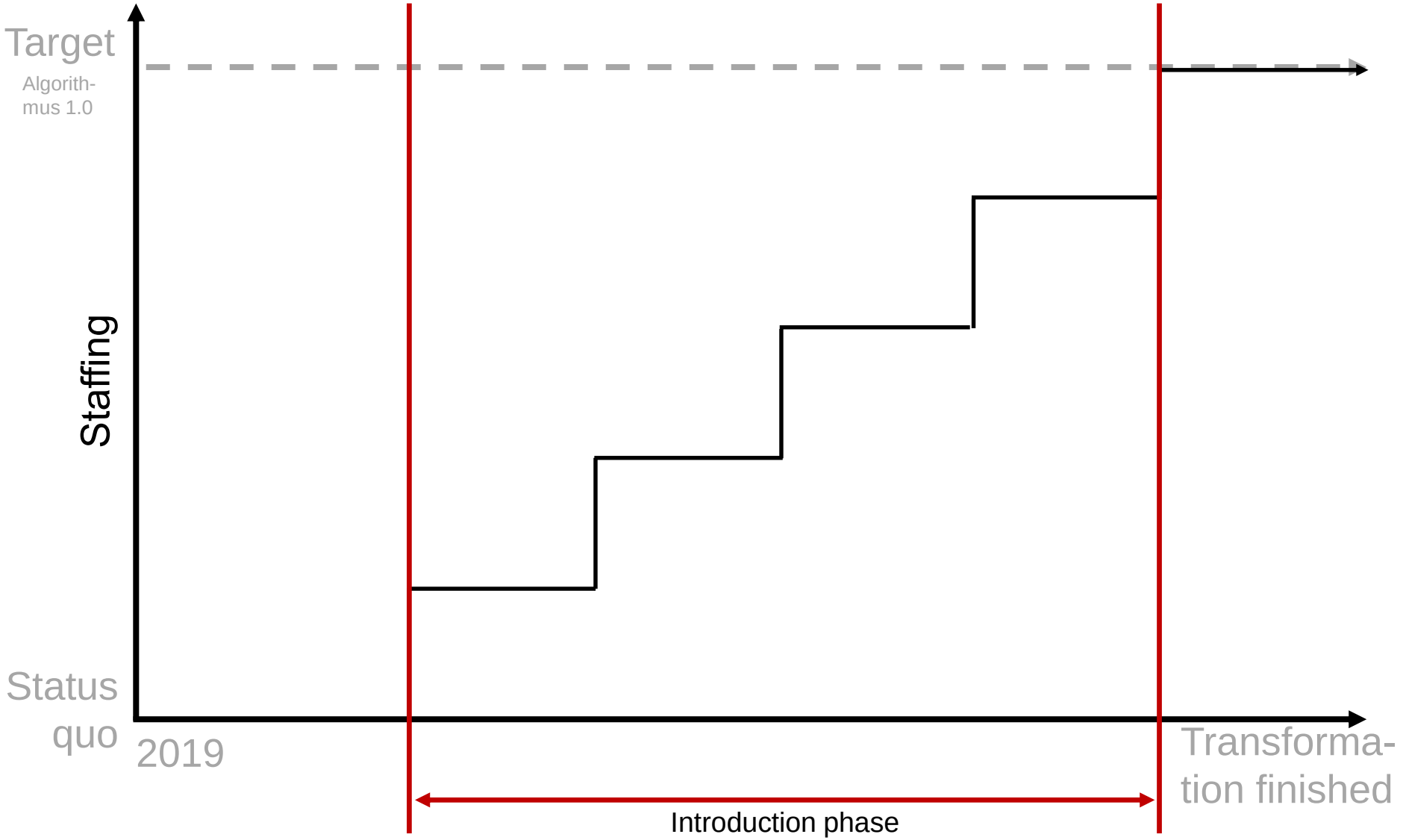
Nurse assistants (qualification level 3)

Auxilliary staff (qualification level 1 or 2)

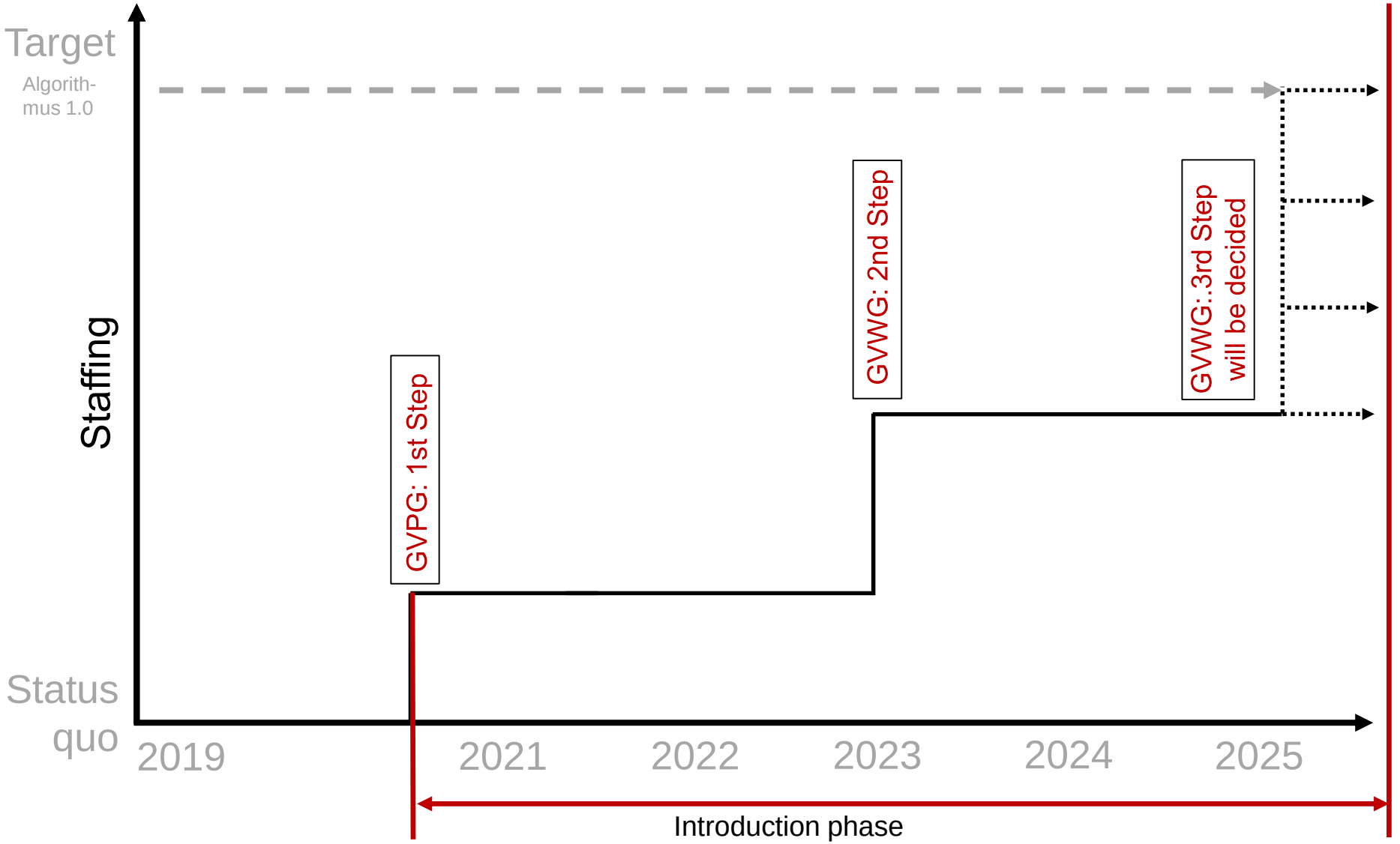
Additional nursing staff will only improve quality of care and working conditions if accompanied by

- Organisational development
  - New roles for registered nurses: planning, advising, supervising, evaluation, delegation
  - Distribution of labour according to competences rather than everyone doing everything
- Human resource development
  - Nurses have to learn (anew) how to care with sufficient time.
  - Registered nurses as well as nurse assistants have to accept new roles.
  - Sufficient numbers of nurses have to be educated and trained. Respective structures are required.

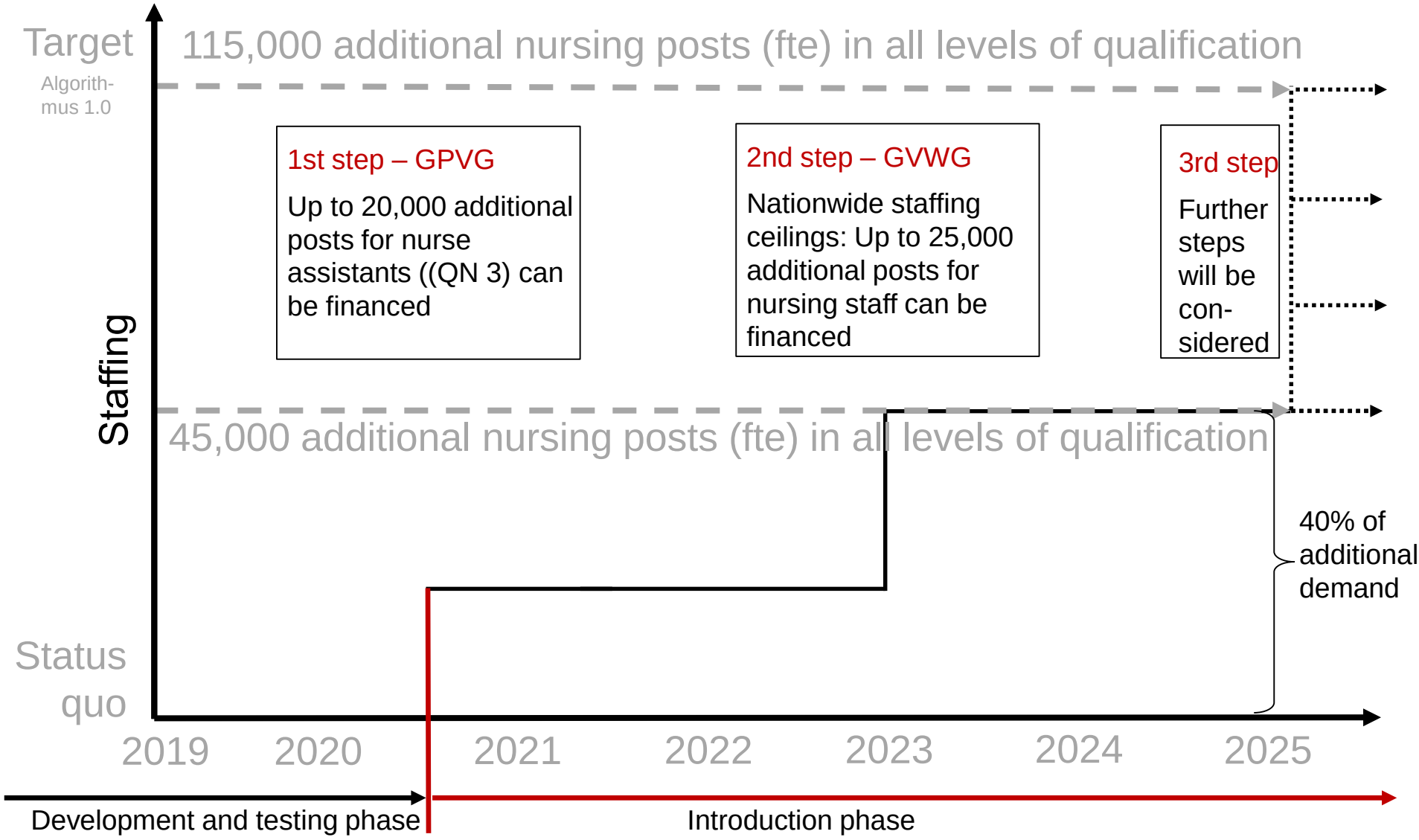
V. Implementation: Recommendations from the project team



V. Current state of implementation

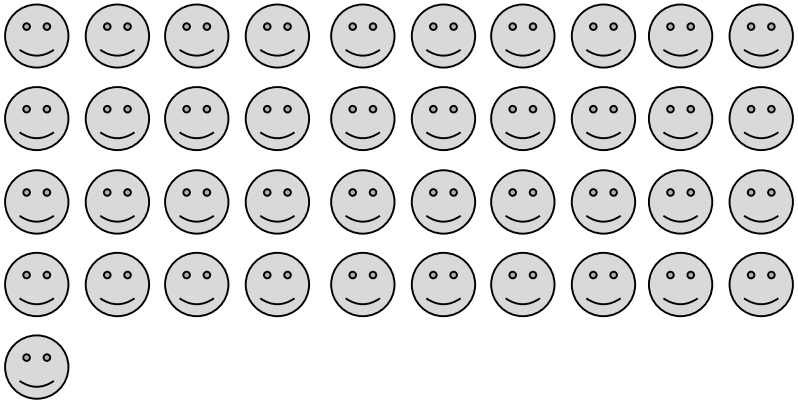


V. Current state of implementation

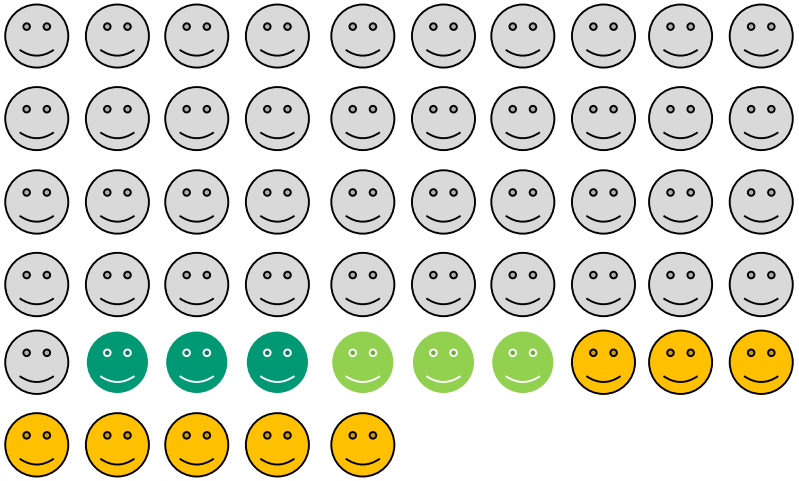


Nursing home with 100 residents and average case-mix

Currently: 41 FTE



Need: 55 FTE



Implemented as part of the GPVG

Implemented as part of the GVWG

Implementation not decided yet

- After more than 20 years of discussion a staffing system has been developed and approved by all relevant actors.
- The new scheme calls for about 115,000 additional nursing posts in nursing homes (fte), almost all of them for nurse assistants, and a replacement of a generalized ratio of registered (geriatric) nurses to other nursing staff by case-mix dependent care-mix ratios.
- Recent legislation imposed two rounds of implementation (2021 and 2023) and the possibility for a third round in 2025.
- Implementation also requires organisational and human resource development – and respective efforts concerning education and training programmes.

Using Kingdon's three streams approach we can draw some lessons from the German experience:

1. If the situation is bad enough the increase of staffing patterns can be put on the political agenda (problem stream).

2. A close shadowing of nursing staff can be used to observe the status quo and to develop a normative view on what should be done and thus provide a formulae for necessary staffing patterns (policy stream).

3. If all relevant actors are part of the process (in this case financing bodies and providers were part of the project's steering committee), even without a particular entrepreneur the solution can be implemented (politics stream).

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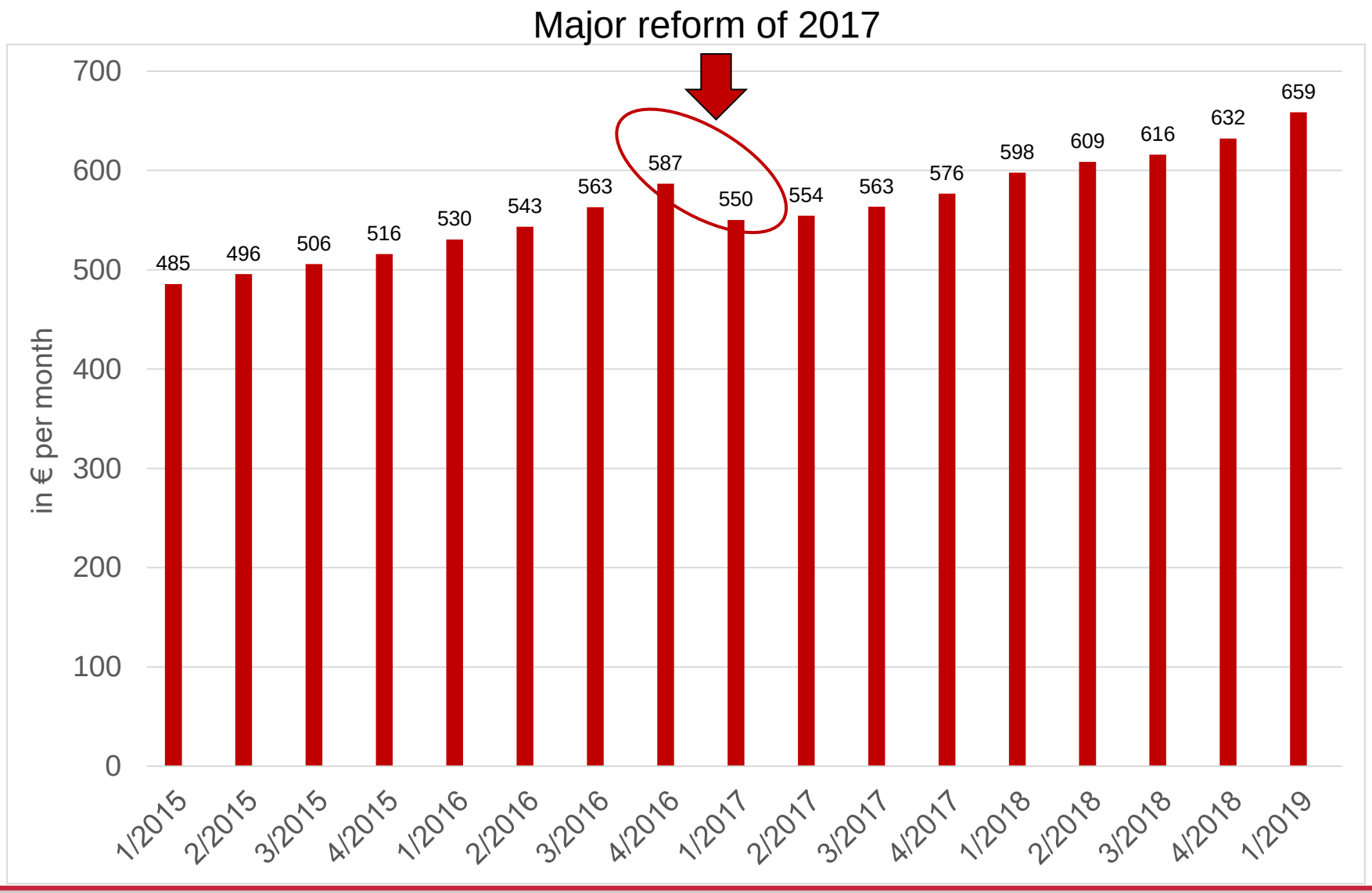
- A conservative welfare state – *such* as Germany – aims at *status maintenance*, i.e. social risks such as illness, disability or the need for long-term care should not endanger the social position a person has achieved during his/her lifetime.
- Mandatory long-term care insurance (LTCI) was introduced to make sure that care-dependent people don't have to rely on social welfare (Götze & Rothgang 2014).
- The share of nursing home residents who rely on welfare has been an indicator for the success / failure of the system.
- Recent developments indicate a failure of the current system.

- Nursing home care reimbursement consists of four parts:
  - Nursing care: a fixed amount is financed by LTCI benefits, the amount on top of that has to be covered by the person in need of long-term care.
  - Room and board: has to be financed by the care-dependent person
  - Investment cost (building, maintenance, etc.): has to be financed by the care-dependent person
  - Costs for training of nursing trainees: has to be financed by the care dependent person.

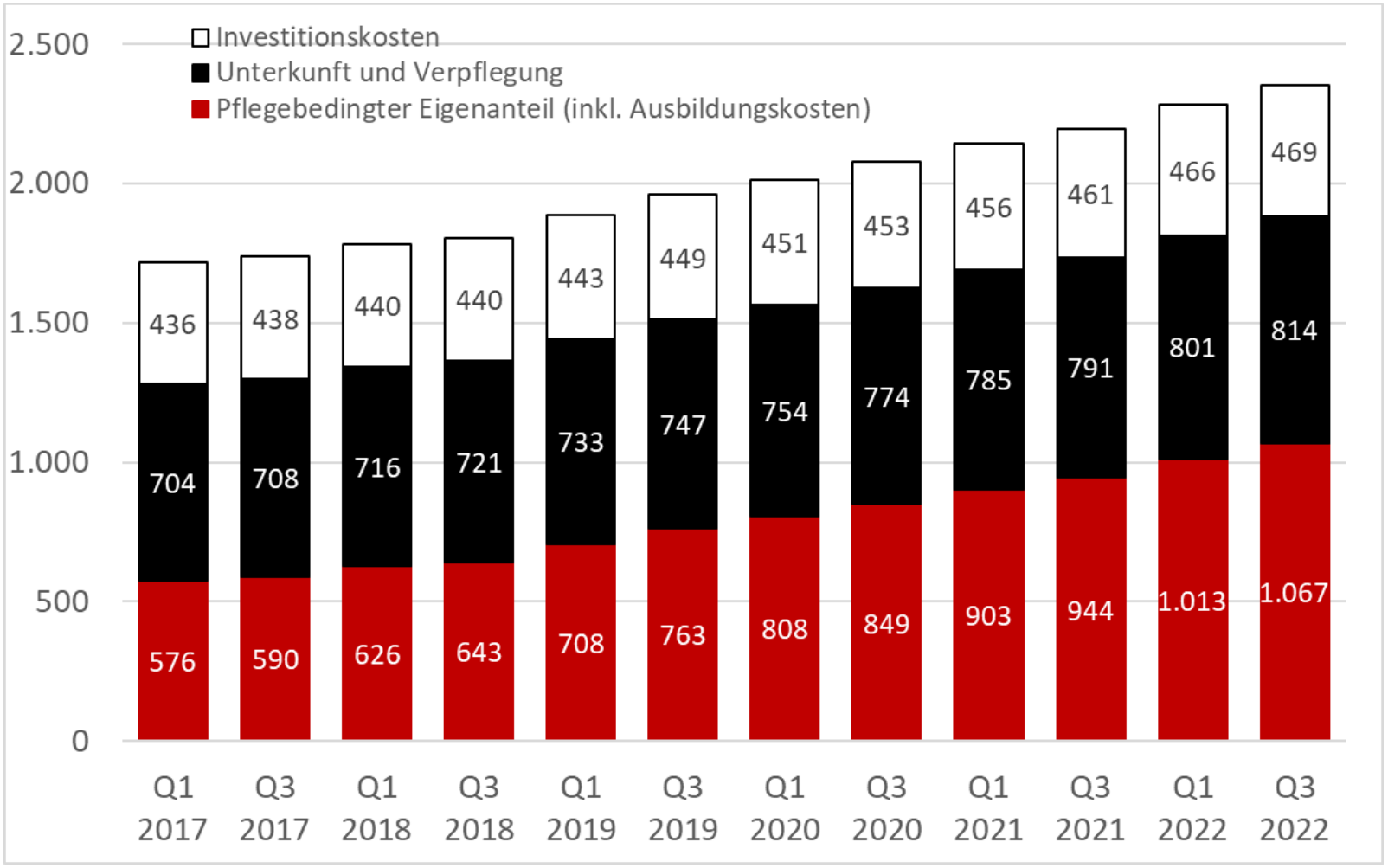
- While benefits have been kept constant for up to 20 years, costs have risen and so have fees. Consequently, co-payments have increased.
- Even the major reform of 2017 only caused a small and temporary relief.

II. The Problem: Co-payments for nursing care



- While benefits have been kept constant for up to 20 years, costs have risen and so have fees. Consequently, co-payments have increased.
- Even the major reform of 2017 only caused a small and temporary relief.
- Since 2017 co-payments have been on the rise again.

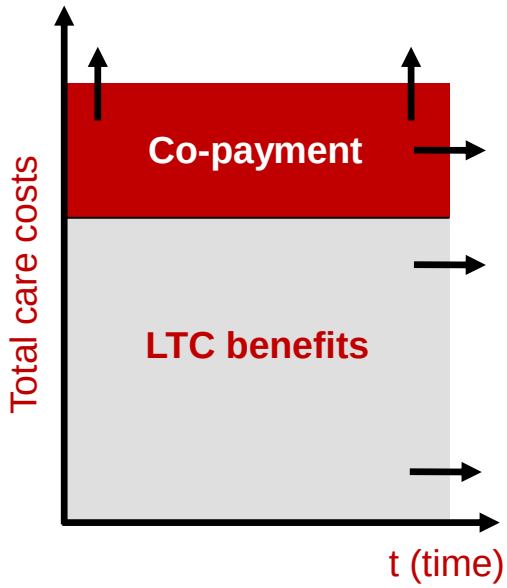
II. The Problem: Co-payments for nursing home residents



Source: Vdek 2022

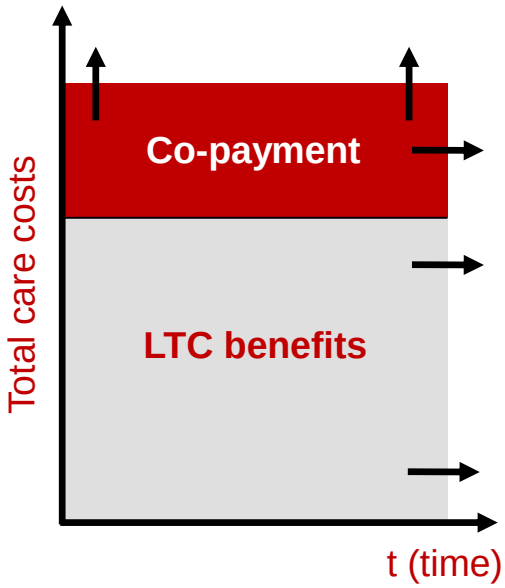
- Under the original scheme nursing home residents bear a double risk concerning the amount and duration of co-payments.

Status quo

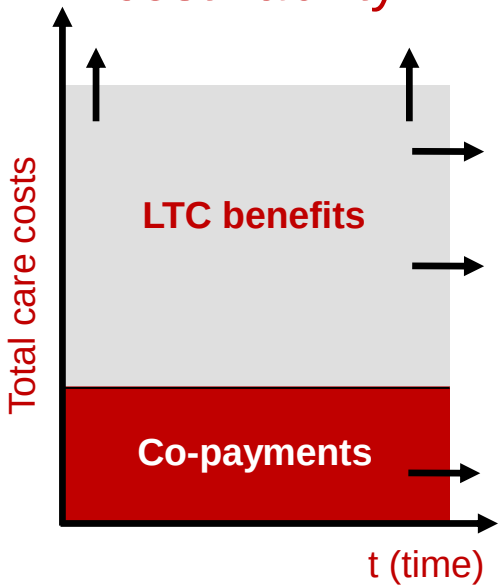


- An inversion of cost liability would mean that the risk of high and increasing total care costs rests with the insurance rather than with the nursing home resident. The risk concerning the duration, however, remains with the resident.

Status quo

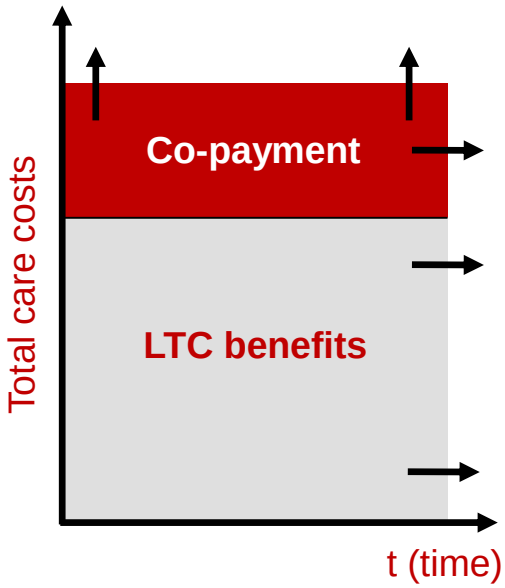


Inversion of cost liability

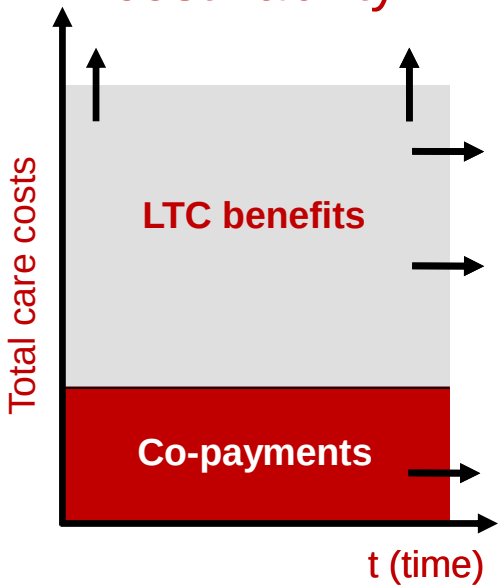


- An inversion of cost liability with a qualifying period for full coverage of care costs would mean that both risks (amount and duration) rest with the insurance rather than with the nursing home resident.

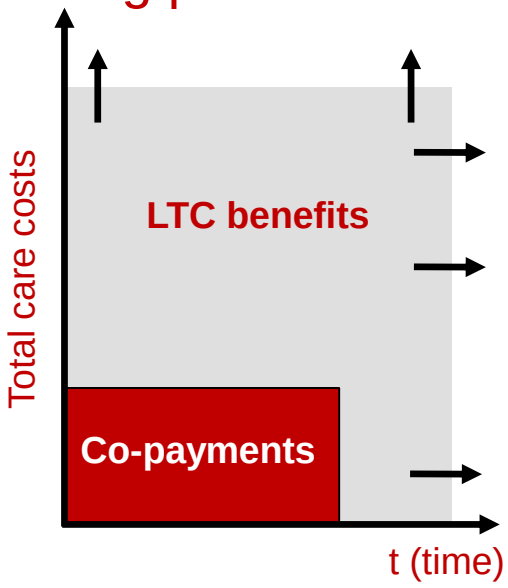
Status quo



Inversion of cost liability



… with qualifying period



Original DOH plan of 4.11.2020

- National cap on co-payments for LTC costs including staff training costs at 700 euros
- Temporal limitation of such payments to 36 months
- Federal states bear the co-payment of 100 euros per month and resident for investment costs
- Tax subsidy of 6 billion euros

Original DOH plan of 4.11.2020

- National cap on co-payments for LTC costs including staff training costs at 700 euros
- Temporal limitation of such payments to 36 months
- Federal states bear the co-payment of 100 euros per month and resident for investment costs
- Tax subsidy of 6 billion euros

Reform Act from Juli 2022

- LTC insurance assumes the cost of the care-related co-payments, which are staggered according to duration of inpatient benefits:
  - For less than 1 year: 5%
  - For 1-2 years: 25% of the care-related co-payments
  - For 2-3 years: 45%
  - For more than 3 years: 70%
- Federal states are not required to assume the cost of further investment co-payments
- Tax subsidy of 1 billion euros

- The Refom Act also contains additional costs for LTC home residents that run counter to the differential exonerative effects:
  - The benefit adjustments which was planned for 2021 was chancelled, leading to generally higher co-payments in 2021.
  - The rules on collective tariff agreements and on increased staff numbers increase residents' co-payments by an average of 151 euros per month (according to Health Ministry's financial tableau) and
  - The integration of the hitherto additionally financed staff into the care-related costs increases the monthly co-payments by an average of 101 euros (according to the Health Ministry's financial tableau).

- In sum, the reform does little to relieve LTC home residents of the cost burden.

- On balance, about half of residents living in LTC homes for less than 2 years are burdened with additional costs, while the other half pay less.

- The average cost reduction of 37 euros constitutes only 1.7% of the average total co-payment.

Dauer der stationären Pflege	Prozentualer Anteil der Heimbewohner	Pflegegrad 2	Pflegegrad 3	Pflegegrad 4	Pflegegrad 5	Gewogener Mittelwert
0-1 Jahr	28,94%	-244,11	-268,71	-294,36	-305,86	-279,09
1-2 Jahre	18,90%	-57,11	-81,71	-107,36	-118,86	-92,09
2-3 Jahre	15,38%	129,89	105,29	79,64	68,14	94,91
3 Jahre und mehr	36,78%	363,64	339,04	313,39	301,89	328,66
Gewogener Mittelwert		72,28	47,68	22,03	10,53	**37,30**

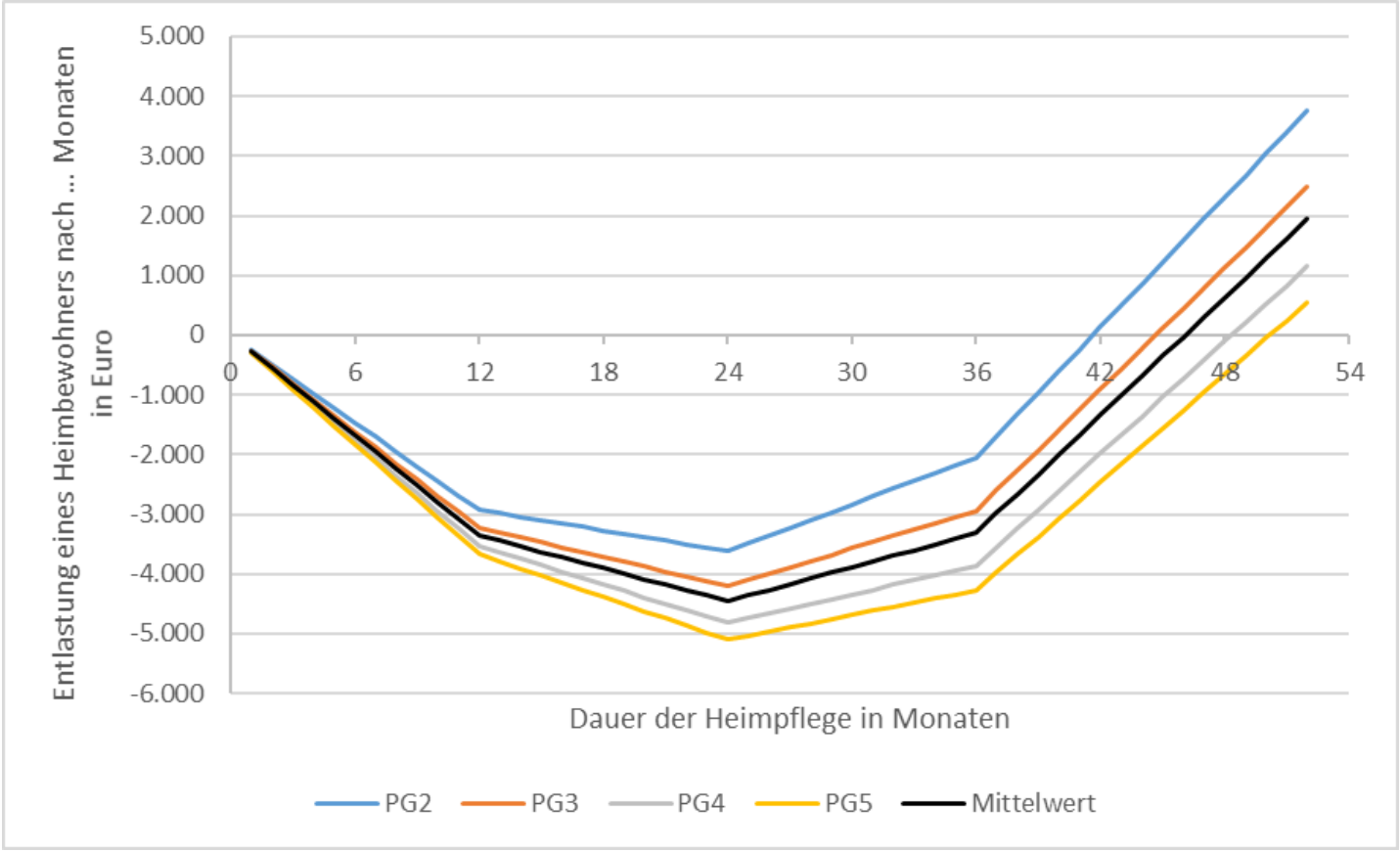
Annahme: Pflegesätze von Juli 2021

Quelle: Rothgang & Müller 2021: 38

- In sum, the reform does little to relieve LTC home residents of the cost burden.

- Overall, the reform leads to a greater cost burden for all residents living in a LTC homes for fewer than 3.5 years.

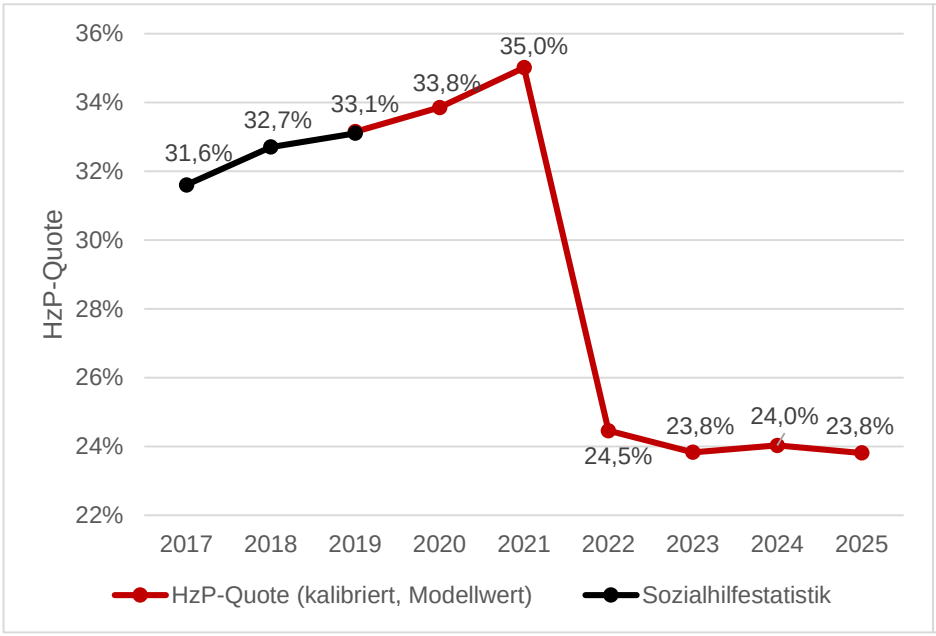
Cumulative relief for a nursing home resident x months after receiving nursing home care for the first time



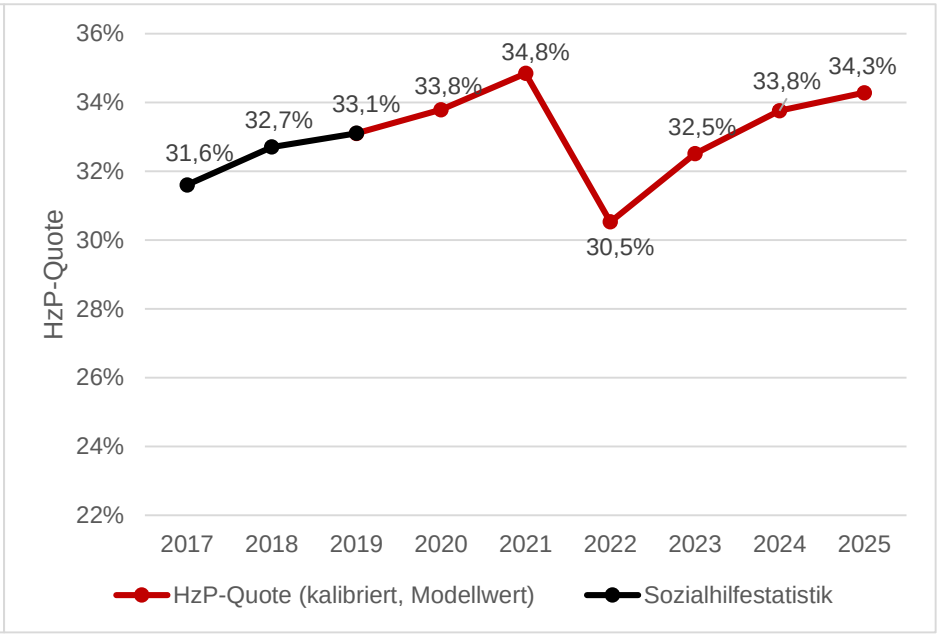
Source: Rothgang & Müller 2021: 39

- In sum, the reform does little to relieve LTC home residents of the cost burden.
- Overall, the reform leads to a greater cost burden for all residents living in a LTC homes for fewer than 3.5 years.
- The reduction of costs for social insurance funds is only temporary.

IV.1 Evaluation of reform effects: Social assistance



Original DoH Plan



Reform Act

(Source: Rothgang et al. 2021c: 23)

- The original DOH plan constitutes a revolution of the system:
  - The costs of future quality enhancements are transferred from the care-dependents to all insurees – and make co-payments more easily predictable
  - The proportion of social welfare recipients is directly *and* sustainably reduced.
  - In the medium and long term, more and better paid staff can be employed without burdening the residents.

- The reform act on the other hand does not solve the problem:
  - The implementation of this proposal still renders the co-payments incalculable and it is not possible to maintain living standards.
  - Even in the short term, fewer people are relieved of costs, and in the medium and longer term, dependency on social security will increase again. Ultimately it is just a matter of buying time.

- The reform act thus falls far behind the changes announced in the Department of Health's original plan, and halfway through the next parliamentary term we will again be facing the very same problems.

- While the Minister's announcement and the original plan, which has taken up the idea of a inversion of cost liability,y looked like a shift into the fast lane, the LTC reform has ended up in a cul-de-sac.

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Thank you for your attention!