Demographic Change, Long-term Care and Chronic Disease Management

Country Report for Germany

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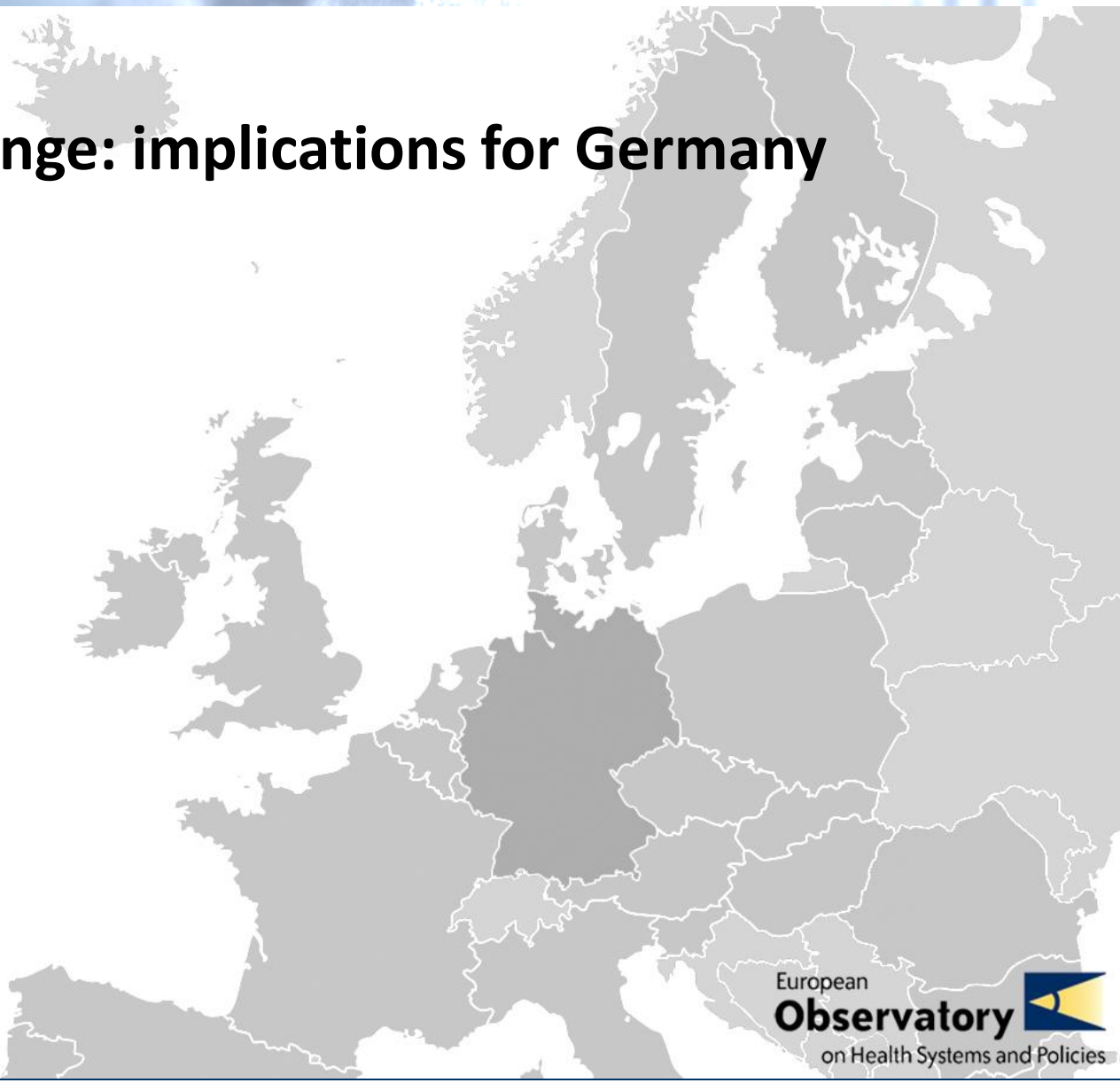
Demographic change: implications for Germany



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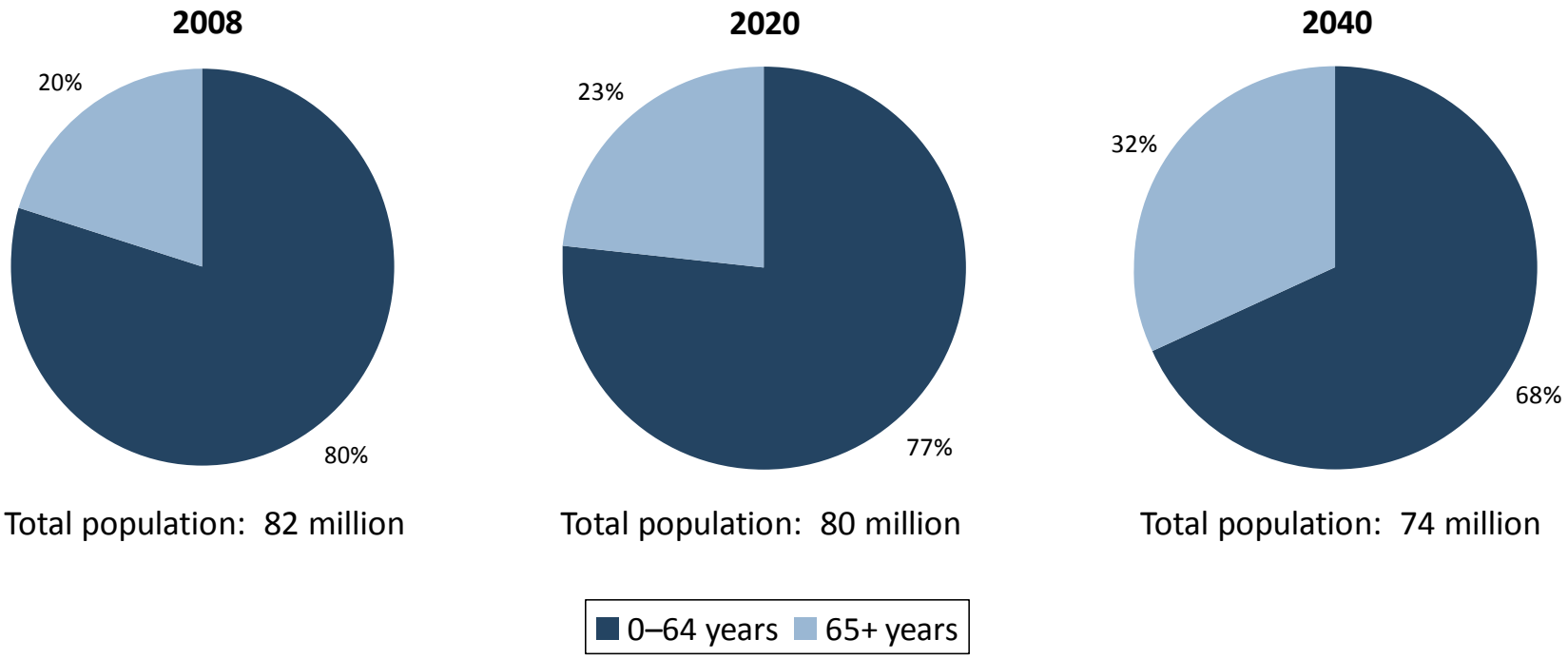
Current situation & projections

- Share of total population 65 years of age and older



Total population: 82 million

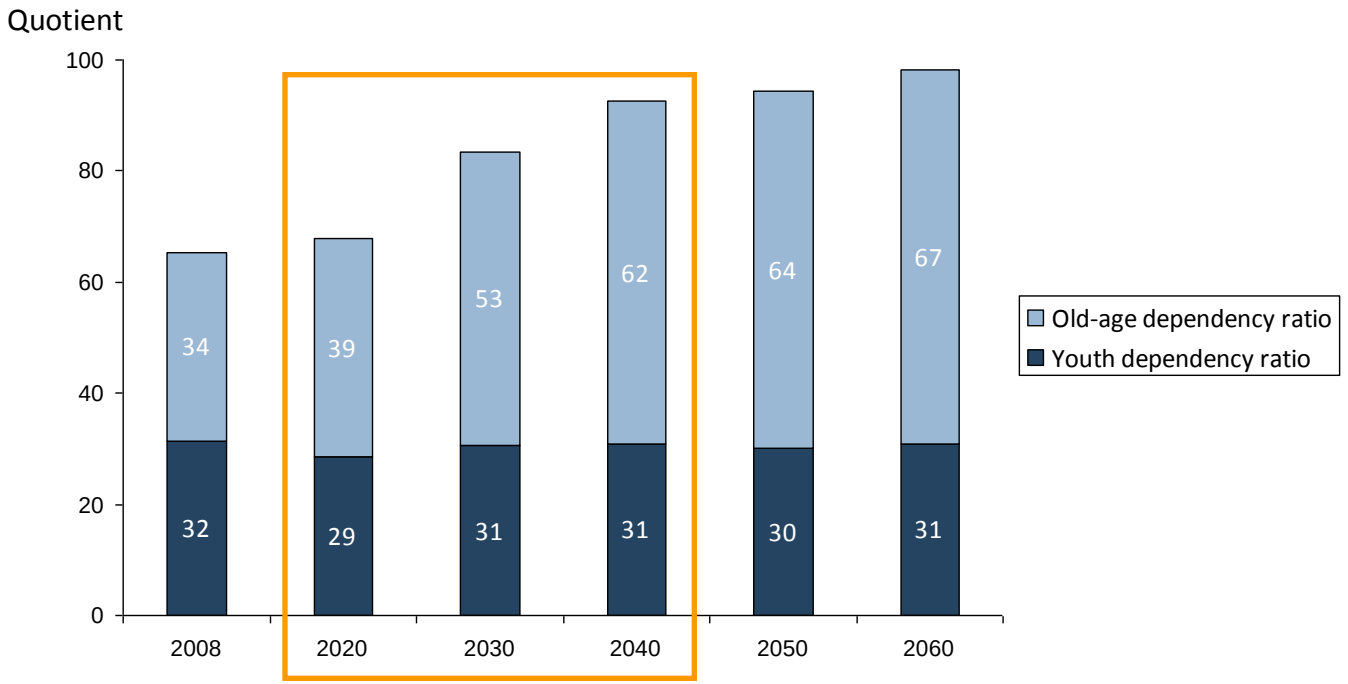
Total population: 80 million

Total population: 74 million

Source: German Federal Statistical Office 2009a

Current situation & projections

- Old-age & youth dependency ratios 2008–2060

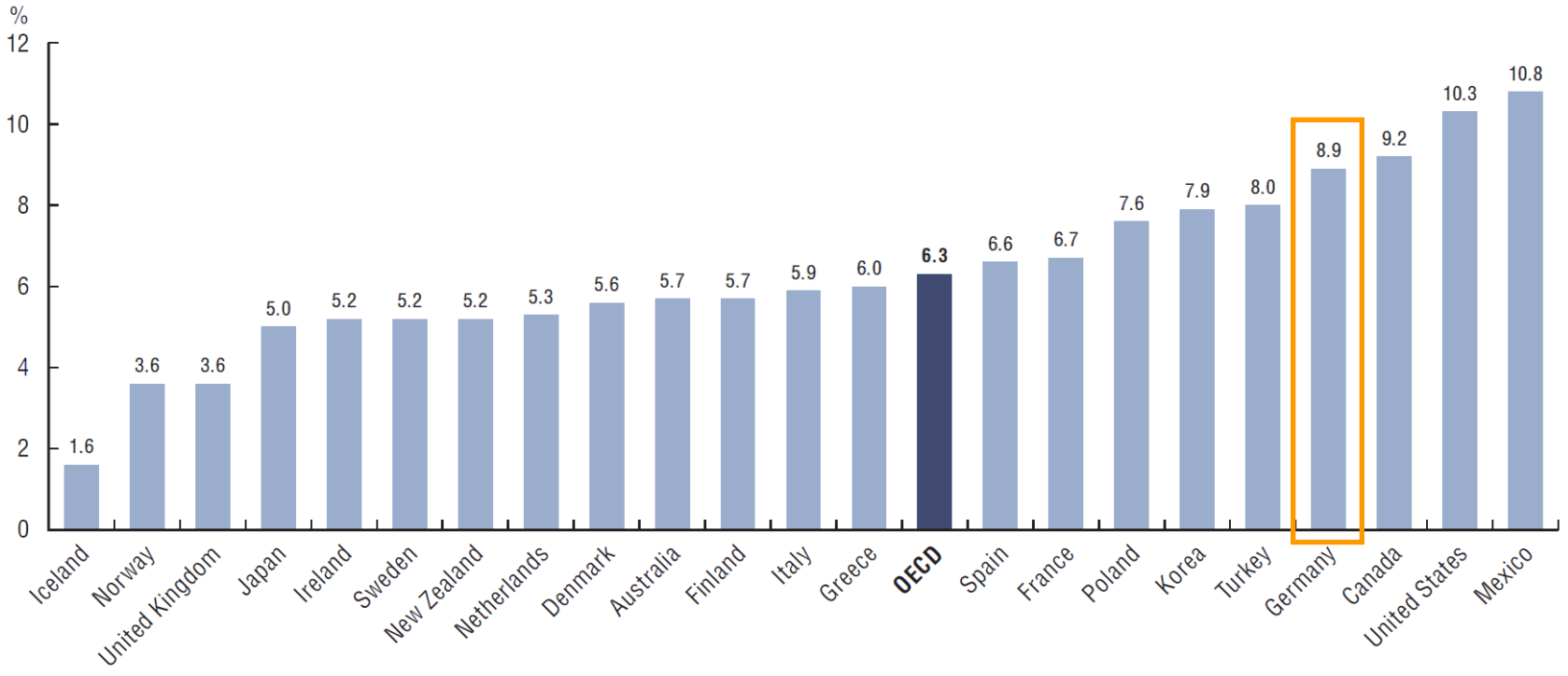


Notes: Youth dependency ratio = number of people aged 0–19 years per 100 people aged 20–64 years; Old-age dependency ratio = number of people aged 65 years or older per 100 people aged 20–64 years.

Source: German Federal Statistical Office 2009a

Current situation & projections

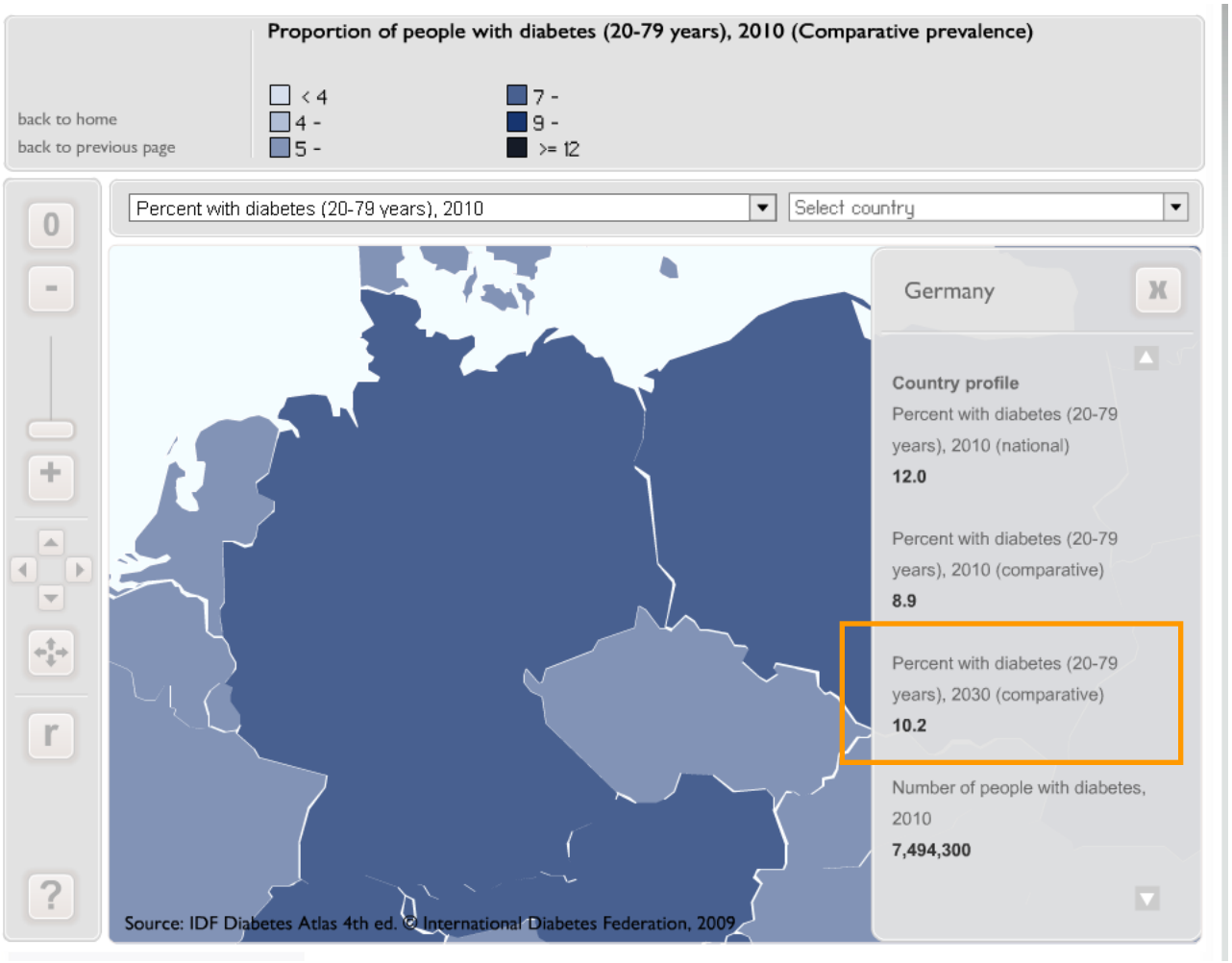
- Prevalence estimates of diabetes, adults aged 20–79 years (2010)*



*Data age-standardized to the World Standard Population

Sources: OECD 2009/IDF 2009; IDF 2010

Demographic change: implications for Germany



Sources: OECD 2009/IDF 2009; IDF 2010

Current situation & projections

- Prevalence estimates of dementia in Germany, according to age group (early 2007)

Age group	Average prevalence rate (%)	Estimated number of cases
65 – 69	1.2	66,000
70 – 74	2.8	111,000
75 – 79	6.0	184,000
80 – 84	13.3	288,000
85 – 89	23.9	256,000
90 and older	34.6	197,000
65 and older	**6.8**	**1,102,000**

Source: Deutsche Alzheimer Gesellschaft 2008

Long-term care in Germany

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The Five Pillars of the German Social Insurance System

- Health insurance (1883)
- Occupational accident and disease insurance (1884)
- Old age and disability insurance (1889)
- Unemployment insurance (1927)
- Long-term care insurance (1994)

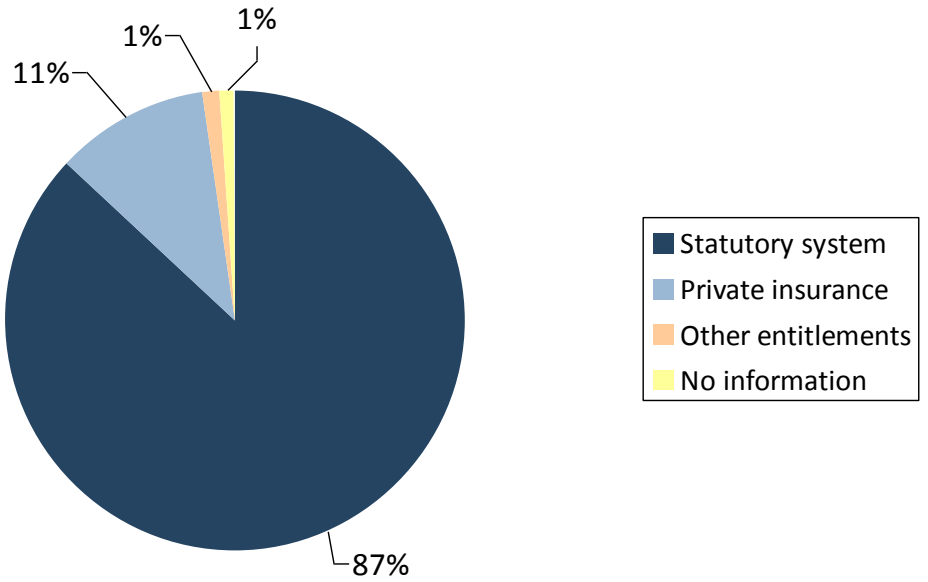
Organization of long-term care payers in the statutory system

- Statutory long-term care insurers are known in English as “long-term care funds” (*Pflegekassen*).
- Statutory health insurers are known as “sickness funds” (*Krankenkassen*).
- Both are quasi-public, not-for-profit corporations organized according to the principle of self-governance.
- The long-term care funds are administered by the sickness funds and are represented at the federal level by the Federal Association of Sickness Funds (*GKV-Spitzenverband*).

Population coverage

- Long-term care insurance coverage is automatic for
  - members of sickness funds and their dependents
  - people with full-cover private health insurance

- Virtually 100% of German population covered in 2007



Source: Busse R, Blümel M 2010

Financing of long-term care payers

- Contributions
  - Payroll tax of 1.95%, split equally between employer and employee (except in the state of Saxony)
  - Insured individuals without children pay an additional 0.25% (**not** employer-matched)
  - Upper threshold on which the payroll tax may be imposed is same as that used for the social health insurance contribution (in 2010: €45,000/year)
- Pay-as-you-go system

Source: Busse R, Blümel M 2010

Eligibility for long-term care benefits

- Persons of all ages who require frequent or substantial help with normal, day-to-day activities for an estimated 6 months or longer
- Day-to-day activities defined as: personal hygiene, eating, mobility and housekeeping
- Eligibility is not automatic; must be assessed by Statutory Health Insurance (SHI) Medical Review Board (*Medizinischer Dienst der Krankenkassen*)
- Eligible individuals assigned to one of three care levels

Source: Busse R, Blümel M 2010

Eligibility for long-term care benefits

Care level I (moderate needs)	Need help at least once a day with a minimum of two activities related to personal hygiene, eating, mobility or housekeeping.
	Help with housekeeping is needed several times a week.
	Overall average duration: at least 90 minutes daily (more than 45 minutes of which must be devoted to basic care)
Care level II (high needs)	Need help at least 3 times daily with personal hygiene, eating or mobility.
	Also need help several times a week with housekeeping.
	Overall average duration: At least 3 hours daily (at least 2 hours of which must be devoted to basic care).
Care level III (very high needs)	Need help round-the-clock every day with personal hygiene, eating or mobility.
	Also need help several times a week with housekeeping.
	Overall average duration of at least 5 hours daily (at least 4 hours of which must be devoted to basic care).

Source: Book XI of the German Code of Social Law (Section 15)

Eligibility for long-term care benefits

Care level I (moderate needs)	**≥ 1.5 hours/day (support with activities of daily living)**
Care level II (high needs)	**≥ 3 hours/day (overall duration; spread over 3 times daily)**
Care level III (very high needs)	**≥ 5 hours/day (round-the-clock care)**

Source: Book XI of the German Code of Social Law (Section 15)

Benefits

- Cash benefits
- Benefits in kind
- Combination of the two
- Some additional benefits (nursing aids, home modifications, nursing care courses)
- **None of the benefits are meant to cover all costs of long-term care**

Source: Book XI of the German Code of Social Law

Benefits

Home care (2010)

	In kind (per month)	Cash (per month)
Care level I (moderate needs)	max. €440	€225
Care level II (high needs)	max. €1040	€430
Care level III (very high needs)	max. €1510 (€1918 in exceptional cases)	€685

Source: Book XI of the German Code of Social Law (Sections 36, 37)

Benefits

Institutional care (2010)

	Day/night care (per month)	Full-time care (per month)
Care level I (moderate needs)	max. €440	€1023
Care level II (high needs)	max. €1040	€1279
Care level III (very high needs)	max. €1510	€1510 (€1825 in exceptional cases)

Source: Book XI of the German Code of Social Law (Sections 41, 43)

Costs of care vs. benefits

Full-time institutional care (2007)

	Average cost (per month)*	LTC benefit (per month)	Out-of-pocket (per month)
Care level I (moderate needs)	€2291	€1023	- €1268
Care level II (high needs)	€2717	€1279	- €1438
Care level III (very high needs)	€3142	€1432	- €1710

*Sum of nursing costs (national average) + €608 room & board (national average) + €376† "investment" costs

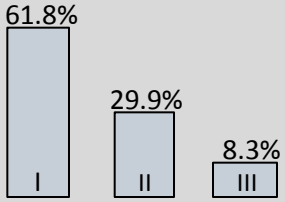
Sources: Germ. Fed. Stat. Office 2009b; SGB XI (Sections 41, 43); †Germ. Fed. Stat. Office 2007

Burden of disability and dependency

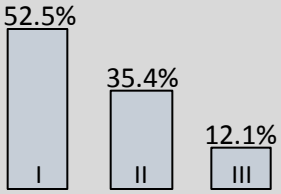
2.25 million people in need of long-term care
(2.5% of the population) in 2007

Home care
1.54 million recipients (68%)

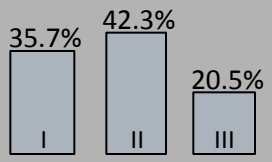
Informal care
1.03 million recipients



Professional care
504,000 recipients



Institutional care
709,000 recipients (32%)



Provided by family & other non-professional caregivers	11,500 providers	11,000 institutions

*1.5% not assigned

Source: Adapted from German Federal Statistical Office 2008b

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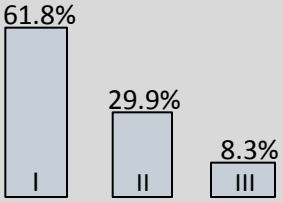

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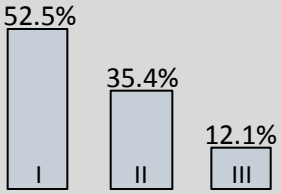

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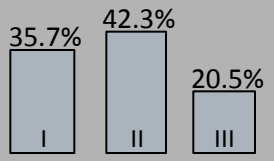

Provided by family & other non-professional caregivers

11,500 providers

11,000 institutions

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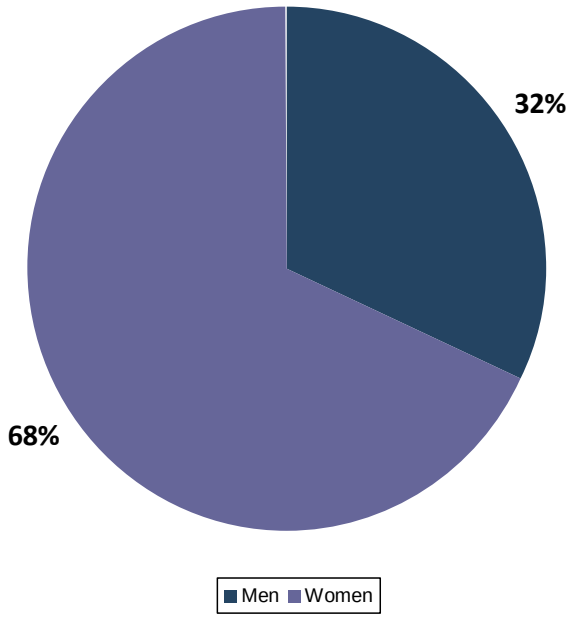
Gender



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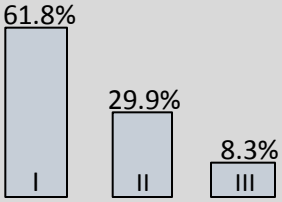

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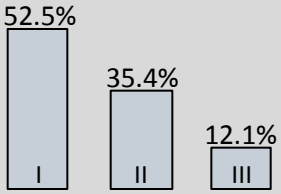

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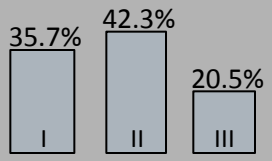

Provided by family & other non-professional caregivers

11,500 providers

11,000 institutions

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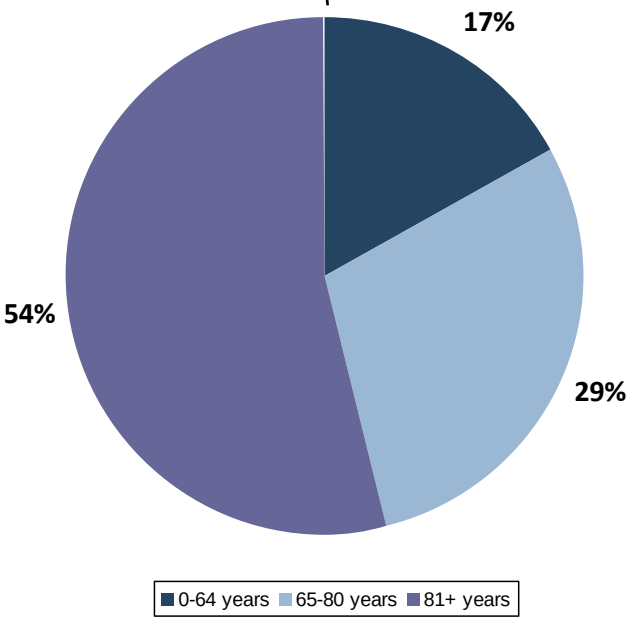
Age structure



Source: Adapted from German Federal Statistical Office 2008b

Burden of disability and dependency

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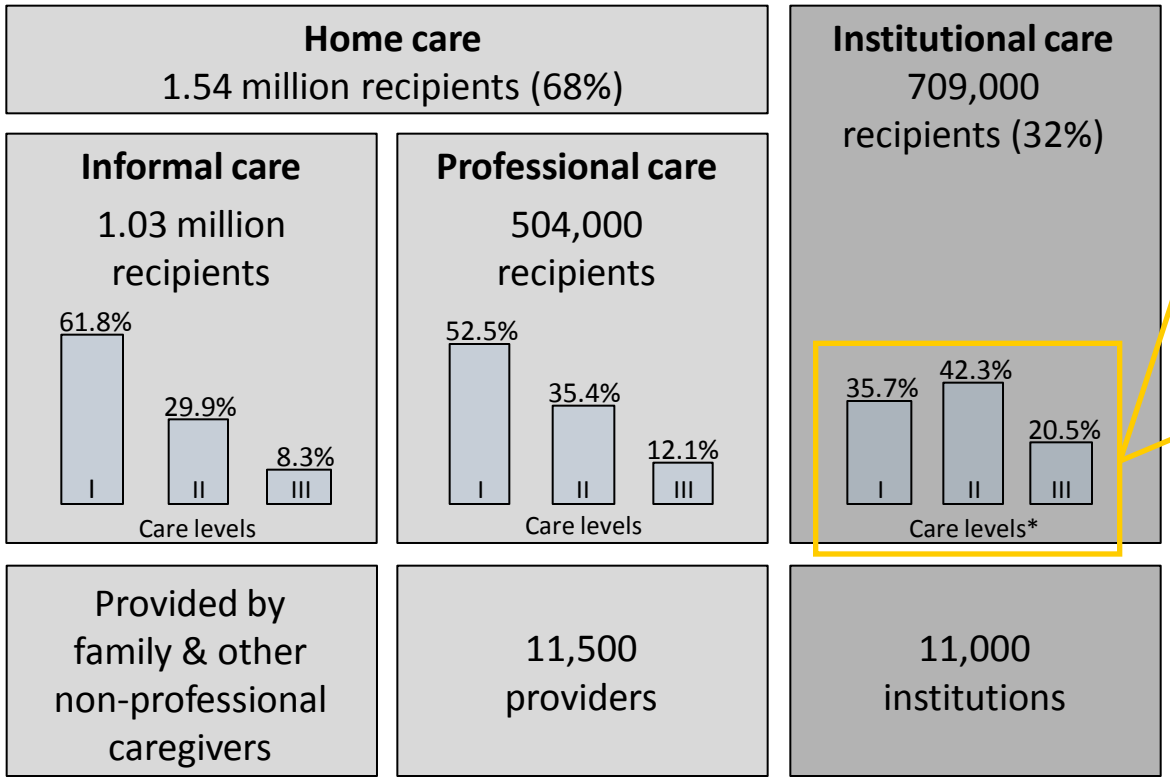


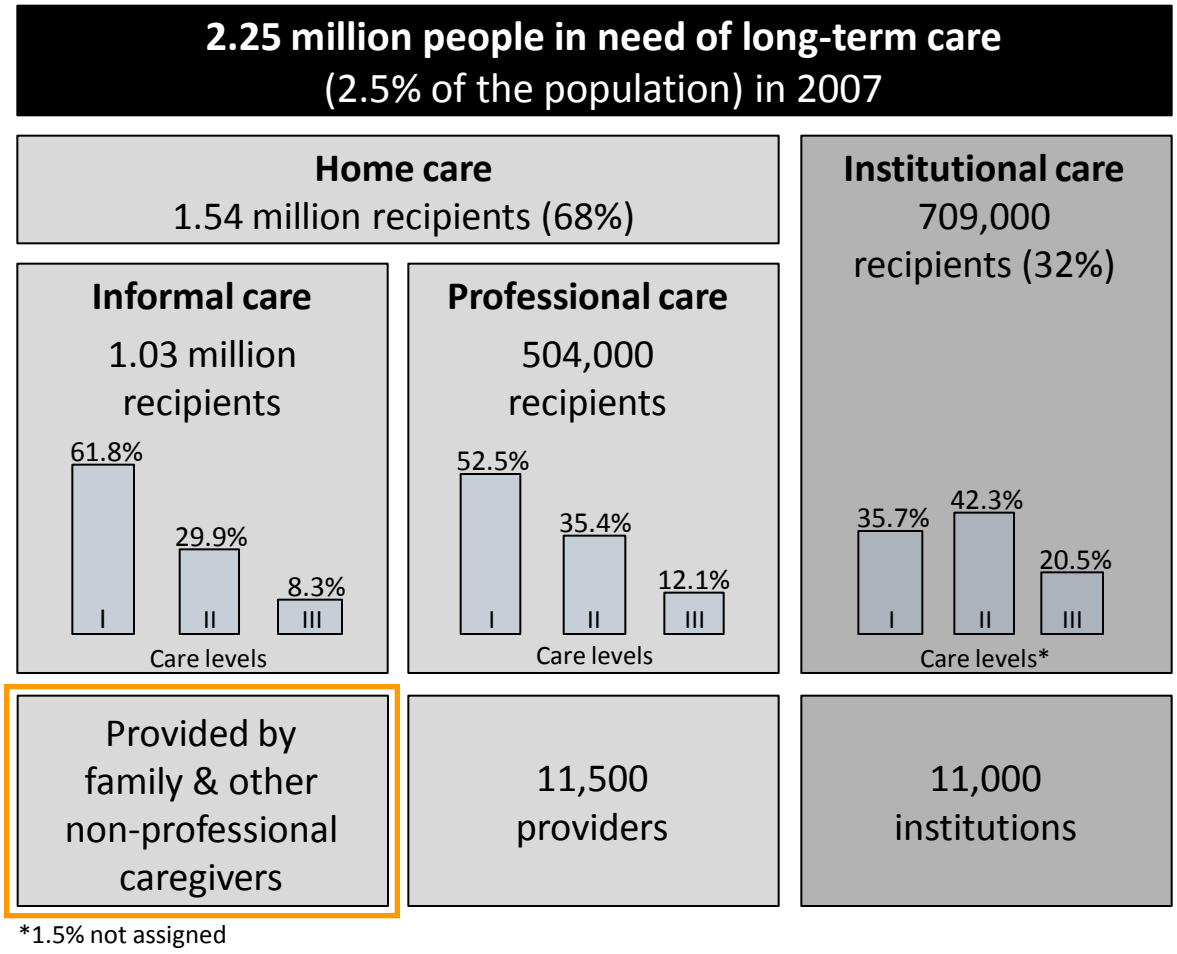
Older than those receiving care at home (48% vs. 28% were 85+ years old)

More likely to be female (76% vs. 64%)

*1.5% not assigned

Source: Adapted from German Federal Statistical Office 2008b

Burden of disability and dependency



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Structure of providers

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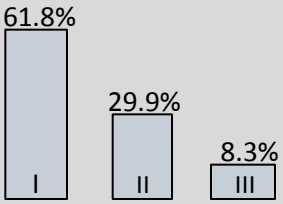


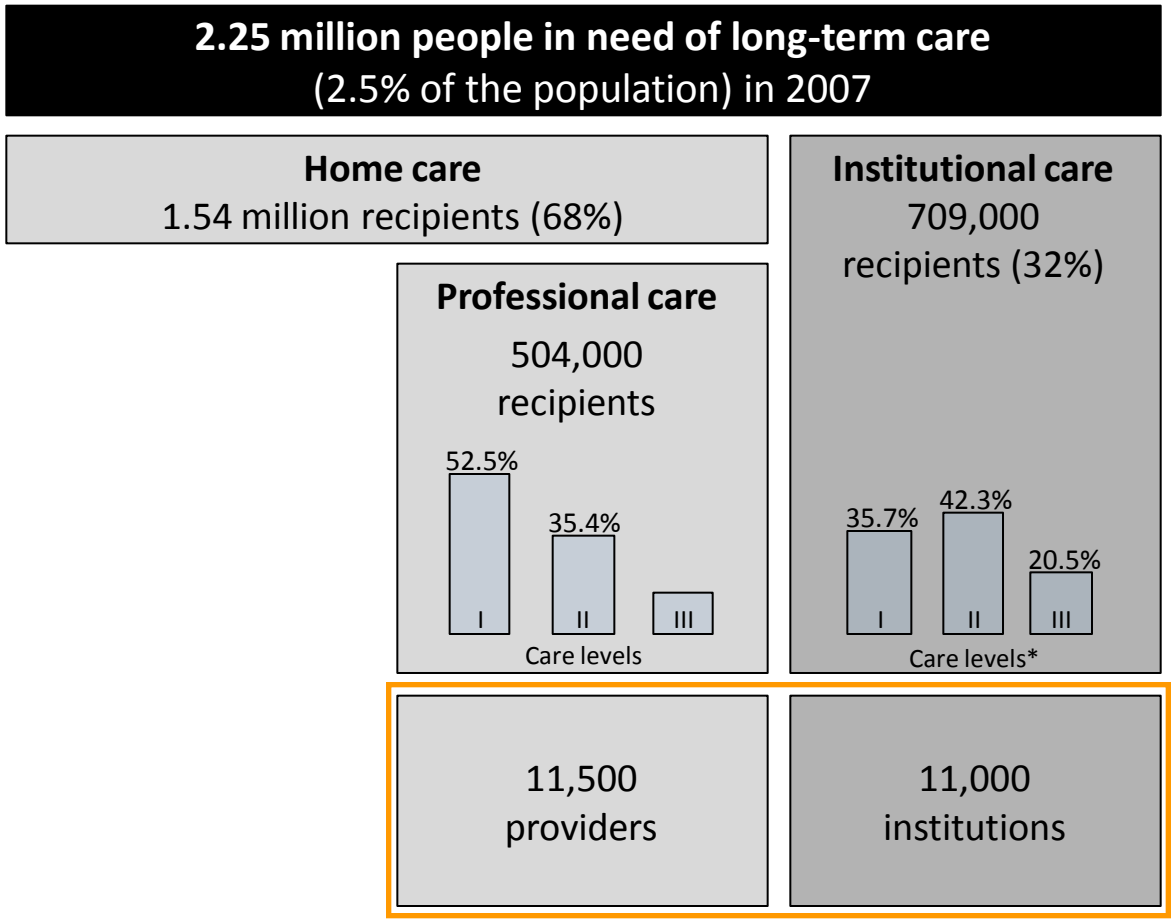
Provided by family & other non-professional caregivers

*1.5% not assigned

- **90%** women
- **33%** of informal carers are 65+ years old
- **60%** are between 40 and 65 years of age

Source: Adapted from German Federal Statistical Office 2008b; Busse R, Blümel M 2010

Structure of providers



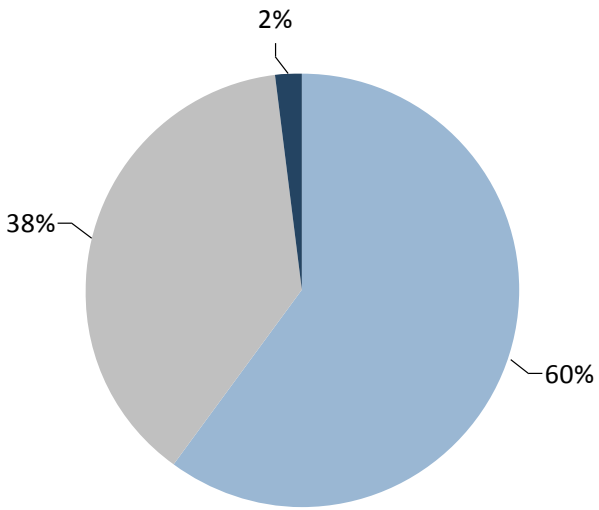
*1.5% not assigned

Source: Adapted from German Federal Statistical Office 2008b

Structure of providers

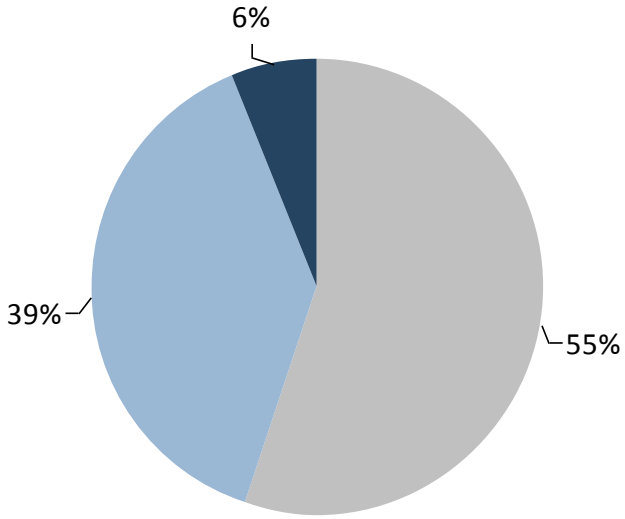
- Principle of subsidiarity applies to statutory long-term care scheme (i.e. private organizations have priority over public institutions in the delivery of care)

Professional home care services



Total providers: 11,500 (late 2007)

Institutional care



Total institutions: 11,000 (late 2007)

Private, for-profit providers | Non-profit organizations | Public providers

Source: German Federal Statistical Office 2008b

Problems with implementation / lessons to be learned

- Eligibility: emphasis on somatic criteria puts people with psychological conditions (dementia!) and their caregivers at a disadvantage

- Benefits: drawing line between services financed by social health insurance and services financed by long-term care insurance has proved to be problematic

Chronic disease management in Germany

Four ways that Germany is tackling chronic disease

- Prevention and early detection
- New provider qualifications and settings
- Disease management programs
- Integrated care

Disease management programs

- Relatively new development in Germany (legal framework introduced in 2002)
- Intimately related to the introduction of free choice among the sickness funds (and a risk adjustment scheme between them) in the mid-1990s
- Coordinating Committee (now part of the Federal Joint Committee, or *Gemeinsamer Bundesauschuss*) asked by legislature to identify conditions suitable for development of DMP based on
    - disease prevalence
    - potential for improving quality of care
    - availability of evidence-based guidelines
    - need for better coordination of care between sectors
    - high expenditure

Accredited disease management programs in Germany

	Enrollees in 2006	Enrollees in 2008	Enrollees in 2009†
Breast cancer (First DMP in 2003)	62,095	100,499	128,388
Type 2 diabetes (First DMP in 2003)	1,689,376	2,708,154	3,242,066
Coronary heart disease (First DMP in 2004)	589,408	1,221,374	1,562,970
Type 1 diabetes (First DMP in 2004)	17,791	93,357	127,663
Asthma (First DMP in 2006)	395	313,914	646,485
COPD (First DMP in 2006)	1802	264,299	506,566
Total:	**2,360,867**	**4,701,597**	**6,214,138**

Sources: van Lente et al. 2008; †German Federal Insurance Office 2010 (data from August 2009)

Key features of accredited DMPs in Germany

- Minimum DMP standards set by Federal Insurance Authority
- Voluntary for patients and providers; there are incentives to participate
- Physicians must meet defined training standards
- Patients must choose coordinating physician; details of ongoing coordination specified in each DMP
- Disease-specific objectives according to evidence-based guidelines
- Patient education & required active participation
- Psychological and psychosocial support
- Initial and follow-up documentation
- Mandatory formal evaluation of DMPs
- **Not linked to special DMP vendors or pharmaceutical companies**

Sources: Busse R 2004; Siering U 2008

How effective are DMPs in Germany?

- High-quality evidence is lacking! Most publications report on relatively small-scale interventions without control group or with inadequate control (e.g. no randomization).
- Second arm of ELSID Diabetes Study (Miksch et al., 2010)
  - Observational design; total of 11,079 patients
  - DMP and usual care groups matched according to a variety of criteria, resulting in 1927 matched pairs
  - Conclusion: Association found between DMP participation and reduction in all-cause mortality (in total sample and in matched population)
- HRQoL study based on ELSID data (Ose et al., 2009)
  - EQ-5D score; questionnaire mailed to random sample of 3546 patients
  - Conclusion: The number of comorbidities may have a negative effect on HRQoL in patients with type 2 diabetes. The German diabetes DMP may help counterbalance this effect.

Problems with implementation / lessons to be learned

- Use of DMPs as risk-adjuster in risk-adjustment scheme before January 2009: incentive for sickness funds to emphasize quantity rather than quality?
- Resistance from physician associations fearing loss of autonomy in treatment decisions
- Onerous documentation requirements for physicians
- Poor choice of study type for mandatory DMP evaluation: lost opportunity!
- DMPs not designed specifically to help patients with multiple chronic conditions

Thank you very much for your time and attention!

European Observatory on Health Systems and Policies

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