Achieving financial and political sustainability in social care funding. What can England learn from Germany's Long-Term Care Social Insurance approach?

Evidence to the Housing, Communities and Local Government and Health Select Committees' Joint Inquiry into the Long-Term Funding of Adult Social Care

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Executive Summary

Following two decades of debate, a long-term care social insurance (LTCI) scheme was introduced in Germany in 1994. Launched at a time of wider welfare state retrenchment, its design includes key features intended to ensure financial sustainability. After a decade of funding stability that built institutional and popular legitimacy, contributions and benefits have been increased and a series of reforms from 2008 onwards has extended the scheme to provide full coverage for people with dementia. While acknowledging the different institutional frameworks of the English and German welfare states, there are nevertheless important lessons that England can learn from the German approach, about both sustainable funding arrangements and achieving consensus on reform. Key lessons include:

- The explicit recognition that need for care, at any age, is a social risk requiring social protection.
- The crucial role of central government in maximising risk pooling and in regulating contributions, benefits and eligibility frameworks.
- The importance of a universal and equitable approach to care funding in order to build political and public support.
- Compatibility with existing welfare structures and institutions to facilitate rapid implementation
- Comprehensive social protection for family care-giving.

1 German Long Term Care Insurance

1.1 Introduction

Alongside existing health, unemployment, industrial injury and old age insurance schemes, in 1994 Germany introduced a comprehensive, universal LTCI scheme.

The main driver for reform was the growing reliance on means-tested social assistance for older people who had 'spent down' their assets to pay for care. This was considered stigmatising and incompatible with citizenship principles. It also caused major concerns from regional (Länder) and municipal governments (responsible for social assistance in Germany) about the impacts on their budgets. Additional considerations were to:

- Protect the health insurance funds from the costs of long-term care.
- Stimulate new service providers, and choice and competition between them.
- Discourage unnecessary institutional care.
- Maintain the principle of subsidiarity that placed responsibility on households for supporting family members, by providing social protection for care-giving relatives.
- Demonstrate it was possible to introduce a social insurance scheme with a stable, sustainable contribution rate, to set a precedent for the reform of existing (defined benefit) insurance schemes.

1.2 Organisation and funding

LTCI offers universal social rights within a strong cost-containment framework. The Federal government has substantial regulatory and cost-controlling powers. The global LTCI budget, contribution rates and ceilings and benefit levels are all fixed by Federal law, which also sets eligibility guidelines. LTCI funds are managed by – but separate from – health insurance funds.

LTCI is a Pay-As-You-Go (PAYG) scheme. The individual contribution rate in 2017 was 2.55% (2.8% for people without children as they are considered more likely to need more expensive formal care services); the contribution ceiling is set at the same level as for health insurance. Half the LTCI contribution is paid by employers and the other half by employees. To overcome employers' fierce opposition to further social insurance payroll costs, trades unions agreed to the abolition of one day's statutory paid holiday. Since 2004, retired people have paid full contributions (rather than these being subsidised by their pension insurance fund), helping to address concerns about inter-generational equity. However, LTCI contributions are small compared with the other German social insurance premia.

LTCI membership is compulsory; non-employed people are covered by the contributions of employed household members. Around 10% of people belong to private care insurance schemes, which are legally required to offer coverage, contributions and benefits equivalent to statutory LTCI.

As a PAYG scheme, LTCI was able to grant benefits immediately, although these were phased in (home care in 1994, institutional care in 1995) in order to build up the LTCI fund.

1.3 Eligibility and assessment

LTCI can be claimed by people of all ages. It reflects the underlying insurance principle that those with similar levels of care needs receive similar benefits. There is no assets/wealth or income means-test and no account is taken of any other individual circumstances. On introduction of LTCI, the eligibility thresholds were developed to fit the funds available. Up to 2008, eligibility depended on the level of 'care dependency' - the amount and frequency of help regularly required with personal hygiene, mobility, eating and housekeeping. Eligibility criteria have gradually been extended to include care needs arising from dementia, learning disability and other mental health problems (see below).

Eligibility criteria are the same for institutional and home care and across public and private LTCI schemes. Claims are assessed by medical services financed by the sickness insurance funds; eligibility decisions are made by the LTCI funds. Although people of all ages (including children) are eligible for LTCI, over 80% of beneficiaries are aged 65-plus and over 55% are over 80.

1.4 Benefits

Benefits can be drawn after a minimum of two contribution years. There are 2 main benefit options:

- A lower value, non-taxable cash benefit. This is awarded to the person needing care, who can pass it to a family member, volunteer or paid private carer.
- Entitlement to in-kind professional services (worth nearly twice as much). This can be thought of as a 'voucher' for approved services.

Despite its significantly lower value, the cash benefit has always been much more popular than the service voucher, thus helping to contain overall LTCI costs. Recently there has been a small increase in numbers of people combining these options.

Levels of both cash and service benefits vary according to the level of 'care dependency', originally at one of three levels, now extended to five (see below). Current benefit levels range from €316/£283

a month (cash benefit for someone with cognitive but no physical impairment) to €1995/£1784 a month (value of in-kind community services for someone with severe physical plus mental impairment).

Benefits are not intended to provide full coverage of care costs, nor the 'hotel' costs of nursing home care. Any shortfall is made up by private funding or (for the poorest who are unable to cover the full costs of nursing home care) means-tested social assistance.

For those eligible for LTCI, other benefits include:

- Payment for substitute care for up to 4 weeks p.a. so family/usual carers can have a break
- Home nursing equipment and contributions to home adaptation costs
- Retirement and accident insurance contributions for non-employed family carers
- Advice and training from nurses for family carers
- Entitlement to unpaid leave for family carers for up to 6 months (with their pension contributions covered)

Almost three-quarters of beneficiaries receive home-based care and almost half are cared for by relatives. Only 30% are in residential care.

1.5 Recent reforms

The initial institutional design was crafted to demonstrate that a defined contribution approach could work in social insurance and was arrived at through broad political consensus. It delivered a decade of stable funding, but at the cost of consistently falling real-terms benefits - a decline in purchasing power of over 20% between 1994 and 2008 . From inception, it was acknowledged that per capita funding (and the contribution rate) would have to rise in the longer term. A series of reforms since the early 2000s have expanded and strengthened LTCI, by extending access and expanding benefits; and addressing the quality of care. There have also been small, incremental increases in contribution rates.

The original LTCI eligibility criteria were heavily criticised for their bias towards physical disability, so from 2002 onwards the scheme has gradually been extended to cover people with dementia, learning disability, mental health and other cognitive impairments. People with dementia are now eligible for both the cash benefit and in-kind service voucher option and benefits under the original three levels of care dependency have been enhanced for those with additional cognitive impairments. Comprehensive new entitlement regulations from January 2017 also resulted in substantial increases in benefits for 95% of existing beneficiaries.

From 2008 onwards, quality monitoring in nursing homes has been significantly stepped up; and 'expert standards of care' (akin to NICE guidelines) have been introduced. Other measures aim to prevent or delay increased needs for care and promote the health and rehabilitation of nursing home residents.

2. Achievements of German LTCI – lessons for England

It is ironic that social care funding in England currently strongly resembles the fragmented, residual, local government focused, means-tested situation that existed in Germany up to 1994, before the introduction of LTCI. What lessons can be learned from German LTCI for achieving sustainable funding reforms in England?

2.1 The crucial role of central (Federal) government in ensuring sustainability

LTCI represents the acknowledgement by German society that the need for long-term care is not a negligible residual risk. Rather, the legislation mandates that long-term care is a social risk demanding social protection; its provision is not an individual family responsibility. Moreover, this is not a partisan, party political issue; the need for reform, the introduction of LTCI in 1994 and the subsequent expansion of the scheme have been agreed by both main political parties.

Federal government is responsible for setting levels of contributions, eligibility criteria, eligibility thresholds and levels of benefits. None of these can be changed without legislation, thus ensuring tight cost containment. Benefit levels were increased for the first time in 2008, and the government must now review whether adjustments are needed every three years. Nevertheless it is remarkable that over almost 25 years, despite demographic trends, major extensions of LTCI to people with cognitive impairments and increases in benefit levels, contributions have only increased from 1.7% to 2.55% (2.8% for childless adults) of salaries.

Central government has also played a central role in developing a care infrastructure (which already largely exists in England). This includes regulating and improving the quality of domiciliary and institutional care services; funding new information and advice centres to improve care co-ordination; and creating incentives to nursing homes to promote residents' health. While implementation of these measures is devolved to regional and local governments, the insurance funds and their Medical Review Boards, Federal government provides the legal framework, policy direction and much of the funding for implementation.

The societal-level pooling of risk, the creation of a single, designated fund and the central role of the Federal government has substantially eased the financial burdens on regional and local governments and provides political and public assurance of the longer-term sustainability of the LTCI funds.

2.2 Universality and equity

LTCI is a universal scheme. All employees, their employers and retired people pay contributions. Eligibility is determined solely on the basis of needs for care; age, assets and income are all irrelevant. The previous stigmatising dependence on means-tested social assistance for those who had 'spent down' their assets has been reduced significantly (although as LTCI does not meet care costs in full there remains some - much reduced - means-testing). Universality is likely to enhance the political popularity of LTCI – disabled children, working age adults and affluent older people are all potential beneficiaries.

Since 2008, LTCI has also become increasingly equitable, as the widely criticised exclusion of people with dementia and other cognitive impairments created by the original eligibility and assessment criteria has been addressed. Equity is also reflected in the higher contributions paid by childless people.

The underpinning principles of universality and equity are likely to have made both initial and subsequent increases in contributions easier to introduce. The hypothecation of LTCI funding also makes an explicit link between contributions made and benefits received/receivable that general taxation does not – again contributing to political and popular support for the scheme.

2.3 Compatibility with existing institutions and structures

Undoubtedly both the introduction of LTCI and its continuing political acceptability owe a considerable amount to the tradition and structures of the established German universal health/sickness insurance scheme. This is in contrast to the use of general and local taxation (with only very limited hypothecation - the new Council Tax 'precept') to fund social care in England. However, UK workers do pay national insurance contributions, which are still widely believed to

create entitlement to free care in old age. The tradition of national insurance could form the basis of a universal social care insurance fund – albeit with the abolition of both the earnings limit and the exemption of retired people from contributions, in order to improve progressivity.

Alternatively, in 1986 the hypothecated, public SERPS pension scheme was reformed to offer an additional private opt-out option. From 1988 onwards, SERPS salary deductions by both employer and employee were mandatory and increased with pay up to a contribution ceiling; scheme members could choose between a PAYG public scheme and a funded private scheme; and the financial risk of a long retirement was pooled. This hybrid approach could also act as a template for a social care funding structure that is more congruent with UK traditions.

Unlike eligibility for LTCI, assessments for publicly-funded social care in England currently involve some professional discretion and a range of factors are taken into account in determining an individual's level of risk. However, there is considerable experience within the UK social security system – particularly Attendance Allowance - of more standardised assessment processes that focus predominantly on needs for care and supervision (and which also avoid a bias towards physical impairment that characterised the original LTCI eligibility criteria). This approach would also be (and could be perceived as) more equitable, lending further popular legitimacy to a new approach.

2.4 Supporting family care-giving

With its cash benefit option, LTCI was designed to support informal care; indeed, there is some evidence that the cash benefit option has actually incentivised family care-giving. There is of course complete freedom in how the cash benefit option is used, so some families may choose to pay volunteers or private carers. In the light of concerns about a possible diminishing supply of family carers, recent German reforms have included additional social protection measures for family carers.

Under LTCI, family carers are not entitled to an income in their own right, as UK carers are with the - albeit very limited - Carers Allowance. However, carers of German LTCI beneficiaries receive a wide range of other social protection measures that provide respite from care-giving and reduce labour market-related disadvantage. It should be noted that these are entitlements and are not dependent on local authority budgets or employer discretion.

Again, these comprehensive arrangements for family carers extend popular interest in LTCI and are likely to enhance its political popularity.

3. Conclusions

It is almost twenty-five years since policymakers in Germany took the plunge and introduced a mandatory social long-term care insurance scheme.

While the LTCI scheme was broadly congruent with the existing social insurance model, it was still a radical departure from past policy. LTCI added the first new social insurance pillar in decades; moved the focus of public funding for care from the regional Länder to the national (Federal) level; and expanded the scope of public welfare effort at a time of welfare state retrenchment across Germany and much of Europe.

The need to achieve political consensus and the general atmosphere of welfare austerity in the early 1990s shaped the predominantly public, defined contribution nature of the programme at launch. Making use of the established health insurance funds and associated infrastructure allowed for relatively rapid implementation. Social long-term care insurance could also be introduced by central government in parallel with existing Länder-level funding institutions, without the need for

immediate institutional reforms (unlike on-going English attempts to integrate NHS and social care budgets).

As LTCI benefit payments are based on current need rather than past income (unlike old age and unemployment insurance), LTCI shares the relatively low contribution ceiling of the German health insurance fund. This has reduced the redistributive impact of the scheme and means the principal beneficiaries are those who would not have qualified for means-tested benefits. The probability of 'catastrophic' care costs for people with average and above average incomes has been reduced significantly by risk pooling under LTCI. LTCI is likely to be very popular amongst this group.

At its inception, the LTCI funding/expenditure calibration (fixed contribution rate, relatively low contribution ceiling and fixed price benefit schedule) delivered multiple goals:

- medium-term contribution rate stability
- universal entitlements to benefits
- support for family care-giving
- a significantly lower means-tested funding burden on the regional Länder
- a significant reduction in citizen reliance on stigmatising social assistance.

After a decade of institutional existence, policy networks and commentators became increasingly articulate about the short-comings of LTCI – particularly the definitions of care needs that discriminated against people with dementia and the falling real-terms value of LTCI benefits. These concerns actors provided a platform on which the second decade of funding growth, eligibility expansion and structural improvement could build.