4QUALITY

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Quality of jobs and services in the Personal care and Household Services sector in Germany

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CONTENTS

1. INTRODUCTION

Germany is characterised by a family model, somehow dominated by the idea of the 'male breadwinner'. However, unlike in Southern European countries, Germany has a highly developed welfare state. The state has a constitutional obligation to provide social welfare (the Sozialstaat). The 'private social welfare', one of the pillars of social welfare in Germany, is based on the public-private cooperation and regulated in particular by the German Social Code.

Therefore, people in need of care in Germany can receive benefits in cash and have recourse to informal care givers in their home (solely), or benefits in kind to get professional home care services, or a combination of both[1]. As a matter of fact, two thirds of individuals prefer to be cared for at home[2].

From a household services perspective, Germany has also introduced specific employment contracts that today dominate employment in domestic services: the so-called 'Mini-Jobs'.

A significant part of personal and household services (PHS) are supplied by individuals, particularly undeclared workers. Various sources estimate that informal employment may reach 90-95% in Germany, a particularly high figure when compared to other European countries[3].

The 'For Quality' project's definition of Personal and Household Services (PHS) embeds both home services to people in need of care and to people that are not necessarily, and reads as follows: "*a broad range of activities that contribute to well-being at home of families and individuals: child care, long-term care for the elderly and for persons with disabilities, cleaning, remedial classes, home repairs, gardening, ICT support, etc*[4]*.*" On this aspect, it has to be noted that a non-negligible part of the data encountered during the development of the present report deal with "home care", which usually includes nursing activities.

[1] Schulz, E., The Long Term care system in Germany, ENEPRI report n°78, June 2010.

[2] Berringer, C., Suhr, R., Peer Review on priorities in reform of care services : Recent developments regarding care services in Germany, Sweden, 2013

[3] Cools, F., Stokkink, D. (dir.), Maarten, G., Valsamis, D., « European evidence paper on the development of personal and household services and the sectors potential to increase employment in Europe » , POUR LA SOLIDARITÉ, Febuary 2013

[4] European Commission, Staff Working Document on exploiting the employment potential of the personal and household services, SWD (2012) 95 final

2. NATIONAL OR LOCAL REGULATION AND POLICIES

2.1. Policy and legal backgrounds

The Home and Institutional Care act (Pflege-Versicherungsgesetz), from 1994, stands as the starting point for the last major reform initiated by the German Federal government to enlarge and improve the national health and long-term care system[5]. Along with pensions, health, accident and unemployment, it introduced a fifth branch to the social insurance scheme - the main framework for social security in Germany – which covers **long-term care (LTC)**[6] needs, as they were previously leading to pressure on the costs of health insurance. This is why, the Social Long-term Insurance (Pflegeversicherung, which we will refer to as "LTCI") was put in place in 1995[7].

Law of Care Enhancement, from 2008, enlarges the range of services covered by the LTCI.

Through LTCI funds, the German legislation provides for various forms of LTC services such as **benefits** for care giving at home **in cash** and **in kind (for community care)**, in day or night care institutions as well as in nursing homes (see table 1 in Annex 1) according to the level of dependency of beneficiaries[8]. So far, the dominant type of benefit of the LTCI is the cash allowance. Besides, **counselling** is provided to persons in need for care as well as their relatives. The scheme also provides family care givers with **training courses**.

The Employee Sending Act, which has been effective since April 2009, sets minimum standards for the working conditions of employees providing services in Germany through companies set in one of the other EU countries.

The Law of Care Time, which passed in 2011, entitles employees to take up to 10 unpaid leave days to take care of their relatives in case of recurring illness.

The Law of Family Care Time passed in 2011 to encourage family members to provide LTC for their families. This law enables employees to reduce their working hours to care for their relatives for a maximum of 2 years. Half of the deducted hours are paid to the employee by their employer. The other half is at the expense of the employee themselves: when returning to their job, employees make up for the expense imputed to the employer by receiving a salary reduced for as much as it has costed them. The Federal Office of Family Affairs and Civil Society Foundation offers employers interest-free loans in order to finance this measure.

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[5] Eurofound, More and better jobs in Home-care work, 2013

[6] Long-term care corresponds to a diversity of personal and household services (PHS) for dependent persons.

[7] Cools, F., Stokkink, D. (dir.), Maarten, G., Valsamis, D., February 2013

[8] Schulz, E., 2010

Law of Care Realignment, from 2012, ensures that financial aid is given by the federal government to help Germans invest voluntarily in their own private care insurance.

From a legal perspective, the need for LTC "*require a significant or major amount of help to carry out the daily and recurring activities of everyday life over a prolonged period of time, most likely for a minimum period of six months*" as a result of a physical, psychological or mental disease or handicap[9].

However, no legal definition of personal and household services exist in Germany, although this term is applied in German finance law. Instructions from the ministry of finance[10] point to this lack of a legal definition and provide a description of what shall be treated as household related services: a job in the sector "household-related services" is a job, which has a strong relationship to the respective household. The activities include the preparation of meals, home cleaning, garden work, and care for elderly dependent persons, disabled people, or children. Remedial classes or recreational activities are not covered.

Besides, in view of improving the working conditions in the PHS sector, Germany was the 2nd EU member state - after Italy - to ratify the C189 ILO Domestic Workers Convention in 2011. It has now entered into force[11].

This has been reinforced by the recent publication of a new standards procedure towards information, advice and placement of personal and household services, which are applicable to all suppliers: DIN SPEC 77003.

As for household services per se, it has to be noted that the rise in personal and household services in Germany was strengthened during the 1990's by the appearance of 'mini-jobs' and then by the Hartz IV reform (2003), which made 'mini-jobs' more flexible and created 'midi-jobs'. Mini-jobs are those from which the monthly revenue does not exceed €450[12]; they provide employees the right to full exemption from social security contributions, whereas employers pay higher social security contributions (30% compared to around 19% for other forms of employment). Midi-jobs are those that provide a monthly salary of between €400 and €800; these provide workers the right to a sliding-scale reduction in social security contributions. In 2010, 230,000 people were working in mini-jobs providing domestic services in Germany (around 3% of the total number employed in mini-jobs). Only people directly employed by a private household can benefit from this system (organisations are excluded).

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[9] Schulz, E., 2010

[10] Bundesministerium der Finanzen, "Anwendungsschreiben des BMF zu §35a EStG": http://www.paritaet-alsopfleg.de : http://bit.ly/1TTaCz9. Last consultation 19/08/2015

[11] International Labour Organisation (ILO), Ratifications of C189, http://www.ilo.org/: http://bit.ly/1Mm9kH2. Last consultation 13/08/2015

[12] Conseil Central de l'Économie, Lettre menseulle socio-économique, N°190, 30/04/2013, p.10

Furthermore, in 2009, the Family Benefits Act was adopted, which provided the possibility for households that use domestic services to benefit from a tax reduction of 20% of the costs of these services, up to a maximum of €4,000 (€20,000 in costs)[13][14].

2.2. Structural framework, funding and actors involved

The Social Long-term Care Insurance provides support for everyday activities (personal hygiene, eating, mobility, and housekeeping). **Cash benefits** are granted to dependent persons according to the individual care level of the user concerned (see table in Annex 1) [15]:

- Care level I (need for care at least once a day): €235 (2012);
- Care level II (need for care at least three times per day): €440 (2012);
- Care level III (need for round-the-clock-everyday help): €700 (2012).

The German population, far from exempt from the ageing phenomenon that is well-known in Europe, still highly depends on the involvement of family members to maintain people with disabilities in their homes as long as possible. The changing family structures have caused a higher recourse to community-based solutions for the care to disabled people – below the retirement age:

- Assisted living residences;
- Care cooperatives;
- Nursing services and ambulatory medical services;
- Volunteering groups and non-profit self-support organisations[16].

The German LTCI system includes benefits for home care – including from informal care giver – and institutional care:

- Benefits in-kind for community care;
- Benefits in cash for informal care;

[13] POUR LA SOLIDARITÉ, Personal Care Services in Europe: European approaches and perspectives on a challenge for the future, January 2012, pp. 24—25.

[14] Cools, F., Stokkink, D. (dir.), Maarten, G., Valsamis, D., February 2013

[15] Schulz, E., 2010

[16] Eurofound, 2013

- Combination of benefits in cash and in kind;
- Respite care at home during a vacation or illness of informal carers;
- Medical equipment and technical aides;
- Day care and night care;
- Short time institutional care;
- Full-time institutional care;
- Long-term care giving in institutions for the disabled;
- Benefits for social security of informal carers;
- Benefits for carers who take long-term care leave;
- Training courses for family carers and voluntary carers;
- Additional benefits for people whose competence in coping with everyday life is considerably impaired;
- Benefits for a personal budget[17].

Since it is now linked to the well-spread social insurance, the LTCI covers almost the entire population in Germany (over 70 million people[18]). People who have subscribed a full-cover private health insurance must acquire a private equivalent, providing the same benefits as the universal public health insurance system[19]. The private insurance system covers another 8.5 million people[20]. The disabled can claim benefits from the LTCI funds on top of the benefits for disabled persons.

Funding of the LTCI is ensured by a system of salary deductions, the amount of which is calculated based on citizens' income.

In 2009, we count seven types of statutory health insurance funds, and therefore LTCI funds. They are legally mandated and under government supervision by law, but remain organisationally and financially independent: they are based on self-administration. They are

[17] Schulz, E., 2010

[18] Kümmerling, A., And who cares for the carer? Elderly Care Work in Germany, Walqing social partnership series 2011.16., September 2011

[19] Schulz, E., 2010

[20] Kümmerling, A., 2011

organised under the Central Association of Health Insurance Funds (GKV-Spitzenverband), which also administers the tasks of the Federal Association of Long-Term Care Insurance Funds (Spitzenverband Bund der Pflegekassen). Together with the following organisations – and with the participation of the Association of Private Insurance Funds - they manage the organisation of long-term care tasks, based on self-government:

- The Federal Working Group of Supraregional Social Welfare Agencies (Bundesarbeitsgemeinschaft der überörtlichen Träger der Sozialhilfe);
- The Confederation of Municipal Authorities' Associations (Bundesvereinigung der kommunalen Spitzenverbände) ;
- the Federal Association of Long-term Care Providers.

Altogether, LTCI funds are *"mainly responsible for capacity planning, monitoring the organisation of care provision and the assessment of long-term care, but also for quality control*[21]*."*

The assessment of needs for PHS is carried out by one of the fifteen Medical Boards (from the Medical Advisory Service of the Statutory Health Insurance Funds, which will determine whether a citizen is entitled for benefits.

Together with the above-mentioned associations, the Medical Advisory Board of the Health Insurance funds set up guidelines for Quality control, be it in institutions or for home care services. Finally, the Medical Advisory Service is in charge of conducting quality audits.

[21] Schulz, E., 2010

3. WORK AND EMPLOYMENT QUALITY

3.1. Career and employment security

As already stated, in Germany, informal care activities are often shared among some members of the beneficiaries' families. As a matter of fact, "*family members providing any kind of help or personal care*[22]" are estimated to amount to 5 to 7 million people, out of a total population of 82.2 million. On the other hand, according to the Federal Statistical Office of Germany on Long-term care statistics, and after calculation by DIW Berlin, only 236,162 persons were employees as staff in home care services in 2007[23]. Therefore, even taking only the lower estimation into account (i.e. 5 million informal carers), formal care givers would only represent 4.5% of all individuals providing long-term care services in 2007.

As a result, assessing the career and employment security perspectives of home carers in Germany is rather difficult, most of the persons undertaking these tasks not being in any contractual relationship for it. Worse still, they tend to be unemployed, reduce their working hours or leave their job to take care of their relatives: according to a survey from 2002, 50% to 60% of informal care givers aged between 15 and 64 years are not employed, and only 19% to 32% of them work full time[24]. A direct consequence is an indubitable lack of professional perspectives for women with a dependent relative: with sons providing help mostly with financial tasks, spouses, daughters and daughters in law are mostly responsible for personal care of their relatives: in this respect, the ENEPRI study[25] reports that "*28 % [of beneficiaries] receive help from their partner, 32 % from the daughter or daughter in law, and 10 % from their son (main care givers).*"

On the other hand, more conclusions may be drawn from the domestic services sector in this particular section. According to statistics from the public administration for mini jobs ("Minijobzentrale"), over 240,000 workers that are subject to social security contributions were employed by private households (i.e. domestic services) in June 2012. Although this measure has gone with significant impact on employment, in particular in the PHS sector, an increase in low pay and precarious forms of employment have been monitored, including the rise of "working-poor"[26].

[22] Schulz, 2010 (p.14)

[23] *Ibid*. (p.45)

[24] Schneekloth, U., Leven, I., Hilfe- und Pflegebedürftige in Privathaushalten in Deutschland 2002 (People in need of care in private households in Germany in 2002), Infratest Sozialforschung, München, 2003

[25] Schulz, 2010 (p.14)

[26] Farvaque, N., Developing personal and household services in the EU - A focus on housework activities, Report for the DG Employment, ORSEU, 2013

3.1.1. Employment status

Contractual relation between employer and employee

Concerning LTC, the private and associative sectors share the market for care service to dependent people with respectively nearly two thirds and 37%[27]. Thus, triangle labour relationships prevail for most of the LTC market in Germany. On the other hand, no contractual relation is foreseen between the user (beneficiary) and the provider (care giver) when the services are informally provided by a kin. As for household services formally provided, direct employment is generally observed, a requisite of the mini-job scheme.

Existence of a collective agreement

No data gathered at this stage. More information is requested from participants.

Nature of employer

The Eurofound reports that "*between 2007 and the end of 2009, the number of employees liable to social security contributions who work in the community-based care sector [i.e. home-care as well as residential care] increased by 13.9%, which equals to approximately 33,000 new jobs*." The number of employees in home-care services or nursing homes has thus been increasing. However, statistics do not cover independently working carers and cannot be extracted from other statistics. Yet, it is estimated to amount approximately 200.000[28].

Has this tendency continued since 2009? If so, participants are kindly invited to provide us estimated figures.

The burden for family (employed) carers being such that they often engage extra private-financed home carers. The latter were estimated to amount 100.000 persons in 2008[29]. Notably, persons aged over 80 with substantial impairments in activities of daily living and living alone engage additional home helpers.

Temporary contracts

No data gathered at this stage. More information is requested from participants.

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[27] Kümmerling, A., 2011

[28] Schulz, E., Pflegemarkt: Drohendem Arbeitskräftemangel kann entgegengewirkt werden (Care market: the threat of staff shortage can be tackled), *DIW Wochenbericht*, Vol. 51/52, 2012, pp. 3–16

[29] Schulz, E., 2010

Regularisation of undeclared work

A large percentage of PHS is supplied by individuals, particularly undeclared workers. However, their number can only be estimated: according to various sources, informal employment in private households may reach 90-95% in Germany, which is particularly high when compared to other European countries[30]. No data has been found on the share of *illegal* employment, including when it comes to migrant work.

Several instruments exist to support the creation of formal employment in the sector of domestic services and social care. The most important is the so-called 'mini-job'[31].

More information is requested from participants, especially on the evolution of the black market as far as PHS are concerned.

Migrant work (figures)

As mentioned above, families do have recourse to additional informal helpers. This is particularly the case when beneficiaries need round-the-clock supervision but opt for an alternative to institutional care. Because of their lower wage, east-middle European carers are usually preferred[32]. The number of undeclared workers from Central and Eastern Europe are estimated at between 100,000 and 150,000[33].

More information is requested from participants.

3.1.2. Income and wages

Minimum wages

The Employment Conditions in the Care Sector Act set the statutory minimum wage for the sector at 9.40€/hour in the western federal states and 8.65€/hour in the eastern federal State in 2010[34].

Family care givers may be paid thanks to the cash benefits received by the person they take

[30] POUR LA SOLIDARITÉ, 2012, pp. 21—25.

[31] Cools, F., Stokkink, D. (dir.), Maarten, G., Valsamis, D., February 2013

[32] Schulz, E., 2010

[33] Pennekamp, J., Geschäfte in der Grauzone. Faz-online: http://www.faz.net/: http://bit.ly/1JsKLJp. Last consultation : 17/08/2015

[34] Wage Indicator and Lohnspiegel, Minimum Wages in Germany with effect from 01-01-2015 http://www.wageindicator.org/: http://bit.ly/1Po6WyJ. Last consultation on 13/08/2015

care of. The amount of benefits varies according to the need of care (see Annex 1).

Employed care givers with (free) board and lodging earn on average between €800 and €1200.

In the case of long-term care services provided to the elderly at their home, it is reported that some providers do not even pay for their employees' costs neither for petrol nor their commuting time, which lowers the income of some care workers.

Median wages

No data gathered at this stage. Information is requested from participants.

3.1.3. Social protection

Access to social protection, retirement

All active people (defined as people who work more than 18 hours a week) are legally obliged to subscribe to social insurance schemes; this makes coverage almost universal. Membership of a care insurance scheme is compulsory for people with sickness insurance coverage. All support for carers in Germany is provided through the long-term care insurance scheme. Thus informal carers' access to support is entirely dependent on the insurance entitlement of the person receiving care. The benefits provided to informal carers include: respite, holiday or stand-in care, technical aids (such as home nursing equipment), or insurance cover (retirement pension and accident insurance for informal carers)[35]. The LTCI funds may even pay their pension contributions; the conditions are to provide care at least 14 hours per week and to be unemployed or to work less than 30 hours per week.

When it comes to people employed under a mini-job contract, they have the possibility to pay the complement for their pension contribution (13.9% in the case of PHS), but this is not compulsory. However, social contributions, although they are reduced or null for the employee (thanks to a higher contribution from employers), remain compulsory under the mini-job scheme. Nonetheless, this status alone does not entitle workers to the social security; another job can entitle mini-jobbers to social security, where contribution from their mini-jobs can be aggregated. Yet, at the end of 2011, the major part of mini-jobbers (i.e. 5 million workers) only had a mini-job. Some of them received other revenues such as retirement or unemployment benefits. One can conclude that the structure offered by the mini-jobs does not constitute a solid safety net for PHS workers in terms of social protection and retirement pension.

[35] Cools, F., Stokkink, D. (dir.), Maarten, G., Valsamis, D., February 2013

3.1.4. Workers' rights

Rights to collective bargaining

One of the direct consequences of the recourse to informal employment for the provision of PHS is a certain lack of organisation of workers. This yields a worse position in negotiations about wages, working conditions, tasks, etc. However, the association "Bundesverband Haushaltsnaher Dienstleister"[36] is a group representing the interests of a very homogeneous group of commercial providers of domestic services.

Little data gathered at this stage. More information is requested from participants according to the different job statuses.

Non discrimination

No data gathered at this stage. More information is requested from participants.

3.2. Skills development and professionalization

3.2.1. Qualification

Qualification requirements

No data gathered at this stage that do not concerned health care for the elderly (nurses). More information is thus requested from participants.

3.2.2. Training

Access to vocational training

Landërs are in charge for training the workforce engaged with vulnerable people. Besides, informal care givers are entitled by LTCI funds to receiving free training courses.

More information is requested from participants, in terms of the nature/length/conditions of training for formal carers, but also perhaps concerning the training of informal carers.

[36] For more information: http://www.bhdu.de/

3.2.3. Career development

Transitions into jobs

No data gathered at this stage. More information is requested from participants.

3.2.4. Recruitment and staff shortages

The need for PHS, in particular that to the attention of dependent persons, is strongly related to age[37]. Therefore, with the ageing population, the Federal Statistical Office foresees an increase of people requiring long-term care, from 2.3 million in 2011, to 3.2 million in 2030, and to 4.2 in 2050[38]. Besides, the number the German workforce will diminish as a result of significant demographic shifts. Germany is likely to further seeking immigration, in particular from non-EU countries[39].

Strategies to recruit and retain employees

As in most European countries, Germany is subject to a general shortage of staff in the LTC sector, especially in the group of qualified workers for the elderly care sector[40].

More information is requested from participants.

Tackling staff shortages

Although it is known a certain staff shortage exists, in particular in the long-term care provided to the elderly, no data has been gathered at this stage concerning the actions taken to tackle staff shortages. More information is requested from participants, not only concerning care for the elderly, but other populations as well as for house work activities, regardless of social/health condition of the user.

[37] Schulz, E., 2010

[38] German Federal Ministry of Health, Selected facts and figures about long-term care insurance, (2012a), http://www.bmg.bund.de/: http://bit.ly/1E6Llu5. Last consultation on 20/08/2015.

[39] Eurofound, 2013

[40] Berringer, C., Suhr, R., 2013

3.3. Health and well-being

3.3.1. Work organisation

Access to occupational medicine

No data gathered at this stage. More information is requested from participants.

Is the work organisation protecting the employee or putting her/him at stress?

No data gathered at this stage. More information is requested from participants.

3.3.2. Risk exposure and health problems

Sick leaves

The LTCI funds cover the expenses of a professional carer or of another family member in a situation where an informal carer is ill, up to 4 weeks per year and up to €1470. However, annual leaves are also embedded in this maximum of 4 weeks leave.

As for professional elderly care workers, they tend to call sick more often than workers from other sectors[41].

More information is requested from participants when it comes to formal PHS workers, regardless of social/health condition of the user.

[41] Kümmerling, A., 2011

Stress-related work

Concerning long-term care activities, studies report an increasing time pressure over the years as well as more and more administration duties and work concentration. The latter results from strong guidelines that employees must follow. Besides, some studies show that the time set for driving from a patient's house to another is not realistic, and thus leads to delays as of the first client in the day[42]. The same study, which is based on national stakeholders' analysis, also mentions the fact some employees complain about the rigidity of the framework provided for each care activity (to the elderly) as it gives them little time to build a relationship with users, or to adapt their care activities to their day-to-day needs; this can cause moral conflicts and additional time pressure.

As for informal carers, LTCI funds provide them with counselling services, including the possibility to have an individual contact person within LTCI.

More information from participants is welcome.

Harshness of work

The jobs of home care giver/domestic worker are known for their high physical and emotional demands. As a matter of fact, a survey has shown that 50% of elderly care workers do not think they will manage to keep the same job until retirement age[43]. The job appears to be particularly demanding in the case users from for the oldest old (80+): additional help from professional carers is often requested for older beneficiaries[44]. In 2007, almost all persons receiving benefits in kind (formal PHS) were at least 80 years old.

All in all, working conditions vary greatly from one patient to another; the facilities (lift aids, special beds, etc.) provided in the users' houses are not all equal. It is also reported that the nature of the job gives few possibilities for home care givers to discuss job matters. This can somehow create a feeling of isolation.

No data gathered at this stage. More information is requested from participants.

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[42] *Ibid.*

[43] *Ibid.*

[44] Schulz, E., 2010 (p.15)

3.4. Work/Life balance

Working time and work schedules

The share of part-time jobs delivering home care services under the LTCI in Germany amounts 70.6%[45]. As a matter of fact, the Walqing study states that many providers of long-term care services dedicated to the elderly have recourse to part-time workers and marginal part-timers to make sure to provide to all patients the attention they need, especially during peak times (morning and evening toilet, meals, etc.).

Non-standard working arrangements (night work, work on Sunday)

No data gathered at this stage. More information is requested from participants.

Journeys between care interventions

No data gathered at this stage. More information is requested from participants.

Working time - Part-time work (voluntary and non-voluntary)

The Walqing study reports that some union representatives have observed that marginal part-time work in home care has significantly increased in the LTC sector as a whole[46]. It also states that part-time workers "*are more inclined to work (non-compensated) overtime and often have bad working times or split shifts (two hours in the morning, two in the evening).*" The conclusion can be drawn that marginally employed care workers are particularly vulnerable in the PHS sector in Germany.

More (detailed) information is requested by participants here.

[45] Eurofound, 2013

[46] Kümmerling, A., 2011 (p.6)

4. SERVICE QUALITY

Overall, PHS are not provided by the public sector, but the latter plays an important role in regulating the quality for personal care with the availability of quality criteria at federal level.

More information would be needed in this sector concerning housekeeping activities carried out through the mini-job employment scheme in particular.

4.1. Availability of services

The number of people in need of care is difficult to quantify. Yet, it is estimated that 3 million people would need home help (housework mostly), but do not fulfil the eligibility criteria to the private and social LTCI funds.

Besides, since July 2008, it takes two years to qualify for benefits under the LTCI. Yet this represents 3 years less than before[47].

More information would be needed, in particular on how actors manage to offer availability of services to anyone ?

4.2. Affordability

LTCI funds negotiate the services and their prices with each care providers. The negotiation being done collectively potentially enables raising buying power.

The LTCI funds cover 75% of the costs of users who choose to be treated from their home, regardless of their age, income or wealth. The remaining 25% are at the expense of users. When the latter cannot afford to co-finance the services, their families must contribute financially (within limits defined by the law). Additional private insurances exist that users – and/or their families - can subscribe to cover these expenses[48].

NB: Contradictory information was found, with a study indicating that "In general, all benefits are capped or given as lump sums. In nursing homes expenses are only co-financed[49]." Or "While the benefits for home care services covers the costs for personal care and help with practical duties according to the level of need of care assessed by the Medical Board Services, the

[47] Schulz, E., 2010 (p.2)

[48] Eurofound, 2013

[49] Schulz, E., 2010

benefits for institutional care covers only a part of the total costs of nursing homes[50]."

More (detailed) information is thus requested from participants on this aspect.

When users cannot afford - even if only partially - the cost for receiving long-term care services, they can apply for means-tested social assistance[51]. *More information is requested by participants here.*

In another vein, a family care giver can take up to 4 week vacation with the LTCI covering the expenses for a professional carer. However, a ceiling applies which is fixed at €1470[52].

Finally, as of July 2008, persons living under the same roof are entitled to pool claims to benefits in kind.

More information is kindly requested from participants on this particular aspect.

4.3. Comprehensiveness of services

When medical boards conduct in-home assessments to assess the need of individuals for PHS, they used to focus largely on physical needs for personal care, nutrition, and mobility. The needs for assistance or supervision were de facto overlooked. Yet, persons with dementia or learning disabilities often need such services[53]. Persons having difficulties to cope with daily activities are now assessed with a different set of criteria; besides, they are entitled to receive benefits with Care level 0. Since January 2013, when fulfilling superior care levels, beneficiaries receive enhanced benefits and services.

Little data gathered at this stage. More information is requested from participants.

Besides, it is sometimes reported that in the case of users diagnosed with dementia, a problem lies with the lack of consideration for the users' gradual loss of independence. Thus, an adapted definition of LTC may help including the needs of all users with limited independency.

[50] Schulz, E., 2010

[51] *Ibid.*

[52] *Ibid.*

[53] *Ibid.*

4.4. Quality of regulation

The German care market is very much regulated, with strict descriptions of the kind of care required by a patient, its length and frequency. Besides, the Medical Advisory Board of the Health Insurance funds set up guidelines for quality control, be it in institutions or for home care services. Quality audits are conducted by the Medical Advisory Service.

In 2003, Germany standardized the vocational training for elderly workers by federal law. Thus, Länders no longer regulate the training themselves. As of now, they are only responsible for the Implementation of training.

More (detailed) information is welcome (quality criteria, quality controls, training requirements, etc…).

Concerning LTC, one of the first quality measures of personal care and housekeeping services to people who receive cash benefits is for a professional care giver to review their situation and report it to the LTCI. The responsibility of calling such professional lies within falls under the beneficiary's. Depending on their care level, beneficiaries receive the visit of a professional care giver from two to four times per year.

Besides, when stresses in caring of informal care givers are assessed, help is offered, when possible. This can lead to measures to improve the home environment[54].

It also has to be noted that, from 1999 to 2007, the recourse to formal home care or institutional care has increased in all care level, to the detriment of LTCI's in cash benefits dedicated to the provision of informal home care services. This is particularly true for older age-groups. *However no qualitative or quantitative data has been found on the improved (or not) quality of the services provided. More information from participants would be of help here.*

Besides, a significant number of good practices have been identified. We can mention the German Charter of Rights for People in Need of Assistance[55], which gives a detailed list of the rights of people living in Germany who are in need of long-term care and assistance. Several dissemination and quality tools were developed on the basis of the Charter, such as wide awareness-raising activities, charter-oriented quality management tools (e.g. self-evaluations, quality circles, mission statements, target agreements) and training material. The Charter is also

[54] *Ibid.*

[55] German Federal Ministry of Family Affairs, Senior Citizens, Women, and Youth and the German Federal Ministry of Health, Charter of Rights for People in Need of Long Term Care and Assistance, 2007: www.pflege-charta.de: bit.ly/1NCpIlp. Consulted on 18/08/2015

used to develop external quality control tools and legislation[56] [57].

4.5. Quality of management and organisational level

Parties responsible for the management and organisation for the provision of long-term care must ensure that national quality standards are developed and updated.

Home care services that have been licensed by a service provider agreement are audited by the medical review board of the statutory health insurance and its counterpart in the Association of Private Health Insurance Funds.

No recent data has been found on the help received by users to choose between cash and services or in developing a care plan or on the coordination of services, especially when multiple persons are involved. More information is kindly requested from participants.

As mentioned earlier, the DIN SPEC 77003 standards procedure for information, advice and placement of personal and household services was published in April 2015. *More information (in English) about its implications is very welcome.*

[56] For more information: http://wedo.tttp.eu/: http://bit.ly/MeIgYL. Last consultation on 18/08/2015

[57] AGE Platform Europe, European Quality Framework for long-term care services, Principles and guidelines for the wellbeing and dignity of older people in need of care and assistance, European project WeDO, 2010-2012.

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6. Annex 1

Benefits provided by the LTCI scheme

		previously	As of 1.7.2008	2010	2012
Home care	*Care allowance*	up to per month in Euro			
Benefits in cash	Care level I	205	215	225	235
	Care level II	410	420	430	440
	Care level III	665	675	685	700
	Care Assistance	up to per month			
Benefits in kind	Care level I	384	420	440	450
	Care level II	921	980	1040	1100
	Care level III	1432	1470	1510	1550
	hardship cases	1918	1918	1918	1918
Respite Care	up to four weeks per year up to ...				
by near relatives 1)	Care level I	205	215	225	235
	Care level II	410	420	430	440
	Care level III	665	675	685	700
by other persons	Care level I to III	1432	1470	1510	1550
Short-time care	up to four weeks per year up to ...				
	Care level I to III	1432	1470	1510	1550
Part-time institutional care	up to ... per month				
	Care level I	384	420	440	450
	Care level II	921	980	1040	1100
	Care level III	1432	1470	1510	1550
Supplementary benefits for people with consi-derable genral need for care	up to per year				
	Care level I to III	460	1200 2400	1200 2400	1200 2400
Full-time institutional care	lump sum per month				
	Care level I	1023	1023	1023	1023
	Care level II	1279	1279	1279	1279
	Care level III	1432	1470	1510	1550
	Hardship cases	1688	1750	1825	1918
Care provided in full-time institutions for the disabled	long-term care expenses amounting to	10% of the fee for the institutional care, but not more than 256 Euro per month			
Consumable aids	up to per month	31 Euro			
Technical aids		mostly provided by a loan basis, otherwise cost coverage 90%, 10% co-payment up to 25 Euro per item			
Measures to improve the living invironment	up to per measure	2557 Euro, considering a reasonable co-payment			

Source : Schulz, E., The Long Term care system in Germany, ENEPRI report n°78, June 2010 (p.31)