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What can England learn from the long-term care system in Germany?

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About this report

The current social care system in England is widely regarded as unfair, complex, confusing and failing to meet growing care needs in the population. But despite a series of reviews, commissions, reports and inquiries, and increasingly urgent calls for reform, change to this system remains elusive.

Germany introduced its current social (or 'long-term') care system in 1995 in response to the challenges of ageing and rising costs of care. The system was developed at a time of significant economic and political upheaval in the wake of reunification. This report seeks to assess the German long-term care system through the lens of the policy challenges that face us in England.

Using a literature review and a series of interviews with experts on the German system both within and outside Germany, we have sought to draw out elements of the German system that could either be incorporated into our thinking or that offer us cautionary tales. While the context may vary, we face common demographic and social challenges. As such, this report is intended not as a critique of the German system, nor as a comparative piece, but as a contribution to the discussions that we hope will ensue in the coming months.

Acknowledgements

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1 Introduction

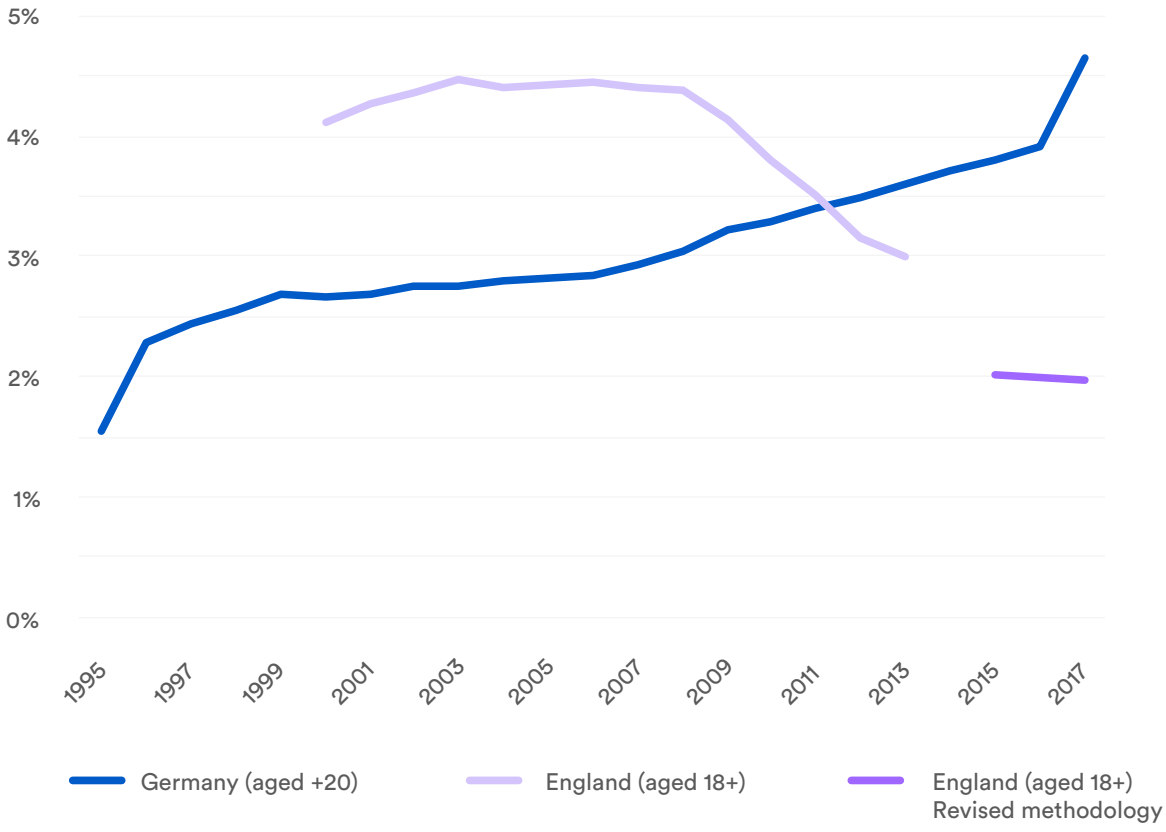
The introduction of the National Assistance Act (1948) in England set the foundations for the social care system as we know it today. Many developed nations have reformed their social care system, but England has yet to do so, despite the fact that the current system of social care is widely regarded as unfair, complex, confusing, and failing to meet the growing care needs in our population. A decade of austerity has seen government funding for local authorities halve in real terms between 2010–11 and 2017–18 (National Audit Office, 2018a), which has led to fewer people accessing publicly funded care, increased numbers of people providing informal care to family and friends, instability in the provider market, and a growing workforce crisis. Increases in the number of people with a combination of health and care needs has exposed the fault line between universal, free-at-the-point-of-use health care, and publicly funded social care that is tightly rationed to those with the highest needs and lowest means.

In the last 22 years, there has been no shortage of ideas for how to reform social care, with twelve White and Green Papers and consultations; four independent reviews and commissions; five select committee inquiries; two All Party Parliamentary Groups on social care; and a Green Paper authored by the Local Government Association. Despite these increasingly urgent calls for reform, real change remains elusive. There is a lack of political consensus over the solution and low public awareness of the problem. At the time of writing, the long-promised Green Paper has seemingly been abandoned after having been delayed five times since its announcement in March 2017 (Jarrett, 2019; Atkins, 2019). There is rumour that the newly formed Johnson government is set to publish a White Paper on the issue but no timetable has been set. In the continued absence of political decision-making, the system looks set to worsen.

Why Germany?

Germany is one of many countries to have implemented a new system of social (or 'long-term') care in the last 30 years. It is frequently pointed to as an example of a system that England could emulate. In many ways, the German system can be seen as a success: it was implemented with high levels of public and political support and, since its introduction, has provided a minimum level of care benefit to increasing numbers of people where England's provision has fallen (see Figure 1). It has also established clear and consistent benefits; a buoyant provider market; and – importantly – it has adapted and responded to changing circumstances.

Figure 1: Long-term care recipients as a proportion of the general population



Source: Our analyses based on BMG, 2019; Statistisches Bundesamt, 2019a; NHS Digital, 2014, Table 2.1 Adult Social Care Activity and Finance: England 2017–18, T2 (Long Term Support during the year); ONS, 2018.

Note: Due to a change in how social care data was collected, for England the years 2000–2013 and 2015–2017 are not comparable. Full cost clients (i.e. those who pay the full direct costs of the services they receive and for their management) were excluded from the data in the

years 2000–2013. Full cost clients were included in the 2015–2017 data. Germany (aged 20+); England (aged 18+).

The German system is not without its limitations and faces a number of challenges. But the limitations of the system, as well as its successes, provide learning and insights for England. This report aims to explore and explain the German system and identify what lessons England could learn from Germany's experience of designing and implementing a new social care system.

We are mindful of the complexities of international comparisons and the perils of transferring ideas from one context to another. We have not attempted to make direct comparisons between countries but rather to draw out elements of the German system that could either be incorporated into our thinking, or that offer cautionary tales. There are many excellent and in-depth academic studies of the German system. This report seeks to complement those by approaching the German system through the lens of the policy challenges that face us in England at present. As such, it is intended as a contribution to the discussions that we hope will ensue during the new government's term in office.

Our approach

This report is based on interviews with experts on the German system both within and outside Germany. The team visited Berlin in November 2018. The interviews and visit have been supplemented by an extensive review of both published and grey literature, identified using a range of databases and a variety of searching techniques.

During the course of the project, we interviewed:[1]

- three academics in the field of long-term care
- one policy-maker at the Federal Ministry of Health
- two politicians from the Freie Demokraten (FDP) and Green Party
- one director of long-term care services, at a national non-profit service provider
- one doctor employed by the Medical Review Board
- one expert on informal care, at a national carers' interest group
- one political advisor on patient rights and protection, at a non-profit foundation for patient protection in the health and long-term care sector
- three experts at a national think tank, active in consultancy and development and implementation of new models of care.

1 Due to the time period required for ethics approval, we were unable to interview service users and members of the public within the time constraints of this project.

Germany and the UK compared

Figure 2: Population indicators in Germany and the UK compared[2]

Total population in 2018

Germany **82.9** million

World Bank 2019a

UK **66.5** million

World Bank 2019a

Average life expectancy at birth in 2017

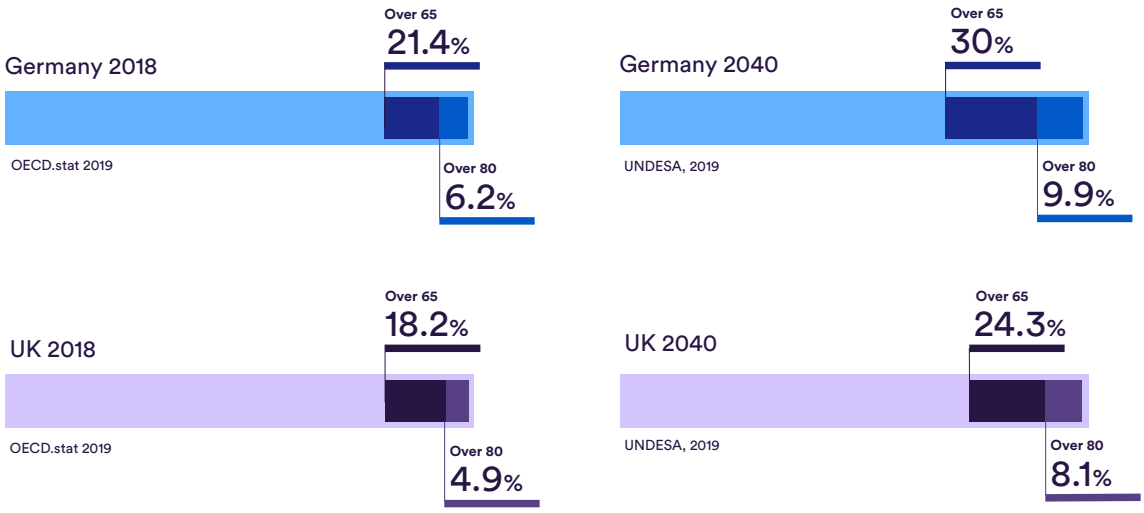
Germany **81.0** years

World Bank 2019b

UK **81.2** years

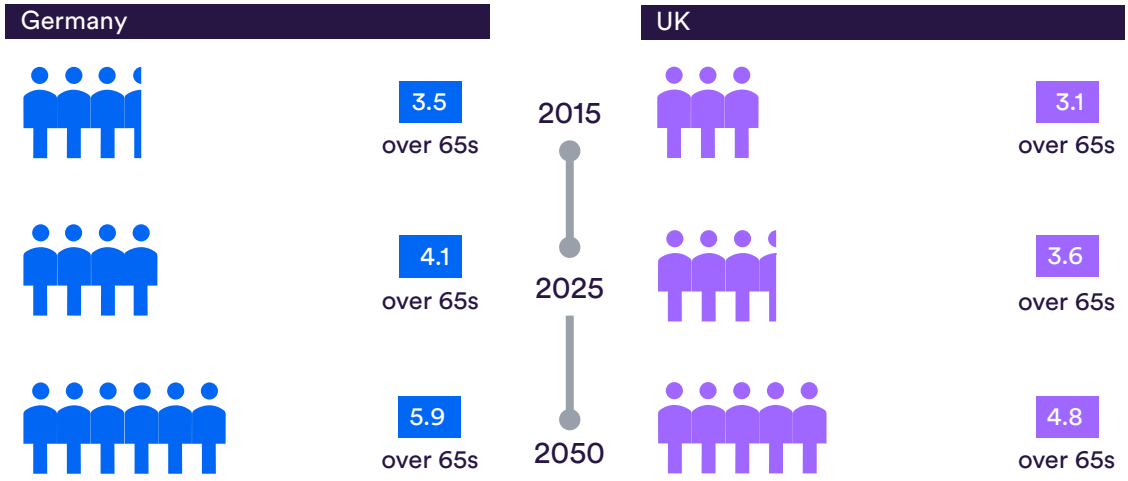
World Bank 2019b

Population 65 and 80 years old and over



2 Although this report focuses on the social care system in England, UK figures are presented here as the best available comparable data. Most recent data used where available.

Number of dependent older people (over 65) for 10 working age adults



UNDESA, 2019

Proportion of adults accessing publicly funded care support

Germany

4.7%

3.1 million

Aged 20 and over in 2017
Bundesministerium für Gesundheit, 2019a

UK

1.7%

0.6 million

Aged 18 or over in 2017-18 (England only)
NHS Digital 2018:T40

Working-age adults accessing publicly funded care support

Germany

588,000

Aged 20-65 in 2017
Bundesministerium für Gesundheit, 2019a

UK

254,000*

Aged 18-64 in 2017-18 (England only)
NHS Digital 2018:T40

* We have excluded full-cost clients, who are those who pay the full direct costs of the services they receive but whose support is arranged by the local authority, which includes regular reviews, support planning etc.

2 The long-term care insurance system

What is long-term care insurance in Germany?

Long-term care insurance (LTCI) in Germany is a social insurance-based system that was introduced in 1995 and is intended to offer all members of society access to a minimum level of care should they need it. Based on the principle of social solidarity, the system can be accessed by anyone with care needs, whether they are an older adult, working-age adult, or child[3]. Benefit levels are based solely on need and not means. They are also not affected by personal circumstances (such as living with a carer) or by diagnosis (whether physical or cognitive). In its design, the system seeks to balance universal entitlement with public, market, individual and family responsibilities (Nadash and others, 2018). The pooling of risk at a national level is at the heart of the system, based on the premise that no individual should have to bear catastrophic care costs. Instead, costs are shared across society. However, the system was intended only to provide a basic minimum level of benefits for all, so there is a built-in expectation that individuals will contribute to their costs at the point of access.

3 The assessment of children is based on the same framework as for adults but the assessment process and form differ slightly.

Box 1: Legal principles underlying long-term care in Germany

LTCI was based on a series of legal principles outlined in the Social Code (SGB XI). The following principles are of key relevance.

Autonomy: Benefits are intended to help recipients lead an independent and self-determined life and recipients have free choice of providers and services.

Prioritisation of home care: LTCI is primarily aimed at supporting home care and the willingness of relatives and neighbours to provide care so that recipients are able to stay at home for as long as possible.

Prioritisation of prevention and medical rehabilitation: LTCI funds support prevention and rehabilitation in residential care.

Personal responsibility: Individuals are responsible for taking part in prevention and medical rehabilitation.

Societal responsibility: Care provision is a task for the whole of society, including local authorities, communities and relatives.

Dignified care: Providers are obliged to ensure humane and dignified care.

Design principles of the German system

The German system is complex, but there are key features that help to describe it.

Pooled national funding

The LTCI system is funded through social insurance premiums which are set at a national level and administered via the network of public and private insurers that were already established as part of the health system (in 2019, there were 109 public funds and 48 private funds). Around 90% of the population is covered by the public LTCI scheme into which people pay via their employer. The remaining 10% (self-employed, civil servants and those

with a yearly income exceeding €60,750) are covered by a parallel private scheme that is identical in terms of benefits. For the purposes of this report, we have focused solely on the public scheme. In the public scheme, health and long-term care contributions are managed by the same publicly owned arm's-length organisations but the two funds are kept strictly separate (Campbell and others, 2010).

Box 2: Germany's health system

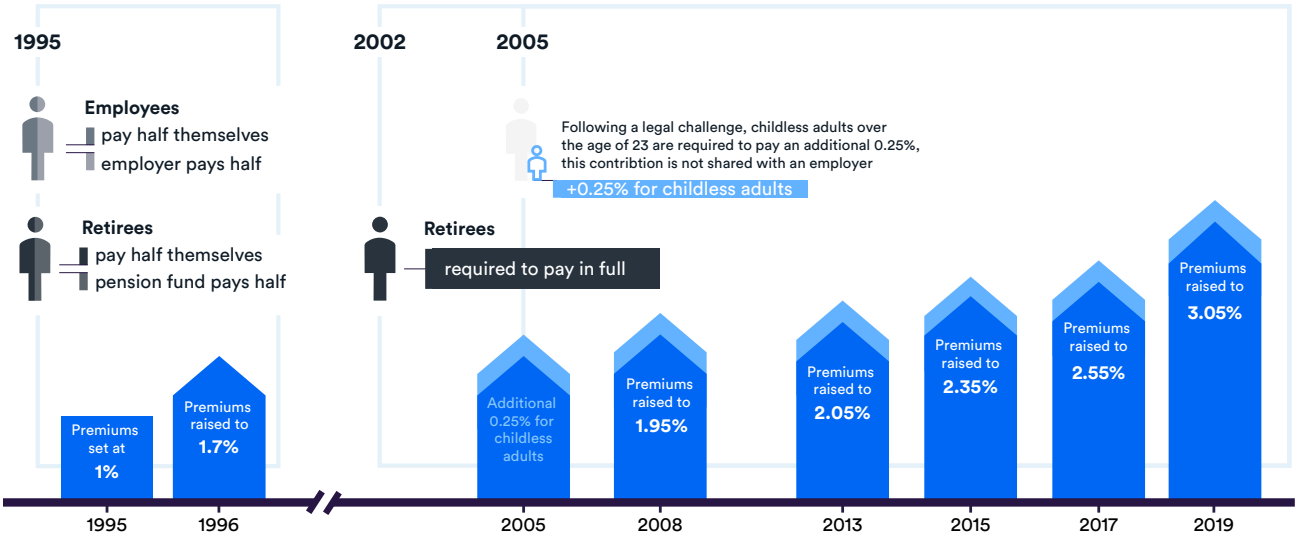
Similar to LTCI, the German health system is financed through mandatory public or mandatory private health insurance. It provides universal coverage for a comprehensive range of benefits, which are generally free at the point of use although limited co-payments may be required for some services. People have free choice of sickness funds and free choice of providers. Contributions are made relative to income and are shared with the employer. Currently, the individual pays 8.2% into the fund and employers pay 7.3%.

German residents are required to start paying premiums into the mandatory public LTCI scheme once they enter employment. Premiums are set nationally as a flat percentage of wages and are shared equally with employers. While individuals' premiums are not adjusted for personal risk, there is some risk adjustment between the funds. Contributions are levied on income from employment only, and up to an income ceiling[4] – in 2019, the income ceiling was set at €54,450 so the maximum monthly contribution an individual would make into the LTCI fund is €138.40 (Vdek, 2019). The income ceiling is an important feature of social insurance in Germany, which distinguishes the model from income tax (Evans, 2002). Individuals' income from other sources (for example savings or value of a home) and income earned over the ceiling is not taken into account (Rothgang, 2010).

4 A note on the income ceiling: this ceiling was introduced to align with the ceiling already established as part of health insurance. The reason for the ceiling in health is that health insurance pays for sick pay which is 70% of income subject to insurance contributions up to the ceiling. It was assumed that those on high income would be able to cover their ongoing costs from a capped income when they fall ill. Also, it protects funds from having to pay exorbitant amounts of money if a person on very high income falls ill.

Since 2002, retired people have been required to pay the full premium themselves (Nadash and others, 2018). Prior to that, they shared it equally with their pension fund. As outlined in Figure 3, contributions have been adjusted over time to account for rising costs of care. Changes to premiums have always been accompanied by system improvements (mainly benefit expansions), which aided public acceptance (see reform timetable in Appendix 1).

Figure 3: Changes to LTCI premium in Germany since 1995



5 A note on the levy on childless adults: The extra 0.25% was introduced after the Federal Constitutional Court ruled in 2001 that contribution rates as they stood contravened the German constitution, which gives special protection to the family. According to the constitution, because parents provide a special service to the general public by raising children – who will add value to society and on whom parents can rely when they require care – it was ruled that, by paying the same contributions as childless adults, parents were not being treated equally. After this point, childless adults over the age of 23 were required to pay an additional 0.25%, which is not shared with the employer. The additional 0.25% is waived for life as soon as an individual becomes a parent. Interviewees (and the literature) indicate that this change was not a point of contention in Germany and was widely accepted by the general public.

6 Of the 0.5% contribution increase, 0.3% is dedicated to closing the funding gap, 0.2% is dedicated to the new workforce strategies.

Standard national eligibility assessment

In order to access services, individuals must pass an eligibility test that is based solely on need. The eligibility process is the same across the nation and managed by the Medical Review Board, an independent body contracted by the LTCI funds. Application forms and legislation are similar for all funds and ages. There is no means test, no consideration of whether the person lives alone or with someone who could care for them and, crucially, the process does not distinguish between a physical and cognitive diagnosis. Anyone can refer themselves or be referred for a care needs assessment. Within three weeks of receiving the application, the Board contracts an independent medical expert to assess eligibility and level of need. The assessors are most commonly medical doctors, but can also be nurses, and have received special and ongoing training.

People are assessed in their own homes, using a standardised form, against five levels of need, ranging from 1 ('little impairment of independence') to 5 ('hardship'). In the early years of the system, eligibility was based on a limited definition of need for care and restricted to physical impairments in four areas of daily life only (personal care, nutrition, mobility and housekeeping). From the outset, policy-makers had aspirations to extend the care definition to take into account needs arising from mental and cognitive illnesses, especially dementia. However, due to fiscal reasons this was only achieved gradually and it was not until 2016/17 that this widened eligibility and a new assessment framework was introduced.

The new framework that came into effect in 2017 and replaced the previous three levels more explicitly incorporates the needs of those with mental illness and cognitive impairment, especially dementia (Nadash and others, 2018). Following reform, the needs assessment now assesses the individual's ability to manage independently in terms of six domains, (GVK-Spitzenverband, 2017):

1 Mobility

2 Cognitive and communication skills

3 Behaviours and psychological problems

4 Self-sufficiency

5 Ability to manage health restrictions and treatment demands

6 Everyday life and social contacts

An individual is considered eligible for LTCI benefits if they are deemed to require care for a period that is likely to exceed a minimum of six months due to sustained physical, cognitive or mental impairments or health-related requirements.

The standardised assessment process is not without criticism, but it provides high levels of consistency and 74% of recipients agree that the care level they have been allocated is appropriate (Schneekloth and others, 2017). Individuals have the right to appeal the decision and apply for reassessment. LTCI funds are also able to reject the application if they do not agree with the findings.

Consistent and clear monthly benefits

On being assessed as eligible for one of the five care levels, benefits are paid on a monthly basis according to a national schedule of payments (see Table 1 and Appendix 2). These payments are fixed for each of the five levels of care needs and do not vary according to where a person lives, their age, means or personal circumstances. Individuals are able to choose to receive their benefits as cash, in kind or a mixture of the two. Offering a mixed benefit option is a specific feature of the German system and is intended to encourage informal caregivers to seek supplementary support from formal services rather than to give up their caring role as care needs increase (Schneider and Reyes, 2007).

The German system was intended to ensure everyone has access to a minimum level of care only and the level of benefit reflects that principle. Consequently, there is an expectation that individuals will use their own money to contribute towards their care when they access services. The amount that an individual has to pay depends on the total cost of their care and their level of need. For example, average monthly out-of-pocket costs for home care and residential care are €269 and €587, respectively (2015 figures; Rothgang and Müller, 2018). In addition to care costs, it should be noted that individuals living in residential homes must also pay for bed and board and

service charges, which means that total monthly out-of-pocket costs for those in residential care are in the region of €1400–€1800 (Heiberger and others, 2017). The decision to exclude room and board was intended to ensure that residential care does not become financially more attractive over home care (Schneider, 1999).

People who cannot meet the additional costs of care can apply for social assistance. In order to access this safety net, they must undergo a means test, which takes account of their income, savings and assets and those of their close family (in Germany, adult children are legally obliged to meet the care costs of their older, eligible parents).

Table 1 sets out the key monthly benefits (an overview of all available benefits can be found in Appendix 2). Cash benefits are less than half the value of in-kind benefits. This recognises that care providers have overheads and need to pay all the employer contributions required of them (for example social insurance, health insurance and so on). Despite their relatively low value, cash benefits are popular in Germany. In 2017, 52% of *all* LTCI beneficiaries chose cash benefits only (Statistisches Bundesamt, 2018). Of those beneficiaries *receiving care at home*, the majority chose cash benefits only, although this has fallen from 71% in 1999 to 68% in 2017 (Statistisches Bundesamt, 2018). This indicates a cultural preference for family care (Blüher, 2003; Schneider, 1999).

Table 1: Examples of monthly benefits by care level, in euros (2019)

Care level	Home care: in kind	Home care: cash benefit	Nursing home care (in kind only)
1	0	0	125
2	689	316	770
3	1298	545	1262
4	1612	728	1775
5	1995	901	2005

Source: BMG, 2019c.

Choice and autonomy for service users

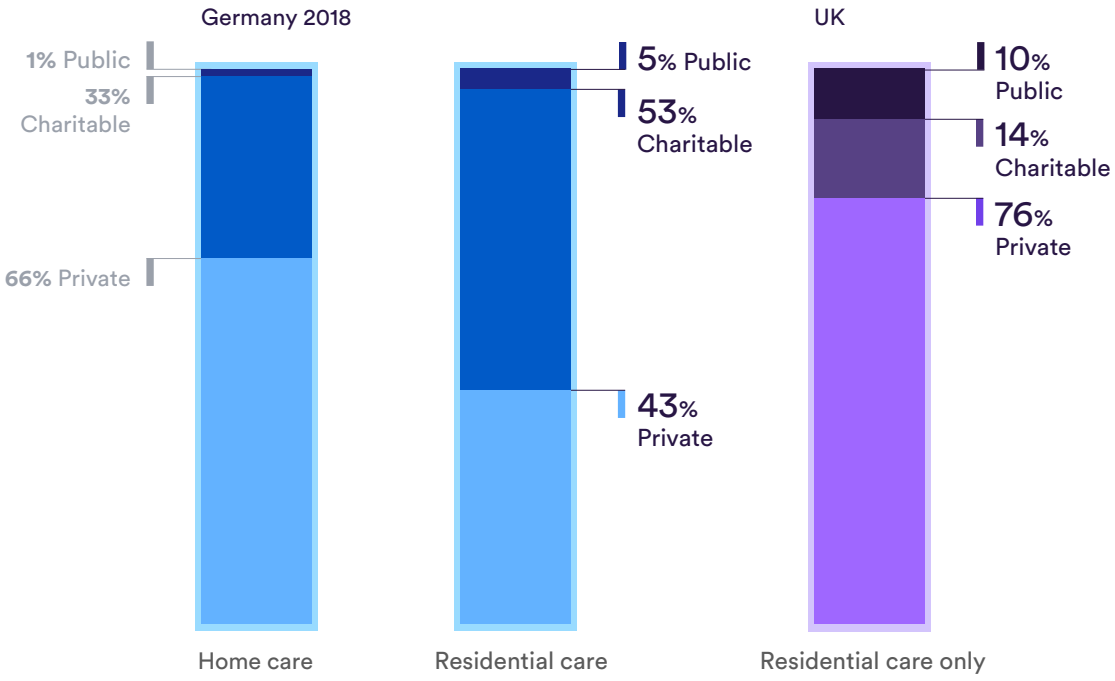
Autonomy is one of the main legal principles on which the LTCI system was originally based. As well as choosing benefits in cash or in kind, service users can choose to receive services from any registered provider. In 2008, the government established advice centres to offer information and support to people choosing between providers. However, interviewees reported that these centres are not operating as effectively as they should and are in need of further development.

Those who opt for cash receive their benefits directly and have absolute control over how they are spent. They can choose to pass benefits on to a family caregiver (Rothgang, 2010) or to contribute them to family income (Nadash and others, 2018). The only requirement is that everyone receiving cash benefits has a half-yearly (for those on care grades 2 and 3) or quarterly (for those on care grades 4 and 5) visit from a local care provider or care advice centre. This is intended to offer support and training to carers and ensure cash beneficiaries are not being abused, neglected or financially exploited (Nadash and others, 2018).

Stable provider market with local flexibility

To deliver services within the LTCI framework, providers must be registered with LTCI funds at a state level (Theobald, 2012a). Providers of home and residential and nursing home care come from the public, voluntary and commercial sectors. The market for care is stable and buoyant and there are few concerns about provider instability. There is light-touch regulation and an inspections regime intended to give a marker of quality to providers. However, policy-makers noted that the current regime is insufficiently sensitive and does not provide individuals with a good measure of quality – it is currently under review.

Figure 4: Care providers by ownership: Germany and UK, 2017



Source: Germany: Statistisches Bundesamt, 2018 ; UK: Laing, 2018, table 2.3.

Individual providers or provider associations negotiate the fees they are paid for services with LTCI funds and social welfare authorities. Although these fees are negotiated on a local level – in order to offer flexibility to meet local needs – they are governed by state and national-level contractual frameworks. Fee negotiations happen regularly and consider current and future cost pressures, which ensures that provider costs are adequately covered. Negotiations also set the prices that providers can charge individuals for bed and board. This means that individual providers cannot charge differential rates for the same service, but there are regional variations in prices.

Why did Germany introduce long-term care insurance?

Germany introduced its new system of long-term care insurance in 1995 in response to a number of driving factors. Events of the late 1980s and early 1990s provided a window of opportunity for serious debate about the need for – and design of – the system, but discussions about the potential for such a system can be traced back to the mid-1970s. Throughout the 1980s, a series of reports and reviews from various interest and political groups set out the case for a long-term care system and urged action at a national level, but a lack of political will and a number of economic setbacks hindered progress (Campbell and others, 2009). Despite these setbacks and complexities, Germany succeeded in bringing about reform. Some of the reasons behind this success, where England has so far failed, are explored in the next chapter.

Demographic and social change

Like England, Germany has an ageing population and shrinking birth rate. However, Germany's ageing is happening at a faster rate and its proportion of over 65s and over 80s already outstrips our own. This speed of demographic change means that although Germany's old age dependency ratio is similar to that of the UK's now, by 2050, for every 10 people of working age, there will be nearly six people over 65 – in the UK this figure will be just under five. Although it is important to note that social care is not just about older people, the change in the older population offers a sense of the scale of likely need and, of course, has implications for the way that social care is funded. In the early 1990s, projections such as these helped to galvanise support for system reform.

Another factor that fed into debate around long-term care was wider societal change. Like many other developed nations, Germany has witnessed the breakdown of traditional family structures with more women working and families becoming dispersed. As a result, traditional caring roles have changed, social networks have been eroded and increasing numbers of older people are now living alone (Arntz and others, 2006). In 2017 in Germany, 6.5 million people over the age of 65 lived alone (an increase of 22% since 2009) (authors' calculations based on Eurostat (2019) and Statistisches

Bundesamt (2019a)). In the UK, the figure is around 3.8 million people (an increase of 12% since 2009) (Office for National Statistics, 2019).

Public discontent

Growing public dissatisfaction with the existing system of care became an important catalyst for change in Germany. Prior to reform, Germany's system was similar to England's in important respects – there was an absence of collective funding and no consistent care offer. Like in England, the costs of care fell on individuals and those unlucky enough to require a long period of complex care faced catastrophic costs. Individuals and their families were expected to sell assets in order to fund their care. Public support was only available from local government, via a strict means-test, for the very poorest or those with depleted means. There was widespread dissatisfaction among the public that the system was forcing older people into poverty.

Local government finances

Pressure from local government was another critical driver of change (Campbell, 2002). Pre-1995, they held responsibility for meeting the care costs of those who were eligible for social assistance (Arntz and others, 2006). The lack of federal support for care costs, combined with growing needs in the population, meant that local government (municipalities and Länder) finances came under considerable pressure.

It is estimated that in 1992, 8.4 people in a thousand relied on social assistance for long-term care (*Hilfe zur Pflege*) (Statistisches Bundesamt, 2009). By 1994, spending on care was a total of €9.1 billion (in cash terms) and accounted for more than a third of all social assistance spending (Statistisches Bundesamt, 2019b). Introduction of LTCI effectively shifted spending on care from local authorities to LTCI funds (Wiener and Cuellar, 1999). By 2000, the number of people supported by social assistance fell to 3.9 in a thousand (Statistisches Bundesamt, 2009) and gross social assistance spending declined to €2.9 billion (Statistisches Bundesamt, 2019b). However, the problem of increasing numbers of people receiving social assistance has re-emerged in recent years (as discussed later in this report).

Political and economic situation

The introduction of LTCI came soon after reunification – an event that brought with it significant economic and political challenges but also opportunities to usher in new debates. The costs of reunification, and the newly introduced tax to finance developments in the East, put even greater pressure on the finances of states and local authorities.

The run-up to the general election in 1990 opened up a window of opportunity for the then Christian Democratic Minister of Labour Norbert Blüm to propose the introduction of LTCI in order to attract voters (Campbell and others, 2009). Despite the post-reunification turmoil and high unemployment rates, it is striking that Germany successfully introduced a social insurance programme financed through income. In the next chapter, we consider what factors might have made this possible.

3 What can England learn from Germany?

The following chapter presents the key lessons England could learn from Germany's experience. It examines factors that made change possible in Germany, where England has repeatedly failed. It also considers some of the features of the German system that English policy-makers could consider adopting, as well as the limitations they may wish to avoid.

1. Cross-party cooperation and strong political leadership

Germany's reform did not happen overnight. A series of attempts and proposals for reform were made over 15 years before change was enacted. However, by the early 1990s, when serious reform was on the table, there was a high degree of cross-party cooperation and a genuine recognition that the issue transcended party politics. As such, the central issue for debate was how to reform the system, not *whether* reform was needed.

Norbert Blüm, long-serving Minister for Labour and Social Affairs and leader of the ruling CDU party at the time, was a significant catalyst for change, able to garner support from all sides and a consistent and determined advocate for reform. Ahead of the 1990 federal elections, Blüm identified the issue of caring for the frail elderly as an issue of sufficient concern as to attract votes. By that point, it was clear to all parties that major policy change was likely and that they had an incentive to get involved in negotiations (Campbell and others, 2009; Campbell and others, 2010).

One factor that helped to garner political support was the fact that the ruling party, which was calling for increased public expenditure for long-term care, was a conservative liberal government associated with fiscal conservatism. Interviewees speculated that had a more left-leaning party been in power,

opposition from conservatives would have been stronger and may have thwarted legislative change.

The design of the system was necessarily influenced by the social, political and economic circumstances of the time and certain compromises were made to increase political acceptability. A Grand Coalition was established to develop proposals for change (Theobald and Hampel, 2013). The process that ensued was one that sought to identify compromises between the ideas and proposals of different stakeholders, from political parties to insurance funds and non-governmental social actors (Theobald and Hampel, 2013). One manifestation of that process was in the response from employers' organisations who argued that they could not afford to pay the contributions for their staff (Chadda, 1995). A process of negotiation resulted in the government abolishing one national holiday (Heinicke and Thomsen, 2010).

Another way the system was shaped was through compromise between different views on individual responsibility. By establishing a system that combines a universal minimum level of benefits with individual payments, it sought to strike a balance between the traditional features of German social policy with an emphasis on individual responsibility and market mechanisms (Theobald and Hampel, 2013). While that design also helped to gain political support by addressing concerns over cost containment, it has meant that individuals have seen their contributions rising as benefits have remained fixed (see 'Lesson 3: Partial costs coverage' for more on this).

Also for financial reasons, the focus of the eligibility assessment was initially restricted to physical needs. The intention was always to widen it to better take account of cognitive issues and to make it more generous, but those reforms did not take place until 2016/17 (*PSG II*) (with the exception of minor benefit expansions in previous reforms – see Appendix 1).

Through this series of compromises and balancing acts, Germany succeeded in undertaking comprehensive reform in order to establish clear foundations for the system. In doing so, the government focused on getting the basic building blocks right. Since then it has been able to adjust and adapt elements in response to changing circumstances (see Appendix 1 for an overview of policy).

Learning for England

Although England lags 25 years behind Germany in reforming its long-term care system, it is interesting to observe that the initial process of reform in Germany was quite lengthy. Germany's story offers hope that, even in the context of significant political, economic and social challenges, fundamental reform can still be achieved. However, there are some obvious differences between where England is now compared to where Germany was in the early 1990s, and it is these differences that offer important lessons.

The first notable difference is that Germany achieved cross-party support for change and advocating for reform was seen as a vote-winner, not as politically toxic. Achieving support was aided by the role of a respected individual who consistently championed the cause and garnered support on all sides. Having a consistent face of long-term care reform who could reach across the political divide helped overcome political complexity and opposition. Furthermore, the decision to opt for an established funding mechanism that was well understood and used for health care helped to unite support. At present, in England, the funding mechanism for health and for care is set to diverge even further as councils are expected to become increasingly financially self-sufficient (Ministry of Housing, Communities and Local Government, 2018).

England has suffered from the fact that social care proposals have typically been put forward at election time – a point in the political cycle where the incentive to collaborate is at its lowest – and any proposals quickly become politically divisive (Humphries, 2019). The reform of social care is a pressing issue which will reach far beyond one political term. Germany's political culture of coalitions – in contrast to our own adversarial system – is likely to have been a helpful factor in forging successful negotiations and complex compromises. However, the passing of the Care Act in 2014 demonstrated that achieving political cooperation is not impossible in England. That process needs to be learnt from and built on.

Secondly, Germany's local governments were instrumental in pressing for change and they supported the centralisation of their role by shifting responsibility for funding and assessments to LTCI. Local authorities in England have been calling for more central funding while retaining local responsibilities. While local government has sought to set out a vision for

social care (Local Government Association, 2018a), it is not clear that they have had the same impact that local governments were having in Germany in the early 1990s, perhaps because of the political climate. In the face of continuing government inaction on this issue at national level, local government needs to continue to press for change and speak with a unified voice, ideally in alliance with providers and other stakeholders.

Thirdly, Germany's political upheaval, triggered by reunification, offered an opportunity to have a wide debate about public services. England itself is undergoing significant political disruption – at the time of writing, uncertainty surrounding Brexit continues and a new Prime Minister has recently been appointed. Although the new Prime Minister, Boris Johnson, identified social care as a key issue in his inaugural speech, it remains unclear as to whether the ongoing political turmoil will usher in opportunities for new political debate or continue to prove a distraction from other areas of domestic public policy. A recent survey of MPs suggests that social care may be an issue of greater concern to MPs than previously thought (NHS Confederation, 2019) and offers some hope for cross-party cooperation.

Lastly, Germany's experience demonstrates that succeeding in making reform politically palatable and affordable may require a series of complex balancing acts with enduring consequences. For instance (as explored later in this report), the choice to provide only a basic level of benefits has helped contain costs but means that Germans are facing increasingly high individual costs. The decision not to align the LTCI system with the German health system and not make it free at the point of use helped to contain costs, but is a source of confusion for the public and frustration for policy-makers. Furthermore, the decision to start small with ambitions to extend the service to offer greater coverage to more people helped with affordability, but it has taken longer than expected to achieve some of those extensions. In making these inevitable and important set of complex compromises, Germany has been successful in establishing a framework for its system that the government has then been able to adapt and adjust. This contrasts with England's approach to date, which has involved a series of short-term, piecemeal and one-off initiatives, including the social care precept, improved Better Care Fund, and various social care support grants (Cromarty and others, 2019).

Recommendations for England

- Cross-party support for change is crucial. Social care transcends party politics and debate needs to be taken out of the political sphere. Identifying a leader who could reach across the political divide could help. With a unified approach, social care reform could be seen as a positive narrative rather than politically divisive.

- Local government is a potentially powerful advocate for change. In the absence of action at national government level, local government (alongside other stakeholders) needs to continue to press for change and speak with one voice on this issue.

- Policy-makers should move away from short-term piecemeal initiatives and towards getting the basic building blocks of a system right. If care is taken to ensure the right building blocks are in place, the system can be adapted and refined in response to changing circumstances.

2. Securing public support: Fair, transparent, familiar and consistent

Public support for the new LTCI system in Germany was high at conception and has remained high during the subsequent 25 years. Although it is not without criticism, there appears to be wide support for the system's fundamental principles and a sense that the basic framework is appropriate. The main critique has focused on the level of benefits (which are seen by some to be too modest) and, until recently addressed, on the inadequacy of support for those with cognitive disabilities.

Widespread public discontent with the previous system meant that public pressure for change was key to successful implementation of a new system, despite the public being called upon to make additional contributions out of their wages at a time of economic difficulty. The clarity of its design meant that the public were able to see that most people would be better off as a result of the implementation of LTCI (Campbell, 2002). Our sources and the literature suggest that high levels of public support were achieved and maintained by ensuring the system was designed to be fair, transparent, familiar and consistent.

The German system has been heavily shaped by national traditions and values, which has helped to secure public trust. At the heart of the German system is a collective and mandatory funding system that pools risk across the whole of society. Underpinned by a strong sense of social solidarity, everyone contributes based on income rather than risk, either through their salary, pension or unemployment insurance, and everyone receives equal benefits according to their needs. As such, it is felt to be a fair way of funding care.

The choice of funding mechanism was crucial to securing public buy-in. Social insurance was a natural choice for funding as Germany has a strong tradition of social insurance in its welfare state and the mechanisms were already established and familiar for health care (Campbell, 2002). It is a funding mechanism that offers high levels of transparency – contributions are handled by a state-run but arm's-length insurance fund and spent only on long-term care (Campbell and others, 2010). As such, although contribution rates have been increased on several occasions over the last 25 years, there has been widespread public acceptance as these increases have been directly linked with clear and visible improvements to the system.

Social insurance was not the only option considered at the time of reform. Taxation was rejected because the level of fiscal burden resulting from reunification was expected to be so large as to make it an unrealistic choice (Theobald and Hampel, 2013). Significantly, politicians and policy-makers within the Federal Ministry of Health also considered, and rejected, mandatory private insurance which would require individuals to purchase their own insurance policy. This option was rejected because it would not provide for the current generation requiring care (Campbell and Morgan, 2005). Policy-makers were also concerned about equity and the fact that those on lower incomes would struggle to pay premiums not linked to their income. They felt that demographic uncertainty would discourage the development of a private insurance market and anticipated conflicts and cost-shifting between private insurers and public health sickness funds (Schneider, 1999). In contrast, social insurance offered a relatively fair, well-understood, established, national funding option that would relieve the burden on local authorities, spread risk across society and provide funding for the existing group of people with care needs.

Introducing fixed contribution rates that are linked to income, a national eligibility assessment process, and set monthly benefits have offered a sense of consistency, clarity and fairness that helped to underpin public support and trust. Requiring retirees to continue to pay in was also seen as an important way of addressing intergenerational fairness.[7] Offering benefits in cash (while believed at the time to be cheaper) also helped to secure support by appealing to a strong culture of autonomy and a desire to support people caring for family members (Campbell and others, 2010).

Learning for England

Public discontent with the previous system was a major factor in bringing about change in Germany. Despite many attempts by various interest groups to raise awareness of this issue in England, public understanding of the current system is poor (Gregory, 2014; Bottery and others, 2018). The issue is often framed in the media as 'an intractable problem' (Kinloch and others, 2018). Individual stories of poor experience of the system have not, so far, translated into a groundswell of public discontent. A survey undertaken in autumn 2018 by the Local Government Association revealed that 44% of people think that social care is provided by the NHS (Local Government Association, 2018b). It is difficult to have a high quality public debate about possible reform because there is a widespread assumption that new proposals (which invariably involve extra public contributions) represent a worse offer than the existing one. This makes social care a very difficult issue for politicians to address. An informed public is one of the first steps necessary in bringing about change and concerted effort needs to be put into achieving this.

Germany was careful to ensure the design of the system went with the grain of social and cultural trends and sought to establish a system that was fair and consistent. While the principles of fairness and consistency might translate across borders, they will necessarily manifest differently according to context. In England, the debate about fairness has been shown to be complex and to cut across a number of dimensions: wealth, income, generation, condition and place (Bell, 2018, cited in Scotland's Futures Forum 2018). The importance

7 Similarly, the requirement for childless adults to pay higher contributions was a key lever the German government used to adjust the social contract between generations, in order to address intergenerational fairness.

of property wealth in the English debate, for instance, was less significant in Germany where levels of homeownership are lower. The decision to levy contributions on income alone may not be seen as sufficiently fair in England where a lot of wealth is tied up in property. Fairness is not just about funding, but also service delivery. Although the Care Act sought to establish a standard minimum eligibility criteria, there is still significant local discretion and wide variation in eligibility and access (Human Rights Watch, 2019). A more consistent national approach would help to drive public support and trust in the system.

Familiarity is another important principle that English policy-makers should consider when it comes to funding mechanisms. While social insurance was a natural choice for Germany, there is no precedent of it here. England's welfare state is largely built on taxation and it is likely that a form of tax will be more highly understood and accepted by the public than a new and unfamiliar approach. It would also require new infrastructure, which would represent a significant undertaking. It will be important to address as many dimensions of fairness as possible within different funding options (Oung and others, 2019). There is emerging evidence of public support in England for funding which is collective, progressive, public and ring-fenced (Sussex and others, 2019). The advantages and disadvantages of ring-fencing funding sources are explored later in this report. Policy-makers may wish to consider introducing a number of funding options in combination.

Recommendations for England

- Achieving high levels of public awareness of social care issues should be one of the first steps in moving the debate forward. Creating a positive vision of the kind of system that could be built would be a good start in building public support for change.

- Designing a funding system that is fair, understandable and familiar to the public is likely to help garner support for contributions.

- Creating a system of benefits and eligibility that is clear and consistent could help build public trust.

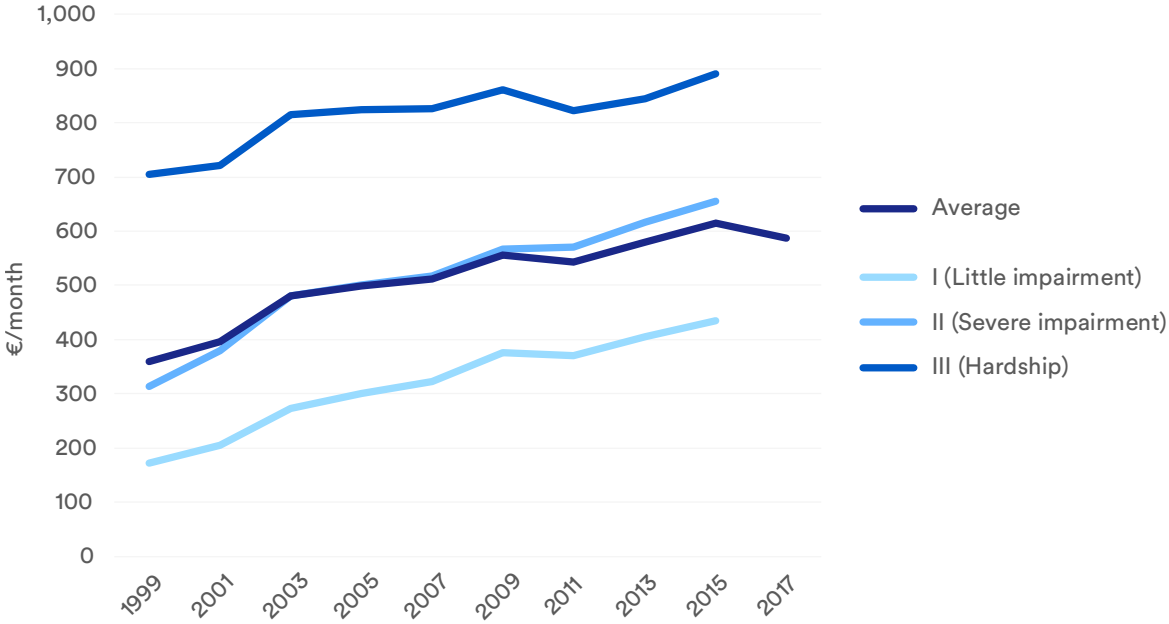
- It is vital that any new system is embedded within, and appropriate to, the English social and cultural context. Some features of the German system are unlikely to transfer directly, but the principles of clarity, consistency and fairness provide sound foundations that could be adapted to suit our context.

3. Partial coverage of costs: balancing cost containment with individual responsibility

By pooling risk at a national level, Germany's system was intended to protect people from catastrophic costs and ensure access to a minimum and consistent level of benefits based on needs not means. Benefits are fixed on a monthly basis and people are required to contribute to the costs of their care when accessing services. The decision to offer partial coverage of costs has successfully contained costs and ensured sustainability, but also created challenges. One of those challenges is that many people are unaware that they will still be expected to pay on accessing care services – this is a legacy of not aligning the LTCI system with the health care system where the majority of services are free at the point of use.

Since care benefits are fixed in Germany, people can still face high costs for care, especially when they require residential care. With people living longer with more complex needs, individuals' contributions for care have risen in recent years – from an average of €359 per month (real terms) for residential care in 1999 to €587 per month in 2017 (Rothgang and Müller 2018, p. 31) – increasing numbers require social assistance to meet the costs of care. In response to this issue, since 2017 all care residents in grades 2 to 5 within the same care home pay the same amount of out-of-pocket payments so that people in higher care grades are not financially penalised (BMG, 2019d). Figure 5 shows this trend in average service user costs for care in residential care settings. Note that, in addition to care costs, individuals living in residential homes must also pay for bed and board and service charges, which means that total monthly costs to service users (including care, room and board and service charges) for those in residential care are in the region of €1,400–€1,800 per month (or €16,800–€21,600 per year) (Heiberger and others, 2017). For comparison purposes, that is in the region of £10,000–£15,000 less than average annual care home costs in England.

Figure 5: Individual service user payments for care costs in residential care, Germany, 1999 to 2017



Source: Adapted from Rothgang and Müller, 2018, Table 1.2.

Note: Inflation-adjusted to 2017 based on the German Consumer Price Index (Statistisches Bundesamt, 2019c). Since 2017, all care residents in grades 2 to 5 within the same care home pay the same amount of out-of-pocket payments.

A central intention of LTCI was to relieve the burden on local authorities who are responsible for paying social assistance – a specific means-tested social welfare scheme that is available to those who cannot cover the cost of care themselves. While the 1995 reforms effectively shifted long-term care spending from local authorities to the social insurance funds (see previous section on why Germany introduced LTCI), recent years have seen a renewed steady increase in the number of people receiving social assistance.

From 2002, the number of people relying on social assistance to fund their care rose continuously, from 3.8 in a thousand in 2002 (Statistisches Bundesamt, 2009) to 5.6 in a thousand in 2014 (Statistisches Bundesamt, 2019d). The widening of the core long-term care offer through the extensive reforms of 2015 and 2016/17 resulted in the numbers of people using social assistance falling to 4.5 in a thousand (Statistisches Bundesamt, 2019d). However, the problem is expected to re-emerge in the coming years as demographic trends

continue. Policy-makers have been considering options that seek to limit the burden falling on individuals and social assistance while stopping short of a move to entirely free care at the point of use. Private supplementary insurance is one option that has been tested. Capping individual costs is another that is being explored.

Addressing the gap: Private supplementary insurance

Although private insurance was rejected as an option for funding the newly reformed system (see earlier sections on this), private supplementary insurance policies have long been available in Germany. However, uptake has been low partly because of limited awareness of the risks of high costs among the public and partly because premiums – typically based on medical underwriting and risk-adjustment – tend to be high (Nadash and Cuellar, 2017). The risk of requiring long-term care increases with age so older people (as well as younger people with established needs) can struggle to find a private fund that accepts them or they have to pay very high premiums. Furthermore, premiums for private insurance are not linked to income level, so premiums can be unaffordable for those on lower incomes.

In an attempt to increase awareness around the limitations of coverage and to incentivise uptake of private insurance, the government introduced a subsidised private insurance scheme in 2013 (*PNG*), called Pflege-Bahr (Nadash and Cuellar, 2017). In this scheme, the government offers subsidies for contributions made to eligible private long-term care policies. This scheme is modelled on a well-established pension model (introduced in 2011) that provides tax subsidies for purchasing private retirement savings products. Pflege-Bahr only supports those policies that are not based on medical underwriting – the intention being to enable older people and those at higher risk due to pre-existing conditions to take out private insurance.

Despite this encouragement, uptake of private supplementary insurance remains low at 4.2% (based on 2017 figures (PKV, 2017; GDV, 2018; BMG, 2019a) and own calculations).[8] The long-term impact and sustainability of subsidised policies remains unclear (Nadash and Cuellar, 2017). Coverage offered by subsidised policies is generally low and therefore of limited use in addressing the issue of rising personal payments (Nadash and Cuellar, 2017). Because subsidised policies are not adjusted for risk, some commentators have raised concerns about the potential for adverse selection (a situation where those at higher risk of needing care purchase policies and fewer low risk people do so). The coexistence of subsidised and unsubsidised private insurance products has potential to exacerbate this risk: unsubsidised products tend to be more attractive to low-risk individuals as they can get cheaper and better coverage through risk-adjusted products. As a result, over time, premiums may go up on subsidised products, thus making them unaffordable or the funds become unsustainable (Nadash and Cuellar, 2017).

For these reasons, policy priorities have since shifted away from private insurance. While Pflege-Bahr was introduced by a coalition of conservatives and liberals, the subsequent coalition government of conservatives and social democrats abandoned the idea. Instead, they expanded the core LTC programme in 2015 and 2016/17 (*PSG II/PSG III*), raising contribution rates and benefits which further reduced the incentive to take out supplementary insurance.

At the time of our visit, politicians told us that the debate around private insurance is likely to re-emerge as Germany examines the longer-term sustainability of LTCI. Whether or not it will have a part to play in the German system in future is as yet unclear.

8 Note that attempts by other countries to introduce private insurance markets have also had little penetration. In the United States, where LTCI has been available for 20 years, under 5% of the population have bought cover, even though 10–20% of the population could afford to be covered (Laing 2018 p.199).

Addressing the gap: Cap on costs

Discussions are currently underway about whether to introduce a cap on user contributions for residential care – a proposal that is supported by the current coalition partners (Zeit Online, 2019), other political parties (Deutsches Ärzteblatt, 2019) and some health funds (Ärzte Zeitung, 2018). Four states have recently presented such an initiative to the Federal Council (Bundesrat, 2019). Popular proposals include capping user contributions at the current national average individual service user costs, potentially financed through tax revenues or higher contribution rates. Another idea is to combine a monthly cap with a cap on the number of years over which an individual would have to make contributions, after which care would be free. This would make care costs more predictable and thus potentially create a more fertile ground for the additional private insurance market and/or encourage people to save for future care costs (Rothgang and Kalwitzki, 2017).

Learning for England

It is essential that any reform to the English system addresses the central problem that individuals are liable for large and unlimited care costs, which can be catastrophic. Germany shared this problem and it sought to protect people against catastrophic – but not all – costs by pooling risk at a national level. While the guarantee of a minimum level for benefits means that out-of-pocket charges are comparatively lower in Germany than England, the rising price of care has seen individuals paying increasing costs and (until recent reforms) growing numbers relying on social assistance. Germany has been able to adjust its system – through increasing contribution rates – in order to slow that increase. This is a lesson that English policy-makers should pay particular attention to.

Recently, proposals for a social care system based on individual voluntary insurance, as opposed to a collective risk pool, have gained traction in England. Germany's experience suggests that we would struggle to make a system based on such an approach work effectively. Unlike in Germany, a market for pre-funded LTCI does not currently exist in England.[9] The first UK pre-funded LTCI product was launched by Commercial Union in 1991, and in

9 Note, however, that immediate needs annuities are products still offered by the private insurance market.

2010 there were nearly 29,500 policies in force (Association of British Insurers, 2014). However, few people under 50 bought pre-funded products, and over the last few years this market has 'virtually disappeared' (Laing, 2018 p.196).

In the Financial Conduct Authority's recent survey, just 39 of 13,000 consumers held LTCI products (Financial Conduct Authority 2018, cited by Bottery and others, 2018). The private market for pre-funded LTCI has struggled to gain traction partly because of the difficulty of pricing insurance policies due to uncertain future risks and uncertainty around the state offer, but also because of a lack of public awareness of the risks of high costs (Dilnot Commission, 2011). Demand for pre-funded products is likely to be particularly low among younger people who have other spending priorities (for example buying a home) (Association of British Insurers, 2014; Laing, 2018; Wittenberg and Malley, 2007). Optional insurance schemes, as recently suggested by some politicians, are therefore likely to suffer from high rates of opt outs and run the risk of becoming rapidly unsustainable (Oung and others, 2019). As such, the view among many in the insurance industry is that, without comprehensive reform to the system, pre-funded products are not likely to be in demand: insurers "cannot see these being developed in the near future" (Association of British Insurers, 2014).

A key decision for policy-makers in England is whether to create a system that is free at the point of use, like the NHS, or one that requires service users to pay at least some costs. The former would require high contribution rates and it would be important to model future likely costs to ensure long-term sustainability. The latter requires careful thought as to what people are likely to be able and willing to pay for care over the long term and where the balance of responsibility lies between state and individual. If partial coverage is chosen, English policy-makers should be mindful of Germany's experience and build in mechanisms to protect individuals from rising out-of-pocket expenditure, possibly through some form of cap. It will be interesting to see how Germany progresses its discussions around a cap on costs. In England, discussions have usually focused on the concept of a lifetime cap on care costs, which can be very difficult to define – considering a cap that is based on monthly or annual costs may help people to understand exactly what the offer is and what the implications are for them.

Recommendations for England

- There needs to be clarity over what costs are covered by any state offer – for example proposals calling for 'free personal care' do not necessarily include bed and board costs and that needs to be clear.

- Offering partial coverage of care costs is helpful in containing costs but it is important to model the future implications of that for both state and individual expenditure. Higher levels of coverage require higher levels of funding.

- Relying on private insurance to form a substantial mechanism for funding care is highly unlikely to be viable. Those who are advocating for private insurance to play a significant part in financing should heed the difficulties faced by their German counterparts.

4. Long-term financial stability: balancing strict ring-fencing of revenue with flexibility

The LTCI funding system was intended to be self-funding and transparent. Contributions go directly into the system and must cover current costs. Funds can only be used for long-term care and supplementation from general tax revenue is prohibited (Campbell, 2002). That design feature offers high levels of transparency and has helped to secure public and political support. The strict ring-fencing (or 'hypothecation') of revenue has also effectively contained costs and kept the system sustainable, but it is relatively inflexible as a funding mechanism. Because the only source of revenue is income-based contributions, policy-makers must use the tightly controlled benefits and eligibility levers built into the system in order to sustain it.

Maintaining financial stability over 25 years

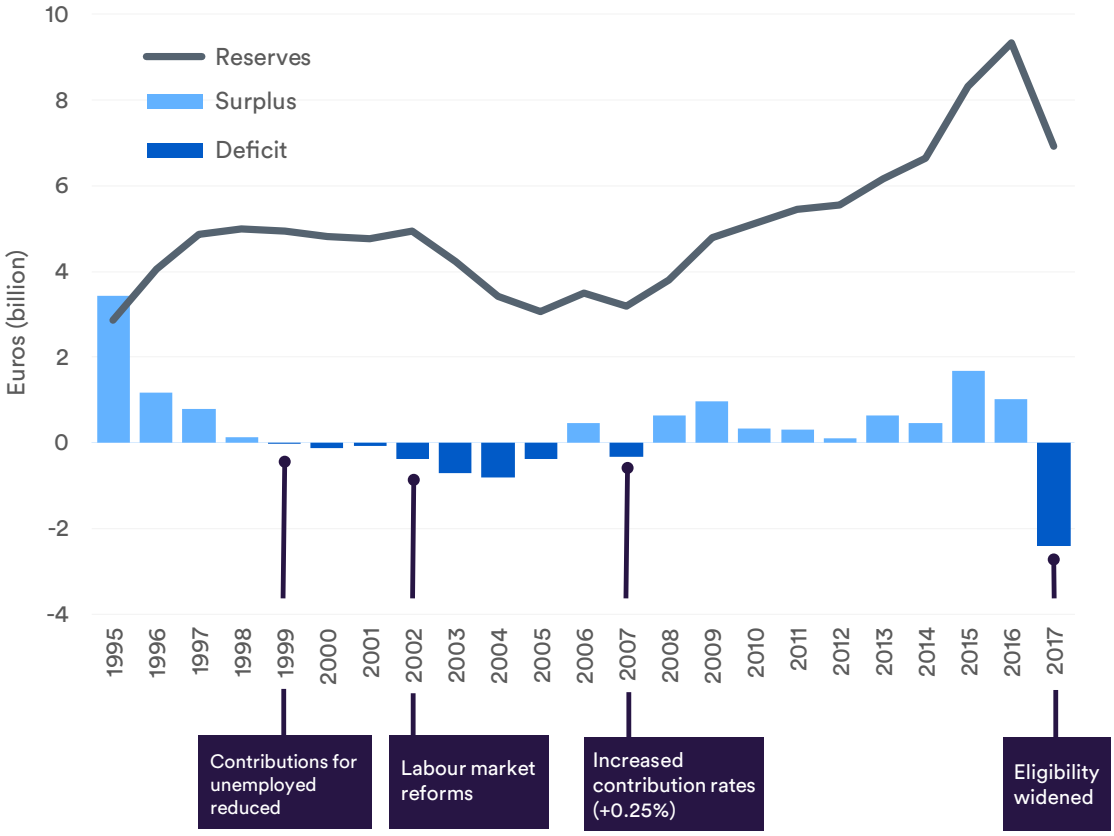
The German government has regularly adjusted contributions rates as well as changed eligibility and benefits in response to changing circumstances and needs. However, LTCI does not operate in isolation and contribution rates have been affected by wider policy, social and economic developments. Being solely dependent on earnings, an income-based contribution system such as social insurance is dependent on the strength of the economy and level of average income. In the first three years of Germany's LTCI, the system built up a considerable surplus (Figure 6), followed by a period of almost balanced budgets (Rothgang, 2010). The years 2000 to 2007, however, saw slowing contributions and increasing deficits as a result of developments in the labour market and wider social policy (Rothgang, 2010; Theobald, 2011) – aggregate wages increased only slowly during this period and a new form of marginal employment with a low absolute level of earnings and exemption from social insurance contributions was introduced. A subsequent decrease in standard employment led to a decrease in LTCI revenue (Rothgang, 2010). At the same time, long-term care contributions for the unemployed (which are paid for by unemployment insurance) were reduced because that strand of social insurance had fiscal problems at the time (Rothgang, 2010).

Until 2008, no automatic indexation of benefits was included in the system. At this time, the government sought to make the system more generous through reforms (*PfWG*) that led to an increase in benefits, a cost of living adjustment, and the introduction of a three-yearly review of benefit levels from 2015 onwards. Those reforms were accompanied by an increase in contribution rates for LTCI and this resulted in a surplus in the years thereafter.

However, the system was in severe deficit again in 2017 as a result of widening eligibility to take account of cognitive issues (*PSG II*) and much higher than expected growth in expenditure. Changes in eligibility were accompanied by a 0.2% increase in contributions, but policy-makers had underestimated the impact more generous eligibility would have on demand. The annual increase in care recipients in the years leading up to the reform was, on average, around 84,000. Following the 2016 reforms, 553,000 more people in need of care received benefits *(PSG II*) (BMG, 2019a) (see also Figure 1). As a result, the system saw its highest deficits since implementation of LTCI (Figure 6) and a further increase of 0.3% on contributions from 2019 was deemed necessary in order to close the funding gap. Despite this deficit, the financial stability of the

fund was not a concern because sufficient reserves had been accrued in the years leading up to the 2016/17 reform (*PSG II*).

Figure 6: Financial development of long-term care insurance in Germany, 1995 to 2017



Source: BMG, 2019b

A timeline of major policy change is included in Appendix 1.

Future sustainability: introduction of a federal reserve fund

Although the financial sustainability of the system is not of immediate concern in Germany, there is a recognition that balancing the finances in the longer term is likely to be challenging. Raising contribution rates continuously to meet rising need is not thought to be a realistic option; in Germany, people already pay a large proportion of their income on tax and social welfare contributions, all of which will likely see further increases over time as its shrinking working-age population will have to sustain a growing older population. The last six years have seen a rise in contributions by a total of 1.0%; and the current rate of 3.05% is expected to sustain the system until 2022 only (BMG, 2018a).

In 2015, policy-makers diverted from the strict pay-as-you-go system in order to save for future need at a time when the economy is strong and revenues high. They introduced a Federal Reserve Fund, intended for use from 2035 onwards to mitigate the expected impact of demographic change on contribution rates as the German baby boom generation hits retirement. The fund is managed by the federal bank and receives 0.1% of annual LTCI contribution income, which is currently at around €1.2 billion per year (BMG, 2017). It is intended to last for 20 years, after which the impact of demographic change is expected to ease; up to a twentieth of it can be drawn upon in a given year. The usefulness of the fund is contested and there are concerns it only partially addresses future needs (Bowles and Greiner, 2015; Deutscher Bundestag, 2017). It does, however, signify clear interest in thinking beyond the political short term.

In light of these uncertainties about the long-term future of the system, ongoing discussions centre on the role of public, private and market responsibilities (Theobald, 2011), and some of the more prominent proposals include mandatory private insurance, a cap on user contributions, and a mixed system of social insurance and tax. Political sources told us that long-term solutions will likely require system-wide reforms rather than small adaptations or rises in contribution rates alone. Examples mentioned include digital innovations to reduce bureaucracy and make processes more efficient, investing in prevention of care needs, and community models of care (see Lesson 9 for more on this).

Learning for England

Germany's approach of putting basic workable building blocks in place allowed for relatively straightforward implementation and a system that has been financially stable and able to provide more generous care over time. The system has not remained static and regular reforms have sought to adjust the system in an attempt to address limitations and sustain it financially.

Germany opted for a strictly ring-fenced revenue source, which has aided cost containment and offered a high degree of transparency. However, without the ability to top it up, it is relatively inflexible – to cover rising costs of care or to provide a more generous offer, the government must either raise contributions or shift more costs to individual service users. In England, there have been

calls to ring-fence additional money raised for social care and there is evidence of public support for such proposals (Local Government Association, 2018a). Germany's experience suggests that English policy-makers should think carefully about the implications over the long term of introducing strictly ring-fenced funding (and associated strictly controlled benefits) and consider building in greater flexibility to respond to changing circumstances over time.

Financial sustainability is also heavily dependent on the ability to forecast demand and expenditures (Nadash and others, 2018) and to adapt and evolve the system accordingly. Funding cannot be considered separate from the delivery and provider side of the system and it is crucial that robust and realistic estimates of future need and expenditure underpin the system. Germany's policy-makers were taken by surprise when extensions of the core programme in 2017 saw higher-than-expected demand, although their ability to adjust contributions meant they were able to respond and re-stabilise the system.

Social care does not exist in isolation: it is tied in with developments in the labour market and economy, wider social policy and the demographic profile of a population. By basing revenue solely on income from employment and pensions, Germany's LTCI system is highly dependent on the health of the economy (Rothgang, 2010). In England, the so-called 'gig economy' and zero-hours contracts are associated with lower tax revenues and national insurance contributions (All Party Parliamentary Group on Responsible Tax, 2018). The number of people in this type of marginal employment has grown rapidly and it was estimated that around 4.4% of the general population were employed in the gig economy in 2017 (National Centre for Social Research, 2018). Decisions around funding options will need to consider the impact of such developments in the labour market now and in the future. Basing funding solely on income may not offer the most stable approach and policy-makers would be wise to consider a combination of different revenue-raising mechanisms that also offer the opportunity to be fair across the generations (for example, income and wealth taxes combined).

In its efforts to maintain the financial health of LTCI, Germany has frequently reviewed and adapted the system over time and responsive and timely policy-making has been key to that (see Appendix 1 for a timeline of major reforms). Long-term care reform in Germany is viewed as a continuous process, rather

than the series of short-term, piecemeal and one-off adjustments that are characteristic of England's social care policy (Cromarty and others, 2019).

Recommendations for England

- Any system of care will need to adapt to changing demographics and remain sustainable in the long term. It is important that mechanisms are built into the system from the outset to allow policy-makers to adjust and evolve the system accordingly.

- Social care funding options cannot be considered in isolation. A strictly ring-fenced revenue source linked solely to incomes is relatively inflexible and vulnerable to changes in the health of the wider economy. A combination of different funding streams (perhaps levied on income and wealth) may offer greater flexibility and fairness across generations.

- Introducing fixed benefits and eligibility offers central government high levels of control over expenditure and an ability to ensure financial sustainability. However, a restrictive offer will have a knock-on effect on individual expenditure and other areas of state expenditure. A realistic projection of the level of costs that are likely to fall on individuals and the state will be crucial in deciding the balance of responsibility.

5. Provider market: balancing stability with local market shaping

Germany has sought to develop a stable and competitive provider market by creating a national regulatory framework to coexist alongside market principles. As such, it aims to balance cost containment, social equity and consumer choice (Theobald, 2012b; Nadash and others, 2018). Following the principle of subsidiarity, the federal government does not get directly involved in care provision or management but does provide a legal framework and oversight of the level and quality of services, their reimbursement and contracting. The reimbursement system as laid out in the Social Code aims to foster competition between providers in order to contribute to an efficient service infrastructure through economic incentives. It further stipulates that

the care infrastructure must be well-functioning, demand-orientated and cost-efficient but delegates responsibility for provision to the federal states (Arntz and others, 2006).

In designing the payment system, German policy-makers sought to combine certainty for providers with state-level and some local flexibility. At state level, a contractual framework (governed by national legal principles) is negotiated between LTCI funds, social welfare authorities and medical review boards. That negotiation process defines elements of services that can be provided. Individual providers then negotiate with LTCI funds and social welfare authorities the total prices for each of those elements of service. The nationally defined benefits schedule that is paid directly to providers covers part, but not all, of that negotiated price. Higher quality providers are able to negotiate higher fees. During that same process, providers must also agree the prices they will charge individuals for bed and board. The eventual care contract stipulating the number of care staff; type, content and scope of services; quality and quality assurance; and the remuneration rates are negotiated on a regular basis (Nadash and others, 2018; Theobald, 2011). Before price negotiations, service providers submit evidence of the type, content, scope and cost of care they provide. Importantly, projections of future expenditure and costs pressures – including general price and wage changes – are taken into consideration to ensure that service providers who operate within the agreed contractual framework are fairly remunerated.

Because negotiations are undertaken regularly and take into account current and future cost pressures, providers have a high degree of certainty. Also, because the contract and fee agreements include all costs (with the exception of service charges and additional services over which providers have some freedom), providers are not able to inflate the portion of the costs that are passed onto individual service users beyond what is stated in the contract. In addition, individual providers are not able to charge differential rates to people receiving the same service. These local negotiations allow flexibility for services to be designed to meet local needs, but there are big regional variations in the prices paid by individual service users (or social assistance) for care.

A competitive care market, with providers from for-profit and non-profit sectors, was deliberately created to encourage competition in order to

drive efficiency, quality and consumer choice (Theobald, 2011). In theory, providers compete on the basis of price and quality (Theobald and others, 2017). The creation of the market has successfully expanded the care service infrastructure (Nadash and others, 2018) and seen many new entrants to the sector, particularly from the for-profit sector (Theobald and others, 2017). Because providers have clarity over their fees into the future and because the aggregate fees adequately cover their costs, the provider market is buoyant and stable.

However, there are concerns about how the market is developing, with some arguing that recent developments run counter to the goal of providing social equity in provision (Theobald, 2011; Theobald, 2012b; Theobald and others, 2017). In reality, competition does not work as intended as prices are not fully the result of free-market processes but of negotiations. Furthermore, quality ratings are insufficiently sensitive to offer service users accurate information on quality. Consumer choice is also limited as the mobility of care recipients is typically low (Mennicken and others, 2014). With large foreign providers starting to move into the market, our interviewees reported that there are increasingly vocal calls for the profits of private providers to be capped and the Health Minister has recently acknowledged it to be a problem (Spahn, 2018).

Some commentators have also raised concerns about a lack of clear incentives within the system to drive efficiency. Local authorities, which are entrusted with the development of a local care infrastructure, have been left with limited powers to shape provision. Although LTCI funds are obliged to negotiate cost-efficient prices (Theobald, 2011), there are no strong incentives for funds to ensure cost savings as any extra fees charged by providers are passed onto individual service users or the social assistance programme (Mennicken and others, 2014).

Learning for England

In England, barely a month goes by without news of a care provider going out of business, struggling to stay in business or handing back contracts to local authorities. Because of market fragility, the government has had to introduce market oversight and a failure regime covering financial as well as quality failure (Care Quality Commission, 2015). In sharp contrast, the German provider market is buoyant and concerns are currently focused on

the appropriateness of providers making large profits and the ethics of a competition and the resultant variation. Germany has sought to combine provider stability with local flexibility in guaranteeing a basic fee at a national level but allowing for local negotiation for part of the costs. More significantly, the stable and buoyant market appears to be explained by the fact that the system is adequately funded and the costs of providing care are covered through a combination of the national benefit and a pre-negotiated set of local fees that are paid by service users. Importantly, negotiations with providers take into account the local context as well as current and future cost pressures. By contrast, providers in the English social care market are subject to annual fee changes which are made irrespective of future cost pressures and many are finding that fees paid by local authorities increasingly fall short of covering the costs of providing care (House of Lords Economic Affairs Committee, 2019).

In England, issues of equity have arisen over the years as self-funders have increasingly subsidised those funded by local authorities (Competition and Markets Authority, 2017). In Germany, the prices that providers can charge individual service users over and above the national benefit level are subject to local negotiation. This means that providers are unable to charge differential rates to people for the same service, other than for optional extras.

Perhaps one of the weaknesses of the German market, where England has a potential advantage, is in the role of local authorities and their relative powers to shape the market. National and state-level frameworks, along with the fact that providers and LTCI funds directly negotiate many elements of provider contracts, mean that although German local authorities were intended to have a market-shaping role, in reality they have few powers. Although the English provider market badly needs stability, policy-makers should be careful not to undermine but instead seek to strengthen the important role that local authorities could play in shaping the market and tailoring it to local need.

However, in recent years, local authorities have seen their financial positions eroded and some have had to use emergency cash reserves (Wainwright, 2019). A recent report found that the proportion of councils funding social care overspends by drawing on reserves increased from 1% in 2017/18 to 4% in 2018/19 and those funding social care overspends from underspending in other departments increased from 41% to 51% over the same period (Association of Directors of Adult Social Services, 2019). The implications

of this for their ability to shape the market need to be considered, as does the proposal to shift to a situation where local authorities raise more of their income locally (Ministry of Housing, Communities and Local Government, 2018). Widening disparities in provision are a growing problem in both countries but in Germany, because care benefits are set nationally and because social assistance for care covers full costs (including bed and board) if an individual is unable to do so, providers enjoy greater levels of stability and certainty and there do not appear to be the 'care deserts' that have opened up in England, particularly in more deprived areas (Incisive Health, 2019).

Recommendations for England

- Offering a partial fee schedule that is set nationally alongside a locally negotiated component has potential to balance certainty with local flexibility. Any shift towards a national framework needs to ensure the approach strengthens and not further weakens local authorities' ability to shape the market.

- Ensuring that the total fees paid to providers adequately cover their costs now and in the future would help to stabilise a very fragile market and reduce the number of areas with very poor provision.

- Requiring providers to negotiate and agree the fees that they can pass on to individual service users would reduce the opportunities for providers to charge differential rates for the same service and therefore reduce inequity in the system.

6. Workforce: planning long-term and across government

Workforce pressures are by far the most acute challenge for the German LTCI system. Although benefits have been made more generous and eligibility has been expanded, care services are still struggling to meet demand because of a lack of staff. At present, all regions of Germany are experiencing severe staff shortages. In 2018, 25,000 to 30,000 care posts were vacant and estimates range from 60,000 to 200,000 vacancies by 2025 (BMG, 2018b). From an

international perspective, the German long-term care workforce is highly qualified (Theobald, 2012a). Most staff have at least one to three years of occupational training. In 2017, 46% (or 180,000) of all staff in home care and 30% (or 232,000) of staff in residential care were qualified health or elderly care nurses with three years of occupational training. 17% of home-care staff and 19% of residential care staff had completed one- to three-year training as care assistants or other care related training (Statistisches Bundesamt, 2018).

The relatively high level of qualifications, especially in home care, can be explained by the fact that long-term care and home nursing is integrated so care workers providing home-based services are required to hold higher levels of qualifications to enable them to provide nursing as well (Theobald, 2012a). However, despite high levels of qualification, care work is not seen as a particularly attractive profession due to the emotional and physical demands of caring, the relatively low pay and perceived status of care workers, and the lack of flexibility in the workplace. In addition, interviewees told us that care work in residential care has become more demanding as care recipients have increasingly complex needs.

In response to workforce pressures, a new reform was passed in 2019 to improve working conditions and strengthen the workforce (*PpSG*). It is the most comprehensive workforce reform to date and required a rise in LTCI contributions of 0.2% to cover the costs. The reform primarily includes the creation of 13,000 new posts in care homes to ease the pressure on existing staff; investment in better working conditions, including family-friendly policies, workplace health promotion, digitisation and reduction in bureaucracy; and changes to nursing training to incentivise uptake, such as abolishing fees and introducing new training schemes. The reform is thought to be a step in the right direction but many of our interviewees felt it was too little, too late.

Even if the newly created posts are filled, it is not clear that they will be sufficient to meet demand. As part of the new reform, multi-disciplinary working groups comprising all relevant stakeholders – including ministries, states, professional and training associations, care providers, health and LTCI funds – were set up to discuss the workforce challenge in more depth and develop further strategies. In June 2019, the government announced a package of new initiatives which include creating a welcoming culture to immigrant

staff in order to boost international recruitment; development of an evidence-based and binding staff ratio to address workloads so as to improve working conditions; incentivising former workers back to the industry through better working conditions; and, crucially, improved wages (Die Bundesregierung, 2019). A major strand of Germany's workforce strategy involves active overseas recruitment – in 2018, only 12.6% (74,634) of its workers in elderly care were from other countries (Bundesagentur für Arbeit, 2019) compared to 18% in England (Skills for Care, 2018) – and it is actively seeking to boost those numbers. In addition to active recruitment of qualified staff, a further noteworthy strategy is establishing German care schools abroad, which enables trainees to receive recognised care qualifications and to acquire language skills prior to immigration. An agreement with Kosovo has recently been signed and potential future partners include the Philippines, Cuba and Macedonia (RP Online, 2018).

A minimum wage already exists in the sector but policy-makers are seeking to introduce new pay frameworks that would enable wages to rise. Despite political will to introduce such a framework across the entire care sector, this has proven difficult to achieve. First, the long-term care workforce is not well organised and trade unions have so far been unable to negotiate collective wage agreements. Second, while collective wages can be more easily implemented across public care providers, it is difficult to mandate this for private providers. Third, raising wages will inevitably increase care costs, which will either require benefit levels to be adjusted and therefore contribution rates to rise, or the private payments care recipients are required to make will increase even further. Recent government announcements suggest that there is a desire to avoid passing these extra costs on to current service users through higher co-payments but that, instead, wage increases should be financed by LTCI funds (Die Bundesregierung, 2019). This would potentially result in higher contribution rates in the long term (Frankfurter Allgemeine, 2019).

Learning for England

England and Germany face similar workforce pressures, with relatively low wages and low status leading to care workers leaving the sector in favour of other industries (Beech and others, 2019). Pressure on fees paid by local authorities in England have depressed wages, and the care sector had a

vacancy rate of 8% in 2017/18 while the turnover rate for all care jobs in the same year was 30.7% (Skills for Care, 2018). Around one quarter of the workforce are employed on zero-hours contracts (Skills for Care, 2018). Higher wages and more favourable working conditions in the health sector are creating further pressures by pulling staff out of social care (Beech and others, 2019).

Germany's experience demonstrates that explicit attention needs to be paid to how services are going to be staffed, alongside reform of the funding system. Both countries have tried to tackle the issue of low pay through the implementation of a minimum wage, but England has struggled to enforce it in the past.[10] In England, there have been worrying reports of non-compliance with the minimum wage in the last few years (HM Revenue and Customs, 2013, cited in Beech and others, 2019). Equally problematic is the fact that, in many areas, the minimum wage lags far behind median wages in the local economy, creating a further disincentive to work in social care (Skills for Care, 2018).

However, as seen in Germany, increasing wages is not a straightforward decision, as any increase in wages will have a knock-on effect on the overall costs of the system. Both countries are working on strategies to address working conditions, insecure contracts and the perception of care work as low status and low skilled in order to tackle recruitment and retention, but more needs to be done to boost staffing numbers to the level required.

One strategy that arm's length bodies in England are exploring is the professionalisation of the social care workforce to help raise the status of care work. England lags behind other nations (including those within the United Kingdom) on this front. In England, a significant majority of direct care roles do not require any formal qualification, but involve a training induction and non-mandatory engagement with the care certificate. Of those direct care staff new to the sector since January 2015, 32% were yet to begin training for their care certificate (Skills for Care, 2018). Germany, by contrast, has a relatively highly qualified workforce. Germany's experience suggests that, while

10 Note that in England this applies to the independent sector; the vast majority of local authority sector workers were already paid above the 2019 National Living Wage prior to its introduction (Skills for Care, 2019a).

professionalisation could be helpful in improving recruitment and retention, it is unlikely to be a sufficient lever on its own and more evidence is needed on its impact.

Policy-makers across government would be wise to recognise that the UK will increasingly be competing with other countries for staff to work in the same industries. It is feared that the UK's imminent departure from the EU is likely to exacerbate the shortages in the care workforce. The International Longevity Centre projects that by 2037, in a worst-case scenario where levels of net migration equal zero, a social care workforce gap of just over 1.1 million social care workers could arise (International Longevity Centre and Independent Age, 2016). At the same time, the government's immigration White Paper (HM Government, 2018) sets out a series of initiatives that will exacerbate workforce shortages. Proposals for a minimum income threshold would create an immigration system that disadvantages those in the care sector whose only option would be to enter through the 'low-skilled' route which offers a very restrictive 12 month visa (Nuffield Trust, 2019).

There is a strong case for care workers to be given special dispensation under such a system. If the immigrant workforce does shrink as expected, there may be a need for wages to rise in order to attract domestic staff – implications for the affordability of the system would be significant as staff costs are estimated to make up around 60% of costs in care homes and 80% of costs in home care (Care Quality Commission, 2016). It is essential that immigration policy is not made in isolation and that the potential impact on social care (as well as other sectors) is fully considered (Leone, 2019). Germany's attempts to take a cross-departmental approach to developing a workforce strategy recognises the need for joined-up thinking across government.

Recommendations for England

- Having a robust workforce strategy built into the design of the system at the outset is crucial. While more money in the system will help to ease workforce challenges, it will not automatically fix them. Careful planning, with strategies for attracting staff, needs to be undertaken.

- Enforcing the minimum wage – and/or raising wages – in the sector may help to retain staff, but the implications of increased pay for the financial sustainability of any reformed funding system need to be factored in.

- Professionalisation may help to attract new staff and retain existing staff but this approach will not be effective on its own; a variety of strategies are required.

- Recruiting staff from abroad is often discussed as a way of filling vacancies, but England will be competing with other countries for the same staff. There is a significant risk that proposed changes to the immigration system will exacerbate workforce challenges by making it more difficult for care workers to enter the country.

7. Cash benefits promote autonomy but may have unintended consequences

The German government made a deliberate decision to include cash benefits as an option within the system. Firstly, offering the option of cash benefits, or a mixture of cash and in-kind benefits, was seen as a way of facilitating home care, by promoting the capacity of the family to provide care (Campbell, 2002). It was also intended to promote control, choice and autonomy and give service users a voice in the system. Secondly, there was an assumption that cash benefits would reduce spending levels overall (Theobald, 2011) by providing a cheaper alternative to professional services. In recent years, it has become clear that workforce pressures mean that the gap between need for care and the availability of staff to provide that care is widening and that, increasingly, informal carers will be required to plug that gap. The inclusion of cash benefits in the system has some advantages but has led to some unintended consequences (see next section for more on reliance on carers).

Although the value is less than half that of 'in-kind' benefits, a significant proportion of LTCI recipients opt for cash benefits and they represent the largest proportion of long-term care expenditure (Heinicke and Thomsen, 2010, p. 14). In 2017, 52% of *all* LTCI beneficiaries chose cash benefits only and 24% chose a combination of cash and in-kind benefits (Statistisches

Bundesamt, 2018). Of those beneficiaries receiving care at home, the vast majority choose cash benefits only, although this has fallen from 71% in 1999 to 68% in 2017 (Statistisches Bundesamt, 2018).This reflects a cultural preference for family care (Schneider and Reyes, 2007) and a willingness to accept a lower level of benefit in order to do so. In addition, at the time of implementation, people found the ability to freely decide how to use cash benefits to be advantageous (Runde and others, 1996, cited in Wiener and Cuellar, 1999). Moreover, the ability to combine cash with in-kind benefits allows people in need of care to receive a benefit mix that closely suits their needs (Schneider and Reyes, 2007).

The extent to which the inclusion of cash benefits as an option has reduced overall spending levels remains unclear. Offering cash benefits at less than half the value of in-kind benefits appears to have allowed the German government to contain costs in the face of rising demand, particularly in the early years[11] (Campbell, 2002; Evers, 1998). However, some argue offering cash benefits may also have introduced supply-induced demand (Campbell, 2002; Campbell and others, 2010) in that people would almost always take cash where they may otherwise have made do with existing arrangements if only professional services were on offer. Therefore, some argue that the existence of the cash benefit has monetised informal care in such a way as to increase costs without a corresponding increase in provision of informal care (Evers, 1998). However, there is little robust evidence specific to Germany to confirm this. The wider literature on cash-for-care schemes suggests that they are largely successful in containing cost, albeit potentially at the expense of quality (Ungerson and Yeandle, 2007).

What is more clear is that the provision of cash benefits entails trade-offs for the wider economy, reinforcing a reliance on women in particular as informal carers at the price of their reduced participation in the labour market (Rhee and others, 2015). Modelling of German data suggests the effect on labour supply in Germany is mitigated to an extent by the inclusion of benefits in kind alongside cash benefits (Geyer and Korfhage, 2015), but there remains

11 Regarding the surplus in the early years following LTCI implementation, Campbell (2002, p. 183) states "Although details of the German cost estimates were not published, it is believed that they were based on one-half cash allowance and one-half services (outside of institutional care), so the savings were considerable when 80% elected cash".

concern that cash-for-care schemes in general reproduce and increase gender inequality in the provision of informal care (Zigante, 2018; Ungerson and Yeandle, 2007).

An unregulated benefit

Cash benefits are paid directly to individuals deemed eligible for care. Like Attendance Allowance and the Personal Independence Payment in England, there are no regulations on how the cash is used and no requirement that funds be used to buy long-term care services or pay carers (Cuellar and Wiener, 2000). There is little systematic effort on the part of the German government or insurance funds to determine how the money is spent, but a recent survey estimates that 59% of people receiving cash benefits use it to pay family or friends and 28% use it to supplement income (as high as 44% for those with the highest care grade) (TNS Infratest, 2017). We heard that cash benefits may also be used for intergenerational transfers, much in the same way as pension income (for example, to support grandchildren's university studies). In practice, therefore, receipt of a cash benefit does not automatically equate to provision of informal care.

The extent to which lack of regulation is an issue for policy-makers and users remains unclear. An in-home mandatory monitoring and advice system has been implemented for those receiving cash benefits. This takes the form of visits undertaken by care providers every three to six months (the frequency depends on the individual's care grade) which are a mix between counselling, support and assessment of quality (Büscher and others, 2010; Nuffield Trust interview, 2018). As there is no national framework for visits, there is wide variation in their effectiveness and format. Culturally, it seems to be accepted that cash benefits can be spent as the recipient wishes and the visits have had a mixed reaction: "care among family members is a personal issue, largely outside the regulatory realm" (Cuellar and Wiener, 2000) and so in some instances, the visits are "perceived as control…not as counselling" (Nuffield Trust interview, 2018). It is not the norm for the assessor to take into account the support needs of the carer as part of a standard visit (Nuffield Trust interview, 2018). A study published in 2010 also found that such visits rarely identified or reported inadequate care or made suggestions for improvement (Büscher and others, 2010).

The 'grey' market

Since the late 1990s Germany has witnessed the development of a 'grey' market in care provision, whereby individuals privately purchase care from unregistered agencies – which employ both qualified and untrained staff – operating within neighbouring European countries (Poland, Czech Republic, and Hungary). The emergence of this market has been associated with the lack of regulation of cash benefits (Glendinning and Bell, 2008; Da Roit and Le Bihan, 2010).

Typically, two migrant care workers provide 24-hour care on a rotational basis, residing with the person in need of care for two to three months at a time and without access to social security or respite. There are an estimated 120,000 migrant care workers in Germany working outside of social and labour regulations (Theobald, 2011); this labour remains largely undocumented (Rada, 2016). Our sources suggested there is little political impetus to understand the true extent of the grey market, with some speculating that this is because it provides a cheap source of labour and helps to both address the workforce shortages and keep system costs down.

Learning for England

In both the German and English systems, the principle of individual autonomy is frequently cited as a policy goal and indicator of good care quality. In England, 'control and autonomy' was specifically identified as one of seven key principles guiding the previous government's thinking ahead of the social care Green Paper (The Rt. Hon. Jeremy Hunt MP, 2018). Cash benefits, in the form of personal budgets or direct payments, are often cited as a way to promote choice, control and independence, representing "the biggest factor enabling users to have more choice and control over their care services" (Scope, cited in House of Commons Public Accounts Committee, 2016, point 10). Improvements to quality of life, but not wider health outcomes, have also been demonstrated (National Audit Office, 2016).

In contrast to the cash benefit model in Germany, which is subject to very little regulation, direct payments in England are currently subject to a range of restrictions and audit (Alakeson, 2010, cited in Gadsby and others, 2013). Some recipients have described this as burdensome and can find it difficult to take on responsibilities as employers of personal assistants

(National Audit Office, 2016). Ensuring that recipients of direct payments have the information, advice and comprehensive support needed to fulfil their responsibilities as employers will therefore be crucial to the future effectiveness and uptake of direct payments (as recognised in the impact assessment conducted by the Department of Health, 2012). The extent of regulation applied to cash-for-care schemes has implications, not only for quality, but also for the structure of the wider social care system (Zigante, 2018). Light or non-existent regulation – for example with unconditional cash benefits – may incentivise informal care but also unintentionally reproduce existing inequalities in its provision (by age, gender, ethnicity and socioeconomic background). Germany's lack of regulation of the sector has also given rise to a grey market of workers. At the time of writing, England's proposed Immigration Bill; inaction on sector funding; and a historic lack of enforcement of employment standards combined with low levels of union membership (Dromey and Hochlaf, 2018) may create fertile ground for such a grey market to develop.

In England, a recent survey suggests 56% of personal assistants employed by direct payment recipients are family members (who do not live in the same household) or friends (Skills for Care, 2019b). In England, as in Germany, informal care provision is not regulated, nor is there data on the quality of care purchased privately in the grey market or provided by relatives or friends (Glendinning, 2018). Individual suppliers of care are not required to be Care Quality Commission registered. Indeed, Courtin and others (2014, p.16) recognise that monitoring quality of care in this area is "a delicate issue for policymakers to address"; it might not be sensitive or feasible to systematically inspect and assess care in the private sphere of the home.

Germany's experience suggests that by expanding cash payments, it is likely that people may increasingly want to pay family or friends to provide care. That is not necessarily problematic and can indeed be beneficial for the individual and their family. However, while national guidance states "there should be no unreasonable restriction placed on the use of [direct payments], as long as it is being used to meet eligible care and support needs" (Department of Health, 2014, point 12.35), local authorities usually do not permit paying family members residing in the same household and there are reports that they do not give people enough freedom over how they are spent – they cannot be used to pay for counselling or gym membership for example (Healthwatch

Birmingham, 2019). Policy-makers need to be mindful that current levels of reliance on informal provision are unlikely to be sustainable given the projected levels of demand for care, the growing complexity of people's needs and the fact that the number of people in need of care is likely to outstrip the number of adult children able to provide care (McNeil and Hunter, 2014). (See next section for more on carers.)

Recommendations for England

- Autonomy and control over care choices is a laudable ambition that will gain public support, but policy-makers need to think carefully about how it is achieved. Offering benefits in cash is one option, but careful consideration needs to be given to ensure sufficient regulation without being burdensome to service users.

- It should not be assumed that cash payments will be a cheaper way to deliver care. Robust estimates of unmet and under-met needs should be established in order to model potential demand for such benefits should they become a widespread option in England.

- Policy-makers need to carefully consider the design of cash-for-care schemes and their regulation so as not to exacerbate existing inequalities in informal care provision (e.g. in terms of gender).

8. Supporting carers: joining up policy is crucial

Traditionally in Germany, the family is the natural place for dignified care (Blüher, 2003). However, the consequences of a system heavily reliant on informal care are causing increasing concern. At the time of our visit, there was evidence indicating widespread exhaustion and frustration among the estimated 2.5 million carers – an issue that has been growing over the past five years. The sustainability of informal care receives high media interest (Rothgang and Müller, 2018). However, the government is seeking to maintain current levels of informal care, partly because it is cost-effective and helps relieve ongoing workforce pressures, and also because promoting home care

was one of the four aims of LTCI (Sato, 2009). With the proportion of people opting for cash benefits dropping over time, there are growing concerns that should more people start to opt for in-kind care, the system will rapidly become unsustainable.

Policy in Germany is becoming actively focused on how to better support carers so that these high levels of provision are maintained. One strand of this focus is on ensuring that employment legislation actively supports carers so that they can remain in the labour market while caring; the second strand considers how best to ensure carers do not lose out on other benefits so that they are not so severely disadvantaged by being a carer.

Employment legislation

The German government has recognised the costs of reduced labour market participation to individuals, employers and the state. They have introduced a number of legislative reforms within the last decade seeking to improve carers' employment flexibility and job security:

- **Short-term absence from work** (*Pflegezeit; Nursing Care Time*): Since 2008, employees have been entitled to a maximum of 10 days' emergency leave to organise care for a relative when there is a sudden need. Employees can also be released from full-time work completely or partially for up to six months. In 2015, a carers' grant was introduced which allows for up to 10 days of emergency leave, set at 90% of the employee's wage, funded through the LTCI fund of the person in need of care (pflege.de, n.d.). As of 2015, a government interest-free loan has also been available to cushion the loss of income for leave taken up to six months.

- **Family caregiver leave** (*Familienpflegezeit*): Since 2012, an employee has held the statutory right to reduce their working hours to no less than 15 hours per week for up to two years. In 2015, a government interest-free loan has been available to employees which allows them to reduce their hours while retaining a proportion of their salary. The loan must be repaid upon returning to work full time.

Uptake of these two initiatives is low, at an estimated 6,750 people in 2018 (Deutscher Bundestag, 2016a). Uptake of the government loans was also very low, at under 250 nationwide (Deutscher Bundestag, 2016b). It is thought

that low uptake can be explained by low awareness among employees and resistance among employers. Few people can afford to cut their working time and lower their standard of living as a result. In addition, people are only legally entitled to absence from work if they work in organisations with more than 25 employees and the employer can withhold the entitlement if there are deemed to be sufficient corporate reasons. It is unlikely that these measures will be enough to prevent further decline in family caregiving and the government has established cross-departmental working groups to focus on the issue and explore options for paid leave.

Social security and wider support

Since 2008, the LTCI funds have paid statutory pension contributions, statutory accident insurance contributions, unemployment insurance contributions, long-term care insurance contributions and subsidies for health insurance on behalf of qualifying caregivers. To be eligible, carers must provide at least 10 hours a week of care, at grades 2 to 5, in the care recipient's home, and be limited in their ability to work due to caregiving responsibilities. Other support includes benefits to pay for short- and long-term respite services (€125 per month for all care levels and up to €1,612 per year, respectively; see Appendix 2 for more details) and training funded by LTCI funds to improve care quality. Carers also have access to case management and counselling through information centres (*Pflegestützpunkte*) where care advisors can signpost and provide information. The federal government has invested €60 million in developing a nationwide network of centres, but there are concerns the infrastructure remains underdeveloped (Rothgang and others, 2010; Nuffield Trust interview, 2018).

Learning for England

Reliance on informal care is already a significant feature of the English social care system, yet much of it is invisible. In Germany, although shifts in attitude are taking place, there is an explicit and upfront narrative that responsibility for direct care is expected to lie with the family as the locus of care. In England, despite there being certain benefits and legal entitlements for carers, there is an absence of clarity "with the system relying entirely on assumptions and implicit expectations" (Beesley, 2006); reliance on informal care is by default not design. As a result the estimated five million adults providing unpaid care for older people in England (Health Survey for England, cited in

Brimblecombe and others, 2018) may not be receiving the support they need – yet were estimated to be worth between £57 billion and £100 billion across the UK as a whole in 2018 (Parliamentary Office of Science and Technology, 2018). Close to one in five carers report having to stop working all together, while one in ten had to work reduced hours (12%) or flexible hours (11%) (Future Care Capital, 2019).

Future care arrangements are a concern in both Germany and England. In England, the projections for likely future care needs are stark: the number of people aged 65 and over requiring 24-hour care will rise by about a third by 2035, and the number of those aged 85 and over requiring 24-hour care will almost double (Kingston and others, 2018). By 2035, the number of over 65s who have both substantial dependency, dementia and two or more diseases will increase threefold (Kingston and others, 2018). Given the challenges in the professional workforce, it is likely that there will be an increasing reliance on informal carers to fill the gaps. However, the projections for future needs suggest current levels of informal care provision will be unsustainable unless accompanied by greater specialist support and training.

In England, policy-makers need an open and honest debate about the respective responsibilities of individuals and families, the state, market and employers. Questions need to be asked about the extent to which a system heavily reliant on informal care is desirable, socially acceptable or, indeed, unavoidable. Because levels of informal care have far-reaching implications for the cost and future sustainability of the social care system as well as for the wider economy, carefully estimating and modelling the future impact of increased or reduced informal care provision needs to be an integral part of reform. Making these issues explicit and transparent will not be without complexity, but clarity around the state offer, expectations of individuals and the role of families would help to underpin long-lasting reform. Furthermore, a future system of care must be designed so as not to disadvantage unpaid carers. Recent rhetoric about rewarding people for making "smart choices" (Hunt, 2019) by saving for their future care needs fails to acknowledge that those providing unpaid care face a double dilemma: currently many are exhausting their existing savings to support relatives, and so are carrying a financial burden now, but they will also potentially be penalised in future when they require their own social care and have limited retirement savings. It is concerning that the government has not included unpaid carers within

its latest consultation on leave entitlements to support families in balancing work and family life (Department for Business, Energy and Industrial Strategy, 2019).

In the meantime, in recognition of the existing (and likely future) reliance of the social care system on unpaid carers, it is crucial that tangible and high quality support is put in place as a matter of priority. While the Care Act (2014) introduced assessments of carers' needs, and sought to strengthen the support available to carers, there is more that could be done. It is worrying that there has been a 10% drop in the number of carers who receive respite care – from 57,440 in 2015/16 to 51,980 in 2016/17 (Scobie, 2018). Adequate support and training will become increasingly important as people continue to live longer with more complex needs. Initiatives being developed in Germany provide ideas for further exploration in England, particularly ways to mitigate against financial hardship and debt among carers by further strengthening carers' allowance (Carers UK, 2018a) – something pointed to by our German interviewees as a positive and unique feature of the English welfare system (Glendinning and Bell, 2008). The UK's cross-department working group (established by the government's Carers Action Plan (Department of Health and Social Care, 2018)), as recommended by Carers UK (2018b) may also pay attention to Germany's attempts to introduce dedicated employment rights for carers to help them find, stay in, and return to work.

Recommendations for England

- Existing levels of informal care have implications for the cost and sustainability of the system (as well as for the wider economy) so need to be properly understood and considered as part of any reform of social care.

- Policy-makers urgently need to start an honest debate about the likely need for informal care in any future system, given the challenges in the professional workforce and the rising level and complexity of need. How responsibilities for care are shared fairly between families and the state applies not only to who pays for care but who provides it.

- The government should work with employers to bring forward dedicated employment rights and consider paid short-term leave, to help carers find,

stay in, and return to work. At the same time, tangible changes are needed to make benefits work better for carers.

- There should be wider recognition that informal care is not a free good. Many informal carers are unable to work and this has implications for other areas of state expenditure and for people's ability to save for their own future needs. Social care does not exist in a vacuum; its design has implications for many other services and the economy and society more broadly.

9. Social care needs to be part of a bigger vision: Building sustainable communities

Germany's vision was of a system that is not just about funding and providing for an individual's need for care arising from age or disability, but also one that promotes prevention, independence and social inclusion. However, despite the Social Code emphasising that long-term care is a societal responsibility, debates around the wider vision for long-term care have only recently emerged. These debates have been triggered by a recognition that future demographic and workforce pressures mean that sustaining the system in its current form is set to be challenging. While the early years of LTCI focused on helping people to stay at home, more recently there has been growing interest in alternative models of community-based care and living. These aim to combine professional help with a suitable home environment in order to keep people well and independent for longer. Initiatives intended to build a caring society and develop a local infrastructure to enable people to live at home are in their infancy, but support for this approach is gaining traction.

One established example of this change in narrative, introduced in 2012, is the provision of an additional monthly cash benefit for those who live in social care flat shares. This is a form of living in which people with long-term care needs share a private flat or house and receive domestic support and professional care together. The intention is to enable people to live independently and in a home environment for as long as possible while being looked after as needed, but with reduced reliance on professional care. Furthermore, shared living arrangements aim to integrate professional

long-term care with informal support from family, neighbours or the community (Doetter and Rothgang, 2017). It is estimated that around 4% of LTCI recipients now live in social care flat shares (Doetter and Rothgang, 2017).

Despite these developments, when it comes to the development of community-level solutions, Germany is generally lagging behind other countries, such as Japan or the Netherlands, due to limitations of the current structure of LTCI in Germany (Hoberg and Klie, 2015). In the German insurance system, money flows directly between funds and care providers or recipients, and the development of the care service infrastructure is mainly left up to the market. Local authorities theoretically have a duty to take responsibility in shaping their local infrastructure but in reality lack the powers to do so. As such, there is no part of the system with a clear incentive to invest in or implement community-level initiatives or innovations.

Hence, a number of German think tanks, advocacy groups, political parties and experts, as well as federal states, are pushing for reform to strengthen the role and financing of communities to enable close cooperation with LTCI funds and a wider implementation of integrated community-based care (Künzel, 2015). 'Quarter' management has become the most prominent and promising approach. This is an urban planning method bringing together different local stakeholders, including citizen groups, local authorities, education, health and care, businesses, transport and infrastructure. The aim is to build elderly-friendly communities comprising a range of integrated health and social (care) services, including community nursing, as well as volunteering services and opportunities for social inclusion and mutual support. The intention is to enable local communities to develop solutions that meet their own needs. This would support healthy ageing in order to delay the development of care needs for as long as possible; and it would reduce reliance on professional services and residential care by those who have already developed needs. While not yet firmly on the national policy agenda, there is growing support among federal states and some pilot projects running.

Learning for England

The pressures from an increasingly ageing population and a growing working-age population with long-term care needs are such that we need to be thinking creatively about how services and the system are designed to be sustainable and appropriate. Preventing or delaying the need for care by keeping people independent for as long as possible is being acknowledged as a priority across the developed world. There is increasing support for wholesale reimagining of long-term care and a rethinking of how our communities and societies operate. There are many pilots of community-based solutions where services are better integrated and designed specifically to support people with care needs to live independently.

England itself is trialling multiple initiatives. One example is Shared Lives Plus, which facilitates intergenerational living where younger people live in the spare room of isolated older people. Other initiatives, such as Neighbourhood Network Schemes, aim to create communities that enable older people to live independently while also offering opportunities for volunteering. The Healthy New Towns Programme (NHS England, 2018) is an example of a large-scale initiative, initiated and driven by NHS England, intended to create whole communities that promote wellbeing and independence for all.

Germany is exploring some early ideas, such as new approaches to urban planning, but these are in their infancy and England appears to be further on in this journey. Important differences in the housing market between the countries means that there are very different dynamics at play, so some ideas will not translate between the two countries. Germany's experience in this matter illuminates the fact that England enjoys a stronger local structure for developing and implementing new approaches to care and that local infrastructure needs to be supported and nurtured. England benefits from a strong and well-developed voluntary and community sector and there has been national investment in organisations such as the Centre for Ageing Better, which encourages a narrative that looks at ageing holistically and not just through the lens of care and need.

Local authorities are well placed to develop and support initiatives, alongside networks of voluntary organisations, and they have potential to play a crucial role in developing new forms of communities that keep people independent for longer while reducing loneliness and isolation. However, the ability of local authorities and charities to exploit these opportunities has been significantly limited in recent years by repeated funding cuts. The infrastructure which could provide the foundations for new communities – libraries, community projects, dementia cafes and so on – have all been eroded over the last decade of austerity. The role that social care plays in society and how it supports and works alongside other public and voluntary services must be considered as part of the wider debate.

Recommendations for England

- Projections of demographics and needs suggest that we need to rethink our approach to care and focus on preventing deterioration and keeping people independent within supportive communities.

- Debate around the future of social care should include how it supports and works alongside all other public services, as well as wider society, to promote wellbeing and independence.

- England has a strong local infrastructure for supporting change but this has been eroded in recent years. Local infrastructure needs investment to develop innovative approaches to prevention and wellness.

- Initiatives being pioneered across the UK and beyond provide a wealth of ideas and evidence on building sustainable communities.

4 Discussion: should and could England adopt a German-style approach to social care?

When discussions about our social care system in England are raised, Germany's long-term care system is often cited as a potential example to follow. This report has demonstrated that there are many lessons to be learnt from both its successes and limitations. Germany's starting point was not unlike our own, but it managed to implement wholesale reform requiring additional public contributions at a time when the country was facing some significant political and economic challenges. So could the German approach work in England?

Any public service, but arguably particularly social care, needs to be firmly embedded in the values and culture of the host nation. After all, attitudes towards caring, family responsibility, funding, independence and so on are deeply rooted in the culture of a nation. So, transplanting the German model of long-term care to England is unwise and unlikely to be a success. However, the principles upon which that system is based do translate across borders and provide foundations for a new system that could be shaped according to the context.

Fair and familiar funding

The English funding system is currently plagued by inequity and unfairness. Costs fall on the individual and there is little you can do to protect yourself from catastrophic costs. But what constitutes 'fair' is complex and very culturally specific. In Germany, social insurance levied on income at a flat rate across generations is felt to be fair. In England, what constitutes a 'fair' funding

mechanism is likely to be different – property wealth, for instance, is so much more prominent in our society (and in the social care debate) and so needs to be considered, particularly in relation to intergenerational fairness.

England also has no precedent of social insurance and establishing such an approach would be challenging, both in terms of the practical infrastructure required but also in terms of public understanding. Taxation is a much more familiar mechanism but the debate would need to focus on the advantages and disadvantages of ring-fencing any new tax. Policy-makers would be wise to consider a combination of mechanisms that draw on contributions from income and wealth in order to ensure flexibility and a sense of fairness. Whatever the mechanism (or combination of mechanisms), it is clear that the basis of a fair and stable funding system must be a collective national pool where the risk of high costs is spread across society and individuals are protected from catastrophic costs. An effective funding system must also raise money now and in the future and be understandable in order to garner public support (Oung and Schlepper, 2019).

Consistency of eligibility

Variation across the country is a key source of public discontent and anger in England. Access to publicly funded care very much depends on your postcode. Although the Care Act attempted to put in place some level of consistency, there is still a high degree of local authority discretion. The implementation of a structured and clearly defined eligibility framework spanning all ages is one element of the German system that could translate to England. Germany's approach to eligibility was to start relatively narrow but to expand to include more people and increase equity. Although that has taken time (for example, to include those with cognitive issues in addition to physical ones), it was an important aspiration from the start.

Clarity of benefits

The German system of benefits defined at a national level offers people clarity over what they can expect from the system. Benefits are awarded on need alone, regardless of age, postcode, diagnosis or living circumstances. Such clarity is in stark contrast to the opaque and confusing process for accessing publicly funded care in England and would be helpful in building

public support for change. It is notable that the German public has been broadly supportive of increases in contribution rates, because they have been directly associated with the expansion of benefits – the transparency of that association has been vital. There is growing evidence that the public is willing to pay into a system where they can see the benefits.

Stability

The fragility of the English provider market is a central concern for people in the social care system. By contrast, Germany has created a buoyant and competitive market. Price negotiation processes, while allowing for some flexibility at state, local and provider level, are governed by highly structured frameworks that ensure stability and certainty for providers. One strength of the English system (albeit arguably weakened through years of austerity) is local authorities and the potential role they play in shaping the market. A national provider framework would need to be carefully designed so as to offer certainty to providers while also seeking to strengthen, and not undermine, the role of local authorities.

Sustainability and flexibility

It is no use designing a perfect system that works today but does not work in 10 or 20 years' time when demographic pressures peak. Germany's experience underlines the importance of building flexibility into the system. One of the greatest successes of Germany's approach was achieving major reform to establish the foundations of the new system (moving away from the principle of means-testing), followed by regular adaptations to respond to changing circumstances and to enhance equity (Theobald and Hampel, 2013). Although its funding regime is relatively rigid, it has been able to adjust other levers to sustain the system as circumstances have changed. This is in direct contrast to England's approach of making piecemeal, one-off changes without having undertaken the fundamental reform to put sustainable building blocks in place.

Sustainability is not just about funding but the entire delivery system. A long-term view needs to consider the role of social care in the context of other public services, communities and society more widely. In particular, we urgently need a realistic workforce strategy that seeks to retain and recruit

homegrown staff but that also seeks to draw in high-quality staff from abroad by ensuring that immigration policy supports, not weakens, the sector.

And of course, we should not forget about the informal workforce. An explicit discussion is needed about the role of informal carers and adequate support needs to be put in place. Particular attention needs to be paid to ensuring that the design of a new social care system protects those who provide unpaid care and ensures they are not penalised in future when it comes to their own care needs and savings.

Can change be achieved?

While the principles set out above could feasibly be adapted to suit an English context, there still remains a question as to whether reform *can* be achieved. Germany's experience suggests we should be optimistic, but it is clear that a number of barriers exist in the English context at present.

Low levels of public awareness and understanding of the system (Local Government Association, 2018b) are an obstacle to change. However, recent high-profile media reports (e.g. BBC's Panorama in May 2019) and other campaigns may start to change that and could lead to the growth in public discontent that was instrumental in Germany. Research suggests that the public are willing to pay for a system if they can see the benefit (Bottery and others, 2018) but whether that would translate to votes in an election is debatable. There is a lack of clear narrative around social care and that lack of clarity is fuelled by different ideologies around individual responsibility. The clear narrative in the German debate was that long-term care is a social risk rather than an individual risk, and that the system should therefore be designed around that principle (Glendinning and Wills, 2018).

At a political level, there remain a number of barriers to change. Germany managed to implement fundamental reform soon after a time of significant economic and political turmoil, but whether our own political turmoil (namely Brexit and the associated political uncertainty) proves to be a catalyst or confounder to change in England remains to be seen. England, in comparison to Germany, is perhaps disadvantaged by its adversarial

political system where Germany is more accustomed to coalitions and the associated compromises.

That said, in England the appetite for cross-party cooperation has been growing: the passing of the 2014 Care Act demonstrated that agreement across party lines is possible. More recently, in November 2017, 90 MPs urged the Prime Minister to establish a cross-party health and social care convention; shortly after, 98 MPs signed a second letter calling for the establishment of a parliamentary commission on health and care funding (House of Commons, 2018). However, low public trust in government (Edelman Trust Barometer, 2018), along with the lack of a single party majority, means that politicians are likely to be nervous about proposing change, particularly after experiences of doing so during recent elections have not been smooth (Davies and others, 2018).

Wholesale reform of social care will require coordinated effort across government departments, but the direction of policy set out by key departments to date indicates that this will be difficult. Proposals as currently set out by the Home Office and included in the government's Immigration Bill, for instance, are set to exacerbate workforce issues in the social care sector (Nuffield Trust, 2019). Moves taken by the Ministry of Housing, Communities and Local Government to further increase the financial self-sufficiency of local authorities have significant implications for the future of social care financing and delivery which may conflict with an attempt to drive consistency and equity across the country in the same manner as Germany.

Furthermore, recent attempts by the Department for Work and Pensions to implement ambitious programmes of institutional reform have not been wholly successful (the roll out of universal credit being one example (National Audit Office, 2018b)), whereas Germany was already equipped with a well-established administrative system to effectively implement reform. These examples raise questions about the ability, and will, of central government departments to bring about wholesale reform of social care.

What is needed in England now is strong political leadership to set out a clear vision for a new system of social care that works alongside, and supports, all other public services. We need to move away from making one-off piecemeal tweaks and, instead, undertake comprehensive reform. This cannot be put off

any longer. We urge policy-makers to start a positive dialogue about social care and we urge politicians of all hues to cross political divides to find a workable, fair and sustainable solution. Germany's experience demonstrates that through compromise, even in the face of significant political and economic turmoil, the foundations of a system can be built.

Appendices

Appendix 1: Timeline of major social care reforms in Germany

Year	Name of policy and summary	Benefits	Eligibility	Informal carers
1995	**Long-Term Care Insurance Act (*PflegeVG*)** Introduction of mandatory social insurance with the aim to reduce fiscal pressures on local authorities and ensure access to long-term care while retaining levels of wealth well above the poverty line.	Monthly benefits for home care (cash, in-kind, combined) residential care, and care aids.	Limited definition of 'need for care': physical ability only.	• Social security cover: pension and accident insurance. • Benefits for respite and short-term residential care.
2002	**Care Benefits Amendment Act (*PflEG*)** Better care for people with limited ability to cope with daily life, especially people with dementia.	Annual benefit for people with a limited ability to cope with daily life.	Extended to people with limited ability to cope with daily life and high need for supervision.	
2008	**Further Development of Care Act (*PfWG*)** Strengthen the home care and service infrastructure, including introduction of care support centres.	• Increased benefit levels. • Monthly benefits for people with limited ability to cope with daily life. • Introduced automatic indexation, starting in 2015.		**Care Time Act (*PflegeZG*)** • Entitled to request leave from work for up to six months. • Social security cover extended to unemployment, health and long-term care insurance.

2012	**Family Care Time Act (*FPfZG*)** Enable family caregivers to better combine employment and caregiving.		Entitled to request a reduction in working hours for up to two years.
2013	**Care Reorientation Act (*PNG*)** Rising costs and demands, falling benefits, and financial burden on families and local authorities; an increasing number of people rely on social assistance to fund residential care. Introduction of subsidised private insurance ("Pflege-Bahr") to address sustainability and expand coverage while limiting government costs.	• Improved benefits for people with a limited ability to cope with daily life. • New benefit for people living in social care flat shares.	
2015	**First Act on Strengthening Long-Term Care (*PSG I*)** Tackle key system issues, including decreasing benefit value, longer-term sustainability through the introduction of a Federal Reserve Fund, and improved support to informal caregivers.	Benefit expansions, including inflation adjustment and raised benefit levels.	Better Reconciliation of Family, Care and Work Act • Carer's grant and interest-free government loan. • Request for employment leave replaced by legal entitlement to leave from work.

2016	**Second Act on Strengthening Long-Term Care** (*PSG II*) Revision of the care definition, eligibility framework and benefit expansions to provide adequate coverage of needs arising from cognitive and mental impairments following ten years of preparation by expert advisory committees and two evaluation studies.	Everyone receives the same benefits according to their care needs and additional benefits for certain groups are no longer needed.	New definition of care needs, care levels and assessment tool to incorporate the need for supervision and ensure parity of esteem of physical, cognitive and mental disorders. Focus now on independence and abilities rather than deficits.	
2017	**Third Act on Strengthening Long-Term Care** (*PSG III*) Improve service provision and infrastructure and strengthen local authorities.			
2019	**Act to Strengthen the Care Workforce** (*PpSG*) Aimed at tackling the workforce crisis, including changes to training, creation of additional care posts, and improved working conditions.			To decrease burden on informal carers, they are now entitled to inpatient rehabilitation even when outpatient treatment would be sufficient.

Appendix 2: Monthly benefits in Germany by care level

Benefits[12] (max. per month in euros, 2019)	Care level				
	1	2	3	4	5
Home care					
Cash	–	316	545	728	901
In-kind	–	689	1,298	1,612	1,995
Home adaptations	4,000 (per adaptation)	4,000 (per adaptation)	4,000 (per adaptation)	4,000 (per adaptation)	4,000 (per adaptation)
Care aids	40	40	40	40	40
Flat share	214	214	214	214	214
Benefits to support informal caregivers					
Relief benefit[13]	125	125	125	125	125
Respite care[14]	–	1,612 (per year)	1,612 (per year)	1,612 (per year)	1,612 (per year)
Residential short-term care[15]	–	1,612 (per year)	1,612 (per year)	1,612 (per year)	1,612 (per year)
Semi-residential care					
Day or night care	125	689	1,298	1,612	1,995
Residential care					
Residential care	125	770	1,262	1,775	2,005

Source: BMG, 2019c

12 Beneficiaries can also choose a combination of cash and in-kind benefits. Some benefits can be granted in combination.

13 Intended for day/night care, short term residential care or low threshold support services.

14 Available for up to six weeks per year when the informal carer cannot provide care due to holidays or illness.

15 Available for up to eight weeks a year when a crisis situation arises in home care or the transition from a hospital stay back home needs to be organised.

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