



Designing Universal Long-Term Services and Supports Programs:

Lessons from Germany and Other Countries

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In 2019, Washington State enacted the first universal long-term services and supports (LTSS) program in the United States. It is a social insurance program, like Social Security or Medicare Hospital Insurance, into which virtually all workers contribute and from which all who meet the vesting requirements will be eligible to benefit.ⁱ Workers will begin contributing in 2022 and vested workers needing LTSS will be eligible to claim benefits beginning in 2025. Several other states, including California, Maine, Vermont, Michigan, Illinois, and Minnesota are considering adopting similar programs in the coming years. While universal LTSS programs are new to the United States,ⁱⁱ a number of other countries have experience with such programs, and most of these countries have been operating them for decades. As state governments in the U.S. embark on the design and implementation of universal LTSS programs, much can be learned

ⁱ Washington State enacted the Long-Term Services and Supports (LTSS) Trust Act in 2019. It pays long-term care benefits up to a lifetime cap of \$36,500. The program will provide long-term services and supports at home, in the community, or in a facility. The LTSS Trust is funded by an employee contribution of 0.58 percent of wages. The self-employed can opt into the program by paying the same contribution rate on their net earnings. Workers become eligible for benefits after contributing a total of 10 years (without an interruption of five or more consecutive years) or three of the past six years. Contributions begin January 1, 2022 and benefits will become payable to eligible individuals starting January 1, 2025. Washington State Legislature, “Long-Term Services and Supports Trust Program,” Chapter 50B.04 RCW, 2019, <https://app.leg.wa.gov/RCW/default.aspx?cite=50B.04>.

ⁱⁱ The primary public payer of long-term services and supports in the United States, Medicaid, is means-tested. In other words, to qualify for Medicaid, a person must have income and assets that do not exceed a certain level, varying by state and by Medicaid pathway. Many middle-income people “spend down”—they use their assets to pay for long-term care until they have very little left and qualify for Medicaid. Those who qualify for Medicaid (whether low- or middle-income) must contribute most of their income to their care costs, losing financial independence, and may be forced to enter a nursing home because they cannot access sufficient home- and community-based services or afford to remain at home. Benjamin W. Veghte, Marc Cohen, Eileen J. Tell, and Alexandra L. Bradley, “Designing a State-Based Social Insurance Program for Long-Term Services and Supports,” in *Designing Universal Family Care: State-Based Social Insurance Programs for Early Child Care and Education, Paid Family and Medical Leave, and Long-Term Services and Supports*, eds. Benjamin W. Veghte, Alexandra L. Bradley, Marc Cohen, and Heidi Hartmann, National Academy of Social Insurance, June 2019, <https://www.nasi.org/research/2019/designing-universal-family-care-state-based-social-insurance>.

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from the experience of existing programs in Europe and Asia. For social insurance approaches to LTSS, Germany's program is the paradigmatic model. This brief begins with an overview of the range of existing approaches abroad to the provision of universal LTSS, and then considers lessons from an in-depth case study of the German program.

Overview of LTSS Programs Abroad

For the past few decades, industrialized countries have been coping with the challenges of an aging population and the decline of the stay-at-home caregiver. In response to both the increased demand for formal care and concern over the costs of informal care (in terms of caregivers' labor market participation, productivity, and health), the public role in long-term care has grown.¹ A growing number of developed countries have either introduced universal public LTSS programs or are exploring options for doing so.

As different countries have increased the public role in LTSS, they have tended to adopt an approach in keeping with their broader social policy culture and framework. Programs can be described in terms of four broad types in terms of their approach to financing and coverage: social insurance, universal comprehensive coverage, residual systems, and hybrid approaches. Below these types are described briefly and broadly, with one or more examples of each.

Social insurance programs provide near-universal coverage and are funded in whole or in part by dedicated contributions by workers and/or their employers. By far the two most fully developed LTC social insurance programs in the world are those in the Netherlands and Germany. The Netherlands was the first country to introduce a social insurance program for LTSS, in 1968, and Germany introduced its program in 1995. The Netherlands has long had the most comprehensive LTSS social insurance system in the OECD, at a cost of 3.7 percent of GDP in 2017.² Its generous benefits, reliance on institutional care and lack of cost-control incentives led to concerns about its fiscal sustainability culminating in a restructuring of the system in 2015, in which most home care was transferred to the social health insurance scheme and ancillary home care supports became tax-funded and block granted to municipalities for local administration as part of their broader provision of social supports.³ Historically, the Dutch LTSS system has provided universal benefits designed to cover most of the cost of care; even after the

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2015 reform, this remains true with the exception of institutional care. Germany's program provides a capped benefit designed to cover only a portion of the cost of care, leaving families to cover the remainder, backstopped by social assistance. Germany spent 1.5 percent of GDP on long-term care in 2017.⁴ Germany's system, introduced in 1995 and expanded several times since, has become a model in many respects for others, in part because it provides robust benefits at a modest cost. Japan's program (adopted in 2000) is based on Germany's, and South Korea's system (2008) is influenced by both Germany's and Japan's systems.

Universal comprehensive coverage provides for the needs of all people with disabilities as a social right, with only minimal cost-sharing. These are single-payer systems funded from general tax revenues. In the decades after the Second World War, the Nordic countries of Sweden, Denmark, Finland, and later Norway – the pioneers in public LTSS programs – transformed earlier public long-term care policies aimed primarily at poor seniors into long-term care programs built on the same conceptual foundations as their broader social policy regimes: universal coverage, comprehensive benefits (with no or low co-payments), state responsibility replacing family responsibility, and local autonomy in administration.⁵ While national governments provide a legislative framework, most of the financing and administration is local. These countries rank near the top of the OECD in public spending on LTSS, with Norway devoting 3.3 percent, Sweden 3.2 percent, Denmark 2.5 percent, and Finland 2.2 percent of GDP to it in 2017.^{iii, 6} Some other countries (e.g. Austria since 1993 and the Czech Republic since 2007) have tax-funded universal care allowances, but benefits are far more modest in scope than in the comprehensive approach of the Nordic countries.⁷

Residual systems primarily provide a safety net for the poor and those who have become impoverished paying for health care and LTSS. They do not provide benefits universally, as the universal-comprehensive approaches do, or to all who contribute and/or vest, as the social insurance approaches do. Rather, applicants must satisfy not only eligibility criteria based on need but also a means test. England and the United States have such systems (and one U.S. state, Washington,

ⁱⁱⁱ In the Organization for Economic Cooperation and Development (OECD) statistics, LTC spending is defined and measured as follows: "LTC spending comprises both health and social services to LTC dependent people who need care on an ongoing basis. Based on the System of Health Accounts, the health component of LTC spending relates to nursing care and personal care services (i.e. help with activities of daily living). It also covers palliative care and care provided in LTC institutions (including costs for room and board) or at home. LTC social expenditure primarily covers help with instrumental activities of daily living. Progress has been made in improving the general comparability of LTC spending in recent years but there is still some variation in reporting practices between the health and social components for some LTC activities in some countries. ... Finally, some countries (e.g. Israel and the United States) can only report spending data for institutional care, and hence underestimate the total amount of spending on LTC services by government and compulsory insurance schemes." Organization for Economic Cooperation and Development, "Long-Term Care Spending and Unit Costs," *Health at a Glance* 2019, <https://bit.ly/3qwupr1>.



has a social insurance program as well). In England the majority of long-term care (LTC) assistance is means-tested, funded by local councils, and provided by independent sector organizations, although a modest Attendance Allowance (for home care) is universally available. (I refer to England, not the United Kingdom, because Scotland, Wales, and Northern Ireland have somewhat different policies.⁸ Wales and Northern Ireland provide more generous benefits than England for home care, and Scotland provides free personal care.) In the United States, the federal-state Medicaid program, described further below, pays for institutional care for individuals with low income and assets; states also have the option of offering home care benefits, and most do so to some extent, typically subject to funding constraints. The United Kingdom as a whole spends 1.4 percent of GDP on LTSS.⁹

There has been momentum in England toward increasing access to publicly funded LTC. The Care Act, passed in 2014, expanded Deferred Payment Agreements (DPAs), whereby local councils initially pay for residential care for those who have low non-housing assets and later recover the cost of care from the value of the beneficiary's home.¹⁰ The Care Act also included a more far-reaching provision that would cap individuals' lifetime care costs at a specified amount, after which the local council would be responsible; but this provision's implementation has been repeatedly delayed and it is unclear if it will ever go into effect.

A hybrid approach. France's long-term care policy is a hybrid between a universal system and an approach based on family responsibility (used in many Southern European countries),¹¹ with a minor social insurance financing component. The anchor program, the Allowance for Personal Autonomy (APA) (introduced in 2002 as a follow-up to measures in the late 1990s) provides cash payments to all those 60 or older who need LTSS, without a means test. However, families are responsible for substantial coinsurance,¹² which increases with income. For instance, the highest earners receive only 10 percent of the maximum benefit for their disability level (in essence paying 90 percent coinsurance). The APA is paid for primarily

out of general revenues, but to address funding challenges, in 2005 a small social insurance financing component, the National Solidarity Fund for Autonomy, was added. Companies pay into this fund the wages they would have paid to workers for a day that had previously been a holiday (Pentecost Monday), and additional funding comes from a small tax on pensions.¹³

The table below notes key features of a range of LTC systems around the world. The systems are grouped according to the four broad types discussed above: social insurance, universal comprehensive coverage, residual systems, and hybrid approaches. The list is not exhaustive, but at least one example of each type is offered. For each system, the table presents information on five program decision points discussed in this report: program structure, financing, integration of LTSS with health care and social services, benefit type and setting, and implementation/governance. As U.S. states consider which policy options to adopt with regard to these five issues, they can consider the choices made by these existing approaches.

Key Design Features of LTSS Programs Around the World, by Program Type

Country (year implemented)	Structure				Financing	Integration	Benefit Type and Setting	Implementation/ Governance
	Universal or means-tested?	For 65+ only or all disabled?*	Transition cohorts covered? (existing retirees)	Start and duration of coverage				
Germany (1995)	Universal	All	Yes	Unlimited	Payroll tax of 3.05% on earned income (split between employers and employees) up to a cap of €58,050 (\$70,751) in 2021; ^{iv} pensioners pay full contribution; childless workers pay supplementary 0.25% contribution; unemployment insurance pays contributions for unemployed	Standalone social LTC insurance	Cash, service, or combined; HCBS & Institutional	National program administered by social LTC insurance funds (organized within the social health insurance funds)

^{iv} Federal Ministry of Health, “Beiträge und Tarife,” <https://www.bundesgesundheitsministerium.de/beitraege-und-tarife.html>, accessed January 13, 2021.

Country (year implemented)	Structure				Financing	Integration	Benefit Type and Setting	Implementation/ Governance
	Universal or means-tested?	For 65+ only or all disabled?*	Transition cohorts covered? (existing retirees)	Start and duration of coverage				
I. Social Insurance								
Japan (2000)	Universal	65+; also for age 40-64 with age-related disability (e.g., dementia)	Yes	Unlimited	50% contributory (split equally between payroll tax and old-age premiums; payroll tax is roughly 1.5% split between employers and employees for those age 40-64 [rate can differ by insurance type] with modest income-related premiums and copayments for those age 65+, defined and different by municipal body); ^v 50% general revenues	Standalone social LTC insurance	Service; HCBS & Institutional	National program, locally administered

^v The financing of the Japanese long-term care system is based on a complex set of factors that change from year to year. Half of the financing is from general revenues of different levels of government, the other half is contributory. Of the contributory half, adults 65 and older pay close to one half through modest income-related premiums structured similarly to Medicare Part B premiums but at much lower levels. The other half is paid by workers aged 40-64 through social insurance contributions matched by their employers. The payroll tax rate for a given year is a function of total system costs. Nanako Tamiya, Haruko Noguchi, Akihiro Nishi, Michael R Reich, Naoki Ikegami, Hideki Hashimoto, Kenji Shibuya, Ichiro Kawachi, John Creighton Campbell, "Population ageing and wellbeing: lessons from Japan's long-term care insurance policy," *Lancet* Vo. 378, Nr. 9797: 1183-1192, DOI:10.1016/S0140-6736(11)61176-8; "Die gesetzliche Pflegeversicherung in Japan," Ministry of Health, Labour and Welfare, February 2013, https://www.de.emb-japan.go.jp/j_info/sozialversicherung/8pflege.pdf.

Country (year implemented)	Structure				Financing	Integration	Benefit Type and Setting	Implementation/ Governance
	Universal or means-tested?	For 65+ only or all disabled?*	Transition cohorts covered? (existing retirees)	Start and duration of coverage				
Netherlands (1968, reformed 2015)	Universal	All	Yes	Unlimited	<p>Long-Term Care Act (WLZ): Contributory (employee and pensioner payroll tax of 9.65% on earned income up to cap of €34,712 [\$42,307] in 2020)^{vi}</p> <p>Health Insurance Act (ZVW): 45% contributory (employer payroll tax of 6.7% on earned income up to cap of €57,232 [\$70,264] in 2020);^{vii} 45% community-rated premiums by employees and pensioners; remainder general revenues^{viii}</p> <p>Social Support Act (WMO): general revenues</p>	Juxtaposition of 3 un-integrated systems: standalone institutional LTC/ intensive home care (WLZ); integrated health / home health care (ZVW); ancillary LTSS (WMO)	<p>WLZ: Institutional and intensive home care (cash, service, or combined)</p> <p>ZVW: home health care including personal care (service or cash)</p> <p>WMO: ancillary home care supports (cash or service)^{ix}</p>	<p>WLZ: National and regional</p> <p>ZVW: National governance; national private health insurers contract with local district nursing for integrated home health and long-term care</p> <p>WMO: Local^x</p>

^{vi} Belastingdienst (Tax Office), https://www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/priv/internationaal/uitkering_pensioen_en_lifjfronte/pensioen_uit_duitsland/premie_volksverzekeringen_en_bijdrage_zvw_betalen/hoewordt_de_premie_wlz_berekend, accessed November 7, 2020.

^{vii} Belastingdienst (Tax Office), https://www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/priv/werk_en_inkomen/zorgverzekeringwet/veranderingen-bijdrage-zvw/, accessed December 26, 2020.

^{viii} Pieter Bakx, Erik Schut, and Bram Wouterse, "Price Setting in Long-Term Care in the Netherlands," Erasmus School of Health Policy and Management, November 2020; Wesley Jongen, *The Impact of the Long-Term Care Reform in the Netherlands: An Accompanying Analysis of an 'Ongoing' Reform*, Ph.D. Dissertation, Maastricht University, 2017, <https://cris.maastrichtuniversity.nl/portal/files/7345428/c5595.pdf>.

^{ix} Peter Alders and Erik Schut, "The 2015 Long-Term Care Reform in the Netherlands: Getting the Financial Incentives Right?" *Health Policy* Vol. 123, Nr. 3 (2019): 312-316, <https://doi.org/10.1016/j.healthpol.2018.10.010>.

^x Pieter Bakx, Erik Schut, and Bram Wouterse, "Price Setting in Long-Term Care in the Netherlands," Erasmus School of Health Policy and Management, November 2020; Wesley Jongen, *The Impact of the Long-Term Care Reform in the Netherlands: An Accompanying Analysis of an 'Ongoing' Reform*, Ph.D. Dissertation, Maastricht University, 2017, <https://cris.maastrichtuniversity.nl/portal/files/7345428/c5595.pdf>.

Country (year implemented)	Structure				Financing	Integration	Benefit Type and Setting	Implementation/ Governance
	Universal or means-tested?	For 65+ only or all disabled?*	Transition cohorts covered? (existing retirees)	Start and duration of coverage				
Republic of Korea (South Korea) (2008)	Universal	65+; also for those under 65 with age-related disability (e.g., dementia)	Yes	Unlimited	60-65% contributory (0.68 % payroll tax** split between employers and employees; 20% tax subsidy; 15-20% co-payment with reduction/exemption for low income beneficiaries ^{xi})	Standalone social LTC insurance	Service;*** HCBS & Institutional	National program administered by National Health Insurance Service
Washington State (United States) (2022)	Universal	18+	No	Unlimited in time; initial lifetime benefit max of \$36,500	Payroll tax of 0.58% on all earned income ^{xii}	Standalone social LTC insurance	Service;**** HCBS & Institutional	State program
II. Universal Comprehensive Coverage								
Denmark^{xiii} (late 1940s)	Universal	All	Yes	Unlimited	General revenues	Part of health and social service systems	Service;**** HCBS & Institutional	National system with entirely local/regional funding and local autonomy and heterogeneity in service delivery
Sweden^{xiv} (late 1940s)	Universal	All	Yes	Unlimited	General revenues	Part of health and social service systems	Service;**** HCBS & institutional	National system with primarily local/regional funding and local autonomy and heterogeneity in service delivery

^{xi} Hongsoo Kim and Soonman Kwon, "A Decade of Public Long-Term Care Insurance in South Korea: Policy Lessons for Aging Countries," Health Policy Vol. 125, Nr. 1 (2021): 22-26, <https://doi.org/10.1016/j.healthpol.2020.11.003>; PwC, "Republic of Korea: Social Security Contributions," accessed November 21, 2020, <https://taxsummaries.pwc.com/republic-of-korea/individual/other-taxes>.

^{xii} Washington State Legislature, "Long-Term Services and Supports Trust Program," Chapter 50B.04 RCW, 2019, <https://app.leg.wa.gov/RCW/default.aspx?cite=50B.04>.

^{xiii} Jon Kvist, "ESPN Thematic Report on Challenges in Long-Term Care: Denmark," European Social Policy Network, 2018, <https://ec.europa.eu/social/BlobServlet?docId=19844&langId=en>.

^{xiv} Pär Schön and Josephine Heap, "ESPN Thematic Report on Challenges in Long-Term Care: Sweden," European Social Policy Network, 2018, <https://ec.europa.eu/social/BlobServlet?docId=19870&langId=en>.

Country (year implemented)	Structure				Financing	Integration	Benefit Type and Setting	Implementation/ Governance
	Universal or means-tested?	For 65+ only or all disabled?*	Transition cohorts covered? (existing retirees)	Start and duration of coverage				
III. Means-Tested Systems (Anglo-Saxon model)								
England^{xv} (1948, reformed 2015)	Means-tested	18+	Yes	Unlimited	General revenues (central and local taxes)	Part of local government services, collaboration with health services	Cash or service; HCBS & Institutional	Locally administered, taking account of central guidance
United States (Medicaid) (1965)	Means-tested	All	Yes	Unlimited	General revenues (federal and state taxes)	Part of health insurance system	Service; HCBS & Institutional	Joint federal-state funding and administration with state heterogeneity
IV. Hybrid approach (Combining universal coverage with substantial family responsibility and a minor social insurance component)								
France^{xvi} (Allowance for Personal Autonomy, 2002; National Solidarity Fund for Autonomy, 2005)	Universal, with benefits decreasing as income increases	60+, strict disability criteria (3 ADLs)	Yes	Unlimited	General revenues with small social insurance component	Part of health and social service systems	Cash or service; HCBS & Institutional	National system locally administered

Notes: *Countries whose long-term care programs do not cover younger people with disabilities have separate programs to address their needs; **The LTC insurance contribution rate is set at a fixed percentage (10.25% in 2020) of the National Health Insurance contribution rate (6.67% in 2020): $10.25\% \times 6.67\% = 0.68\%$; ***Cash benefits are very low and only rarely provided, e.g. in areas where service providers are insufficiently available; ****Family members may be paid for approved personal care services; ***** Cash benefits are very low and not universally available.

^{xv} Edith Bocquaire, "Long Term Care Coverage in Europe," *Long-Term Care News, Society of Actuaries*, Issue 41, May 2016, <https://www.soa.org/globalassets/assets/Files/Pubs/pub-2016-05-ltc-coverage-europe.pdf>.

^{xvi} Blanche Le Bihan, "ESPN Thematic Report on Challenges in Long-Term Care: France," European Social Policy Network, 2018, <https://ec.europa.eu/social/BlobServlet?docId=19847&langId=en>.



In designing LTSS systems, each country grappled with a similar set of challenges. Some of the most important ones, and differences in national responses to them, are highlighted below:

- **Coverage.** As the table above shows, all types of LTSS social protection except the means-tested systems of England and the U.S. (Medicaid) provide coverage to all, not just those with limited income and assets. Most countries with universal coverage have some components or parallel sub-systems that are means-tested. For instance, social insurance programs typically do not cover room and board in LTC facilities, and a means-tested program can help low-income people pay for this.¹⁴ Japan and South Korea do not start full coverage until age 65, except for aging-related disabilities like dementia, which are covered at younger ages as well. Most countries have separate or complementary programs for younger people with disabilities. Typically, these disability programs came first, and dedicated long-term care programs were added more recently in response to the challenges of an aging society.
- **Transition cohorts.** All existing LTSS programs (except Washington State's) have covered those who were already disabled or retired when the program was introduced. Even the contributory social insurance programs have covered everyone meeting the disability criteria immediately or quickly; the Dutch system has no vesting requirement, while the German system has a two-year vesting period. Covering transition cohorts was done in part because of the political infeasibility of failing to do so. In some social insurance systems, the contribution rate is set higher than would be necessary to cover only working-age program contributors in order to subsidize the coverage of disabled and retired people who were not able to contribute during their working lives. In

Germany, retirees must contribute to the system; they pay the full social insurance contribution rate (the sum of the contribution rate which workers and their employers pay for working-age adults).

■ **Start and duration of coverage.** While there is debate in the United States around whether new LTSS social insurance programs should provide front-end coverage (for one or two years, or up to a lifetime maximum amount) or back-end catastrophic coverage, all existing models abroad provide coverage of unlimited duration.

■ **Financing.** Social insurance programs are funded in whole or in part through contributions by plan participants (workers and/or their employers and in some cases retirees as well), while universal comprehensive and residual systems are paid for predominately out of general revenues. Social insurance programs are funded – and also tend to be administered – on a national level to achieve maximum risk-pooling, whereas tax-funded systems usually have a strong local component in both funding and administration. Social insurance financing is largely insulated from politics – i.e., contributions cannot be taken out of the fund and used for other purposes, while tax-financed systems are highly subject to changes in annual budgetary priorities of those in elected office. Over time, due to financing challenges, intergenerational equity concerns, and cross-national learning, there has been a convergence in financing methods across models. As the table above indicates, many countries now rely on a combination of funding sources that includes national and local taxes, payroll contributions, retiree contributions, and family responsibility for some of the cost of care. Social insurance programs abroad have comparatively high contribution rates (half of which is typically an employer match) on earnings below a cap, whereas the Washington State system has a comparatively low contribution rate (with no employer match) on all earnings. A key rationale for this difference is income inequality: it is much higher in the U.S. than in the other nations under comparison here,^{xvii} and furthermore income among high earners in the U.S. is growing at a much faster rate than average income.^{xviii} As a result, if the Washington State program’s contribution base excluded high income, it would not

Social insurance financing is largely insulated from politics while tax-financed systems are highly subject to changes in annual budgetary priorities of those in elected office.

^{xvii} Based on Gini coefficient, the U.S. has the fifth highest rate of income inequality in the OECD; South Korea ranks 11th and Germany and the Netherlands rank 25th and 26th in income inequality. OECD, “Income Inequality,” OECD Data, <https://data.oecd.org/inequality/income-inequality.htm>, accessed February 13, 2021.

^{xviii} Pew Research Center, “Most Americans Say There Is Too Much Economic Inequality in the U.S., but Fewer Than Half Call It a Top Priority,” January 2020, <https://www.pewresearch.org/social-trends/2020/01/09/trends-in-income-and-wealth-inequality/#fn-27661-9>.

grow with the economy, leading to financing challenges over the long term. With regard to the share of LTSS costs borne by the public system vs. the beneficiary, universal-comprehensive systems tend to have minimal co-payments, while in many social insurance programs – as well as in France’s hybrid approach – benefits are capped and families contribute significantly to the cost of care.

■ **Integration.** A major challenge everywhere is insufficient – or utter lack of – coordination among the LTSS, medical, and social service components of care. While in some countries long-term services and supports are part of the broader health care and social service infrastructure, that does not mean that they are well integrated into that infrastructure. This fragmentation can lead to uncoordinated health care and long-term care, and it means that beneficiaries and their families must often navigate multiple administrative processes and funding streams.¹⁵ Fragmentation also often yields inefficient incentive structures such as to prematurely medicalize a long-term care need. Social insurance programs face a particular challenge in this regard because they tend to be dedicated to insuring a particular risk, namely LTSS, with funding and administration that are distinct from health care and social services. In 2015 the Netherlands split coverage of LTSS from a single comprehensive long-term care insurance scheme into three different sources of financing: social LTC insurance for institutional care and intensive home health care, social health insurance for other home health care (including personal care), and national general-revenue financing – block granted to municipalities – for ancillary home care supports. A key lesson from the Dutch experience is that this dis-integrated approach to funding and administration has made it more difficult to coordinate these different types of care (although it has provided some level of integration of home health care with personal care). Like the Netherlands, Belgium – not discussed in depth here – provides some long-term care benefits through its health insurance system. The Netherlands has experienced unintended consequences of spreading LTC administration across multiple financing schemes: municipalities, for example, are incentivized to shift home care costs to more expensive institutional care settings covered by the national social insurance program.¹⁶ Many OECD countries have set the goal of better coordinating health and long-term care.¹⁷ And there have been ambitious policy initiatives in several countries designed to achieve this goal, for example England’s efforts at “joint commissioning” of health and social care since the 1990s, and Japan’s “community-based integrated care” reform campaign since 2012. The challenge of integrating care is formidable, however, and to date the results of these efforts have been disappointing.¹⁸ The most promising innovation has been the Buurtzorg (Dutch for “neighborhood care”) model of community nursing in the Netherlands, a nurse-led model of holistic home care created in 2006 and now gradually spreading to other countries.¹⁹ Interestingly, this innovation came not from public policy, but from a non-profit organization.

■ **Benefit type and setting.** The first universal long-term care programs, namely those in the Nordic countries and the Netherlands, began with a strong emphasis on institutional care, motivated in part by the goals of moving the responsibility for care from the family to society and unburdening female labor-market participation in the process. This approach also entailed a focus on service rather than cash benefits.²⁰ Similarly, when Japan introduced its universal long-term care program in 2000, it did so with the slogan “from care by family to care by society.”²¹ By then, the goal of long-term care policy had shifted away from institutional care toward aging in place in most OECD countries. Japanese policymakers sought to unburden prime-age women from informal care obligations in the family and did so with a combination of formal home care and institutional care offerings. From the 1990s onward, home and community-based care gained ascendance in most LTSS systems in part for cost reasons, and in part to improve consumer choice and autonomy and facilitate aging in place. These policy goals inspired, for example, the incentivization of home care in the reforms of the Dutch LTSS system in 2015. In the Netherlands’ new tripartite system, beneficiary out-of-pocket expenses are significantly higher for institutional care than for home care: the social LTC insurance program provides institutional LTC and intensive home health care, with initially modest co-payments that can increase after four months in relation to income and wealth up to €2,419/month (\$2,973/month), while the companion social health insurance scheme’s home health care (which includes personal care) has no copayments or deductibles and the ancillary LTSS (transportation, meal delivery, supervision) provided by municipalities has a deductible of only €19/month (\$23/month) in 2020.²² In countries with conservative social policy regimes, such as Germany or Austria, LTSS policy is strongly anchored in the principle of subsidiarity, namely that the “state will only interfere when the family’s capacity to service its members is exhausted.”²³ In these countries, new public LTSS benefits were designed to support and supplement family caregiving, not replace it. In Germany, families were given a choice between service benefits, cash benefits, or a combination of the two; cash benefits were included as a way of demonstrating “appreciation” for family caregivers and thereby formalizing their role in the LTSS system.²⁴ Austria’s benefits were provided solely in cash, for similar reasons (but also in response to advocacy by the disability community for self-directed care).²⁵ Japan and South Korea, while adopting the German LTSS model in many respects, took a different approach regarding benefit type, rejecting cash benefits largely due to concerns they would reinforce gendered patterns of work and care and reduce female labor-force participation. Japanese policymakers were also concerned take-up of cash benefits would be much larger than for service benefits, which would render the system too expensive.²⁶



Case Study: Lessons from the German Experience

Germany's LTSS social insurance program (*die Soziale Pflegeversicherung*) is the paradigmatic social-insurance approach internationally, with a quarter-century of experience from which policymakers can learn. Several other countries, including Japan and South Korea, have largely modeled their programs on Germany's. What makes Germany's system particularly attractive for U.S. policymakers is that it has achieved near-universal coverage with a robust benefit package and a self-funded, fiscally conservative approach. Part of the political compromise that led to enactment of the German program was keeping its fiscal footprint modest, and the program has largely delivered on this promise.²⁷ Germany spends slightly less than the average of its peer nations on long-term care – 1.5 percent of GDP, compared to 1.7 percent on average for the 17 OECD countries reporting long-term care expenditures – despite having a mature public program.²⁸

Germany's LTSS insurance program was designed to achieve multiple goals: to dramatically increase the supply of public LTSS benefits to help meet the demands of the age wave; relieve the growing burden on communal social assistance programs; relieve the burdens – financial and otherwise – experienced by individuals needing LTSS; ensure that the overwhelming majority of people needing LTSS need not rely on means-tested supports; and support and reward the care work performed by families, among others.²⁹ It succeeds on all of these fronts, to varying degrees, and enjoys strong public support across the political spectrum. It also faces new challenges.

To delve deeper into the German experience, I conducted semi-structured interviews with senior officials and stakeholders in the German long-term care and care leave systems in addition to conducting a review of legislative documents, administrative reports, and program data. Below I summarize key lessons from the German experience with regard to the LTSS social insurance program's coverage and financing, benefit structure, and family-centered program design. I then broaden the long-term care policy lens to encompass recent efforts in Germany to leverage care leave to meet LTSS policy challenges and conclude with a discussion of LTSS workforce challenges.

Coverage and Financing

The German LTSS social insurance program is contributory but achieves near-universal coverage.^{xix} It does so primarily by having a low vesting threshold, employing an expansive definition of vesting to include non-contributing family members (see “Family-Centered Program Design” further below), and leveraging a pay-as-you-go financing approach (together with the low vesting threshold) to cover those who were already retired at the time of enactment.

Workers earn benefits in the scheme for themselves and their family members through their social insurance contributions. To be a qualified individual, a person must have had a prior insurance period (Vorversicherungszeit) of at least two out of the past 10 years before applying for benefits. Most people meet this prior insurance requirement by contributing directly, but being a family member of a contributor can also count toward the prior insurance period.³⁰ Workers pay 1.525 percent of their earnings (up to an indexed cap of €4,838 [\$5,925]/month or €58,050[\$71,065]/year in 2021) into the LTSS fund, matched by their employers.³¹ Self-employed individuals pay the entire 3.05 percent contribution rate on their own. If a worker’s spouse and children are not working and contributing on their own, they are covered by their spouse’s/parent’s membership in the program. For children, such coverage extends through age 18, or through age 23 if they are not working and through age 25 if they are undergoing education, training, or a national service year.³² Childless workers age 23 or older pay a supplemental 0.25 percent contribution to compensate for their anticipated greater degree of reliance on the program’s benefits, bringing their part of the contribution rate up to 1.775 percent (the employer match for such workers remains 1.525 percent).

From the program’s launch through 2007, premiums were held constant at 1.7 percent of income (workers and their employers each paying 0.85 percent) up to the cap.^{xx} During these first 13 years of the program’s existence, benefits were not increased to maintain


^{xix} A unique feature of the German approach to universal coverage is the option of substitutive, private insurance for certain categories of workers, namely higher earners, civil servants, and the self-employed. This dual system has deep historical and institutional roots (originating initially in the health insurance system, over which the long-term care insurance system was layered) and is predicated on a complex regulatory apparatus (including guaranteed issue and equivalent benefits) that has not been duplicated in any other country. Only 10 percent of the population is covered by such private substitutive LTC insurance. Lorraine Frisina Doetter and Heinz Rothgang, “The German LTC Policy Landscape,” CEQUA LTC Network, May 2017, https://1d520973-35f0-4e46-8af0-304ac08d8794.filesusr.com/ugd/442c21_299a62535bac40179f7fe3500dcf71bd.pdf.

^{xx} The program’s initial premium of 1.7 percent was phased in over the course of 1995 and 1996. In 1995 the premium was 1 percent (from January onward), with only non-residential care benefits available (starting in April), and reached 1.7 percent in July of 1996, when residential care benefits became available as well. Bundesministerium für Arbeit und Sozialordnung, “Erster Bericht über die Entwicklung der Pflegeversicherung seit Ihrer Einführung am 01. Januar 1995,” December 17, 1997, https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/5_Publikationen/Pflege/Berichte/1.Pflegebericht.pdf.

their purchasing power. Since then, there have been several reforms that nearly entirely corrected the decline in benefit purchasing power while also qualitatively expanding the scope of benefits (in 2008, 2010, 2012, 2015, and 2017), with corresponding increases in premiums – to 1.95 percent in 2008, 2.35 percent in 2015, 2.55 percent in 2017, and 3.05 percent in 2019.³³ These qualitative benefit expansions are described in the next section. A key lesson from the German experience has been that once even a modest program is up and running – enabling families to better meet needs which they had previously been forced to meet on their own or with the help of social assistance – public support for improving and expanding the program develops, even if this requires increasing premiums accordingly.

Another key component of the German LTSS program's ability to achieve near-universal coverage despite being contributory is its leveraging of a pay-as-you-go (PAYGO) financing approach to cover those who were already retired at the time of enactment, and allowing seniors to earn vesting status after only two years of contributions, despite not having contributed throughout their working career. A key coverage and financing decision point for all new LTSS social insurance programs is how to address challenges related to generational transition and intergenerational equity. A program could focus on covering tomorrow's seniors, by requiring prolonged contribution before vesting is attained. This 'funded' approach pays future benefits out of the premiums of today's workers, which earn substantial investment returns in the meantime. By allowing for a period of contribution and investment prior to payment of significant benefits, the level of premium required to fund benefits can remain low. This was the approach in Washington State, for example. Only very gradually and over decades does such an approach ease the fiscal burden on general-revenue-funded LTSS (in the case of the U.S.: Medicaid LTSS), but it does allow the premium for the new program to be set much lower. By contrast, Germany's program chose to cover nearly everyone needing LTSS very quickly, including those who were currently retired, requiring only two years of vesting. This was done in large part to quickly ease the burden of long-term care costs on local social assistance budgets.

In a 'pay-as-you-go' (PAYGO) system such as Germany's, the program builds up no reserves and enjoys no investment income – current contributions pay for current benefits. In this system, the demographic shift experienced by Germany (and nearly all OECD countries) brings a significant risk that as Baby Boomers age into their mid-70s and beyond, to keep the self-funded program solvent, either program benefits would need to be markedly cut or premiums markedly increased, or some more modest combination of the two.³⁴ To mitigate this risk, starting in 2015 Germany began devoting one-tenth of one percentage point (0.1 percent) of premiums to a separate fund (*Pflegevorsorgefonds*) invested to help pay benefits for the aging Boomers from 2035 onward. In a funded system, such as Washington State's, this is not needed. But in Germany's PAYGO system, this mechanism is



necessary to equalize the burden of funding the cost of demographic transition across generational cohort and helps stabilize the premium rate needed to fund benefits over the long term.^{xxi} Another approach to the demographic challenge in Germany's PAYGO system could include easing immigration of young workers to improve the ratio of contributors to beneficiaries.

Germany's decision to largely grandfather in coverage of the first generations of beneficiaries, despite their not contributing throughout their careers as subsequent generations would do, created intergenerational inequity. This inequity was partially mitigated by requiring all retirees to contribute to the program throughout retirement (unless and until entering beneficiary status). Doing the latter also lowered the overall contribution rate required to fund the program in perpetuity by broadening the contribution base to include not only workers but also retirees. After retirement, workers pay the entire social insurance contribution on their own; it is deducted directly from their Social Security (German statutory pension) checks.

Overall, the German system achieves near-universal coverage despite not utilizing a tax-financed universal approach as in the Nordic countries. It does so by socializing across the pool of contributors the costs of covering certain population groups who either may not contribute at all (e.g., children, non-working spouses) or whose contributions may not cover the full amount of their expected benefits

^{xxi} For a more thorough discussion of funded vs. PAYGO approaches to LTSS social insurance financing, see Benjamin W. Veghte, Marc Cohen, Eileen J. Tell, and Alexandra L. Bradley, "Designing a State-Based Social Insurance Program for Long-Term Services and Supports," in *Designing Universal Family Care: State-Based Social Insurance Programs for Early Child Care and Education, Paid Family and Medical Leave, and Long-Term Services and Supports*, eds. Benjamin W. Veghte, Alexandra L. Bradley, Marc Cohen, and Heidi Hartmann (Washington, DC: National Academy of Social Insurance, 2019) and on the theoretical foundations of this issue see Heinz Rothgang, *Theorie und Empirie der Pflegeversicherung* (Berlin: LIT Verlag, 2009).

(e.g., those who were retired or near retirement at the time of program enactment, people with disabilities that onset prior to age 18). In other words, if these groups who could not fully “pay their share” from an actuarial perspective were not eligible for program benefits, the program’s overall social insurance contribution rate would be lower.

Benefit Structure

A guiding principle of German social policy is subsidiarity, which stipulates that the government has a responsibility to step in only when smaller solidarity communities, like families or civil-societal organizations, cannot address a need; in other words, larger solidarity communities (like members of social insurance risk pools or federal taxpayers) are to be protected from being taken advantage of by smaller solidarity communities not carrying their own weight. In long-term care policy, this means that public programs support families’ role in care, but do not replace them.

As such, Germany’s LTSS social insurance program is not designed to provide (near-) comprehensive benefits, as the Nordic model and to a lesser extent the Dutch system does (and as Germany’s own health insurance system does). Rather than paying the full cost of necessary care supports (*Bedarfsdeckung*), Germany’s benefit structure covers only part of the need (*Teilkostendeckung*), paying up to a fixed Euro amount – graduated at five degrees of care needed, ordered inversely with degree of autonomy – and leaves the rest of the care need for the family to pay for or to provide informally. (Note: This approach differs from co-payments, e.g. in U.S. employer health insurance, which are calculated as a fixed amount [\$30, for example] a consumer pays for a covered service after she has met her deductible; or co-insurance payments, which are calculated as a fixed percentage of the total cost of a covered service).

In institutional care settings, the remaining cost of care beyond what the social insurance program pays is high and has grown considerably in recent years. On a monthly basis among those receiving the highest care level benefit in nursing homes, this remainder cost owed by beneficiaries (*Eigenanteil*) averaged €2,015 (\$2,412) in July 2020, after deducting from total inpatient costs the maximum program benefit of €2,005 (\$2,400).³⁵ This beneficiary cost has increased 14 percent on average across Germany from January 2018 through July 2020 and the trend is expected to continue without a policy intervention. For in addition to paying only part of the cost of the personal care component of in-patient long-term care, the LTSS program does not pay anything toward room and board. This makes the social insurance benefit inadequate for nursing home care for many. In 2019, one third of LTSS social insurance beneficiaries in institutional care settings

had to rely on social assistance for long-term care (*Hilfe zur Pflege*), and this share is projected to rise further in the coming years. In response, in November 2020 the Health Ministry announced plans for reforms that included a €700 (\$852)/month cap on remainder costs owed by beneficiaries for the first three years in institutional care settings, after which the social insurance program would assume all these costs with reimbursement from general revenues. Initial projections suggest that this reform, if enacted, would reduce the share of institutional care recipients needing to rely on social assistance for long-term care to one quarter.^{36, xxii}

Growing out-of-pocket costs for nursing home care are at the forefront of LTSS social insurance reform debates in Germany and provide an important lesson to policymakers in the United States. Designing the insurance program benefit structure in isolation is insufficient to serve the program goal of benefit adequacy. Focusing cost control on program costs alone is only part of the picture and is politically unsustainable. Holistic social insurance policy design needs to focus not only on limiting the cost of the public program but also on the limiting out of pocket costs for beneficiaries. Achieving this policy goal requires developing a framework for limiting cost growth in long-term care, not just long-term care insurance. Germany has tackled this challenge in the health care sector but has as of yet failed to adequately do so in the institutional long-term care sector. The policy challenge is multifaceted and complex and requires regulating provider pricing, wage levels, immigration policy, policies related to family contributions to the cost of care, and social assistance policies that serve as backstops to the social insurance program. As the growth in out-of-pocket costs for institutional care shows, while Germany's new LTSS social insurance program was highly ambitious in its design, it was explicitly modest in scope. Three key components render the system fiscally conservative. First, as all traditional social insurance programs, it is self-funded from contributions by or on behalf of workers. Second, its partial or 'basic' benefit structure constitutes a capped entitlement, with benefits limited to a modest level to ensure the program's costs are contained. And third, from the introduction of the program until reforms enacted in 2008 (and effective from 2014 onward), there was no statutory mechanism for regularly indexing benefits for inflation.³⁷ As a result, their purchasing power

Holistic policy design needs to focus on limiting not only the cost of the public program but also out-of-pocket costs for beneficiaries.

^{xxii} Another attempt to reduce out-of-pocket costs for long-term care in Germany was public subsidies for private supplementary LTC insurance (*Pflege-Bahr*). These policies have not succeeded in gaining take-up: less than one percent of the population has purchased them, while another three percent have unsubsidized private supplementary LTC policies. Lorraine Frisina Doetter and Heinz Rothgang, "The German LTC Policy Landscape," CEQUA LTC Network, May 2017, https://1d520973-35f0-4e46-8af0-304ac08d8794.filesusr.com/ugd/442c21_299a62535bac40179f7fe3500dcf71bd.pdf.

eroded significantly over time. A key lesson the country has learned is that a legislative mechanism is necessary to ensure that benefits roughly keep pace with the cost of care. Without such a mechanism, Gen-Z, for example, would receive a much smaller LTSS benefit than Gen-X. Since 2014 (with indexation effective in 2015), benefits in the German system are now being reviewed every three years and adjusted to keep pace with increases in the cost of living, within the constraints of the overall economic situation.³⁸ This is very similar to the legislative mechanism for benefit adjustment in the new Washington State LTSS program, whereby the latter is foreseen annually rather than every three years.³⁹ The lag in Germany's benefit adjustment constitutes a further cap on program costs. In the case of neither Germany nor Washington State are benefits indexed automatically or to some measure of the actual cost of long-term care, which tends to rise faster than price inflation. This is another dimension of the capped entitlement both systems provide.

Monthly benefits in Germany's LTSS insurance program are capped at a specific dollar amount of services, cash, or a combination of the two. The cap depends on the degree of intensity of support. Originally, the program's benefit structure was geared to a beneficiary's physical care needs and the duration of care needed; there were three different "levels" of need, with the benefit cap increasing with the severity of need. The way the system defined benefit eligibility largely excluded individuals with dementia or other cognitive impairments, however. In 2017 a new benefit structure was introduced that was designed to address this problem. It made benefits available to persons with severe cognitive impairment on an equal footing as for persons needing LTSS due to physical impairments.⁴⁰ This was achieved through redesign of the benefit structure based on the beneficiary's degree of autonomy. The new benefit structure fully encompassed for the first time people with a need for supervision, not simply support with the activities of daily living. A lesson from the German experience with benefit design is that eligibility determination requires careful consideration and can have unintended consequences.

The German LTSS program gives beneficiaries considerable latitude to choose how to spend their benefit. Beneficiaries can choose their provider and setting. They also have a choice between cash or in-kind benefits, or some combination of the two. Cash benefits, termed "cash for care" (Pflegegeld), are intended not to be sufficient to pay the full cost of needed levels of professional home care but as "material acknowledgment" of the sacrifices made by family members, neighbors, or friends who provide informal care to LTSS program beneficiaries.⁴¹ The subsidiarity assumptions here are clear: Smaller solidarity communities like the family and volunteer community are expected to step in first, whose economic sacrifices are mitigated only modestly by cash benefits from the national social insurance program. The reinforcement of gendered patterns of work and care is also clear, as cash benefits encourage family care (performed disproportionately by women,

who often temporarily or permanently leave the workforce to provide it) or hiring informal care workers (also predominately female) at substandard wages.^{xxiii}

Benefit amounts rise with the intensity of care need, from Care Grade 1 (a service reimbursement benefit of up to €125 [\$152] monthly, plus ancillary benefits of up to €4,000 [\$4,848] for home modification) to Care Grade 5 (the maximum level of benefits for people with significant support needs). Cash benefits are related to the severity of care need, ranging from €316 (\$383) monthly for Care Grade 2 to €901 (\$1,092) monthly for Care Grade 5.⁴² In-kind benefits (professional home care and related LTSS services) similarly increase with care need, from €689 (\$835) for Care Grade 2 to €1,995 (\$2,418) for Care Grade 5.⁴³ A range of ancillary LTSS benefits are available as well, such as day and night care, respite care, and care counseling.

Family-Centered Program Design

Germany's LTSS social insurance program, like its broader social policy infrastructure, is both designed to support families and predicated on the expectation that families contribute to the care of their members. This family-centered approach has implications for coverage, financing, and benefit design.

With regard to coverage and financing, a major advantage families enjoy is that a breadwinner's contributions can insure not only that worker but her or his spouse and children, if they themselves are not working and required to contribute. The flip side of this coin is that families can be on the hook for incurred care costs that exceed what the social insurance program pays. As noted above, the German LTSS system is anchored in the principle of subsidiarity: the government has a responsibility to step in only when smaller solidarity communities, like families, cannot address a need.

Since the German LTSS program's inception, families – including adult children – have been asked to pitch in to pay any costs of care that exceed the amount of social insurance benefits provided. If a person utilizes professional long-term services and supports beyond what the insurance program pays and beyond which the individual and her or his spouse or partner can afford out of their income and assets, the beneficiary can apply for benefits from the communally financed social assistance program for LTSS, *Hilfe zur Pflege*.⁴⁴ The local social assistance program can then seek to recoup the costs from family members. As discussed above, in recent years the costs of institutional care have risen much faster than LTSS social insurance benefits. The growing burden on the children of those receiving institutional care from

^{xxiii} A consequence of the subsidiarity principle in the German system – where benefits provide only partial coverage and are paid in some cases in cash in order to support family care – is reinforcing gendered patterns of work and care. This is even more pronounced in the Austrian system, which relies primarily on cash benefits. See Elisabeth Hammer and August Österle, "Welfare State Policy and Informal Long-Term Care Giving in Austria: Old Gender Divisions and New Stratification Processes among Women," *Journal of Social Policy*, Vol. 32, Nr. 1, 2003::37–53, <https://doi.org/10.1017/S0047279402006888>.



the increasing gap between what the LTSS program pays and what LTSS providers charge led to a legislative reform at the end of 2019. Now, the obligation of children to reimburse the social assistance program for their parents' remaining LTSS costs (Elternunterhalt) is limited to adult children with income above €100,000 (\$121,200).⁴⁵

With regard to benefit design, where the LTSS program 'intervenes' in the provision of LTSS, it endeavors to respect and support the role that family members play in care.⁴⁶ The inclusion of cash benefits as an option in addition to service benefits is a key means of achieving this policy goal. In particular, cash benefits in the German system have virtually no strings attached. Beneficiaries can use them to compensate family members for their care. But these benefits may also be used to hire low-wage or even gray-market care workers. The workforce implications of this will be discussed further below. The key point here is that cash benefits make it easier for individuals to age in place and in many cases be cared for by loved ones. Cash benefits may also be combined with in-kind benefits such as professional home care aides.

In sum, the LTSS social insurance program supports families' role in care, but does not seek to replace it.

Leveraging Care Leave to Meet LTSS Policy Challenges

One of the clearest lessons German policymakers learned after the first decade of LTSS social insurance implementation was that LTSS benefits for those needing care would on their own be insufficient to address the long-term care policy challenges of societies whose demographics, family structures, and labor markets were undergoing significant transformations. Leave benefits for family caregivers would be needed as well. For it was not only that society was aging; the rate of female labor-market participation was increasing, marriage rates were declining, women and couples were having fewer or no children, and there was a shortage of paid caregivers.⁴⁷

The modest cash-for-care LTSS benefit (*Pflegegeld*) discussed above was designed as a means of acknowledging and partially compensating family caregivers, but it was not designed to make it possible for family caregivers to partially or completely leave the workforce to care for a loved one. For the first decade after enactment of the LTSS program, Germany did not offer any leave benefits for family members of someone needing LTSS. Given the growing need for care supports and the shortage of paid and unpaid caregivers, Germany began experimenting with a range of incremental policies intended to make it easier for people to balance care and work. From 2008 onward several statutory changes made it possible for caregivers of close relatives^{xxiv} needing LTSS to receive unpaid family leave:⁴⁸

- 2008: The Caregiver Leave Act (*Pflegezeitgesetz*) provided two *unpaid* leave options to care to a family member in the home:
 - Short-term unpaid leave for up to 10 work days (no notice required, no restrictions on employer size); and
 - Up to 6 months of part-time or full-time leave (*Pflegezeit*) (10 working-days notice required; only at employers with 15 or more employees).

It also provided up to 3 months of part-time or full-time *unpaid* leave to be with a close relative in the last phase of life (only at employers with 15 or more employees).

- 2012: The Family Caregiver Leave Act (*Familienpflegezeitgesetz*) added a provision to address cases where someone needs to take longer-term part-time leave to provide care to a family member in the home without leaving the workforce. It created a structured mechanism by which a worker, with their employer's approval, can reduce their work time down to a minimum of 15 hours per week for a period of up to 24 months. Because the minimum work hours are an annual average, the Family Care Leave Act gives workers considerable flexibility in balancing work and care. Additionally, the law provided up to 50 percent wage replacement during family caregiver leave, paid by the employer. Employees had to repay the employer, however, by working full time for a lower wage until the leave benefit was repaid.
- 2015: In light of very low take-up of the unpaid leave options of the Caregiver Leave Act, the Law on Better Reconciliation of Family, Care, and Work (*Gesetz zur*

^{xxiv} Close relatives are defined as: a grandparent, parent, mother/father-in-law; a spouse, life partner, sibling, spouse/life partner of a sibling, sibling of a spouse/life partner; a child, adopted child or foster child of one's own or of one's spouse or life partner; nieces, nephews, and grandchildren. <https://www.bmas.de/DE/Themen/Arbeitsrecht/Vereinbarkeit-Familie-Pflege-Beruf/vereinbarkeit-familie-pflege-beruf.html#:~:text=2.,Arbeitsleistung%20bis%20zu%206%20Monate.&text=Der%20Anspruch%20auf%20Freistellung%20besteht,mit%2015%20oder%20weniger%20Besch%C3%A4ftigten>.

besseren Vereinbarkeit von Familie, Pflege und Beruf) amended the Caregiver Leave Act and the Family Caregiver Leave Act by providing:

- Partial wage replacement for the short-term leave in the Caregiver Leave Act (*Pflegeunterstützungsgeld*);
- The option of receiving an interest-free loan to cover some of a person's essential living costs during the 6-month period of leave above and the 24 months family caregiver leave;^{xxv} and
- A legal claim to family caregiver leave (8-weeks notice required; workers for employers with 25 employees or fewer excluded).

As a result of this series of care leave reforms, family members in Germany today can take up to ten days off of work with nearly full wage replacement paid by the LTSS social insurance program on behalf of the person needing care. The program also makes key social insurance contributions on behalf of family caregivers. It pays Social Security (retirement insurance) contributions for anyone who regularly takes care of one or more people with a care grade of 2 to 5 for at least 10 hours and at least 2 days a week at home and who is not employed for more than 30 hours a week. It also pays unemployment insurance contributions and subsidizes health and long-term care insurance contributions for some family caregivers. Family caregivers also have Workers' Compensation (statutory accident insurance) coverage.⁴⁹

In 2017, the terms 'caregiver leave' and 'family caregiver leave' were included for the first time in the German micro-census questionnaire. After assessing the results, the Federal Statistical Office estimates the total number of people who took caregiver leave or family caregiver leave in 2019 at approximately 93,000. But looking at take-up of financial support for employees in the form of interest-free loans, figures published by Federal Office of Family Affairs and Civil Society Functions (BAFzA) show that take-up of the carers' grant was below the expectations set out in the draft legislation. In light of this, the Family Ministry's Independent Advisory Board for the Reconciliation of Care and Work (*Beirat für die Vereinbarkeit von Pflege und Beruf*) has recommended replacing the 6-month loan for care leave with a tax-financed wage-replacement benefit akin to Germany's parental leave benefit (*Elterngeld*). The Advisory Board proposes that this new paid care leave benefit be available for a maximum of 36 months. Under the proposal, workers could take full leave benefits for up to 6 months or take

The Family Ministry's Advisory Board has recommended replacing the 6-month loan for care leave with a wage-replacement benefit akin to Germany's parental leave benefit.

^{xxv} Workers caring for close relatives who are minors needing long-term care may also take complete or partial leave for up to 6 months or take partial leave for up to 24 months.

partial leave benefits (reducing work by at least 5 hours/week and working at least 15 hours/week) for up to 36 months. The benefit would replace 65 percent of the income of a high earner (or up to 100 percent of the income of a low earner).⁵⁰

The main lesson from Germany's experience with care leave policy has been that without paid care leave benefits, very few workers take leave. Care (i.e., family) leave policy and LTSS policy are best conceived in concert from the start. Robust care leave policy is a critical tool in mitigating the effects of the LTSS workforce shortage. It also accords with the desire of many care beneficiaries to be cared for by loved ones.

Workforce Policy

Another key lesson from the German experience is that even a well-designed LTSS program will struggle to provide quality, accessible care if not accompanied by long-term LTSS workforce planning and policy. For decades, demographic and labor force trends have made an eventual workforce shortage in Germany's long-term care sector predictable. The population is aging and stay-at-home caregivers are declining, and hence a shortage of both professional and family caregivers is on the horizon.⁵¹ Policies aimed at addressing the expected shortage of professional care workers have been piecemeal and incommensurate to the scope of the challenge. A critical component of the current LTSS workforce consists of migrant workers, mainly from Eastern Europe. One part of this is guest workers brought to Germany by recruitment agencies for temporary stints after which they return to their home country. These workers are engaged (not formally employed) by families seeking to make their cash benefits go further. They often live with their clients and in such cases are referred to colloquially as "live-in" or "24-hour" care workers. There is only sparse data available on the number of such agencies or workers. A Ministry of Health survey in 2019 asked care recipients whether they had a live-in care worker in their household. Among those with the highest level of care need (Care Grade 5), 12 percent relied on such live-in care workers.^{xxvi} Additionally, a significant share of beneficiaries engage migrant care workers for non-live-in home care.⁵² One study estimated the total number of migrant care workers engaged by German households (live-in and non-live-in) at between 100,000 and 200,000.⁵³ The government turns a blind eye to substandard migrant care work arrangements because these benefit families and, some argue, benefit these workers as well because even though they are experiencing substandard wages and working conditions in Germany, they are earning more than they would in their home country. One could argue that the LTSS program is even predicated on this cheap labor in that it is aware of

^{xxvi} Among beneficiaries with lower levels of care need, a smaller share had live-in assistance. German Federal Ministry of Health, "Wissenschaftliche Evaluation der Umstellung des Verfahrens zur Feststellung der Pflegebedürftigkeit," 2019, <https://bit.ly/3pxlBQF>, 91-92.

this issue but has not sought to thwart it and continues to attach no strings to these cash benefits. Allowing cash benefits to be used to pay substandard wages to guest workers also mitigates the formal workforce shortage and reduces program expenditure by paying out more cash than service benefits (the latter are available up to a higher monthly cap).

Furthermore, it depresses wages in the formal LTSS workforce sector by significantly reducing demand, further saving money for the program (in benefit expenditure) and for families (in remaining out-of-pocket costs beyond what the program pays). Because many of these guest workers live with their clients, paying standard wages for this work would far exceed the program's current benefit levels and financial capacity.

Even a well-designed LTSS program will struggle to provide quality, accessible care if not accompanied by workforce planning and policy.

The foreign guest workers paid with the program's cash benefits are precarious because they do not have union representation or collectively bargained rights or wages. The main union for long-term care workers in Germany, Verdi, has not organized them. Organizing them would also be challenging given that the recruiting agencies tend to keep them in Germany for only a few months before they return to their home country. One measure proposed by Health Minister Jens Spahn would be to offer higher benefits to program beneficiaries who legally engage live-in care workers.⁵⁴ Such a demand-side approach could, however, end-up privileging a small segment of the immigrant population without addressing the working conditions of other care workers.

Immigration reform that offers a path to citizenship for these and other prospective long-term care workers would plausibly go far in addressing the formal LTSS workforce shortage. That policy option has not gained significant support in Germany. Moreover, Germany is not alone in facing an impending LTSS workforce shortage. If Germany sought to address this problem through immigration it would be competing against many other European – and more broadly, OECD – countries. Immigration, even if it were embraced as a solution, could therefore likely provide only part of the answer.

What has gained support across the political spectrum is improving the quality of care jobs so that more people will choose to enter the field, and those who do enter the field choose to remain in it. In 2018, the federal government convened a national roundtable, "Concerted Action Care" (*Konzertierte Aktion Pflege*) to develop a policy framework to make care work more attractive. In practice, it was focused more broadly on developing consensus around policies that would address the workforce shortage.

Led by the Minister of Health (who oversees the LTSS program), the Minister of Labor and Social Affairs, and the Minister of Family Affairs, Senior Citizens, Women and Youth, Concerted Action Care brought the umbrella organizations of several dozen key stakeholders in the LTSS system – from government officials to non-profit insurers to for-profit and non-profit providers to unions – to the table. The group presented a consensus interim report in November 2020 which agreed on a diagnosis of the problem and promising elements of a solution.⁵⁵

The group agreed that what is needed are:

- **More care workers**, and proposed achieving this through a combination of improving working conditions and making it easier for foreign care workers to be credentialed and employed in Germany;
- **Better pay for care workers**, and proposed raising wages, including introduction of a differentiated minimum wage for different levels of care work;
- **More funding for the LTSS social insurance system as a whole** in order to make the aforementioned reforms possible without increasing out-of-pocket costs for beneficiaries;
- **Expanded vocational training of care workers** by increasing the number of slots in existing training programs, creating continuing education programs to upskill long-term care nursing assistants (to address high turnover), and conducting public outreach to recruit people into the profession;
- **More responsibility for care workers**, giving them more discretion and decision-making authority e.g. in their collaboration with doctors;
- **More digitalization** in the form of reducing the time and energy devoted to filling out paperwork, increasing ‘telecare’, and increasing use of technology to support care work (while engaging care workers in so doing).

The governing coalition is already working on implementing some of these approaches while others will be explored further in the course of the Concerted Action Care process.



Conclusion

As state governments in the U.S. embark on the design and implementation of universal LTSS programs, a range of insights can be drawn from decades of experience with such programs in a number of OECD countries. For social insurance approaches like the one adopted in Washington State, much can be learned from Germany's scheme. Germany has leveraged the self-funded nature of traditional social insurance design to significantly reduce what would have become an overwhelming burden on communal social assistance programs. The program started small in scope and despite qualitative benefit expansions over the years – mostly around better coverage of cognitive impairment – has maintained a modest fiscal footprint, spending less as a share of GDP than the average of its peer nations. Despite being contributory, it achieved near-universal coverage within a few years of implementation primarily by having a low vesting threshold, employing an expansive definition of vesting to include non-contributing family members, and leveraging a pay-as-you-go financing approach (together with the low vesting threshold) to cover those who were already retired at the time of enactment. It offers those needing care flexible benefits that constitute a range of choices including formal care, family care, or some combination of the two. Most fundamentally, it has made LTSS universally accessible and affordable by people of all ages needing LTSS.

Lessons can also be drawn from some major challenges facing the German LTSS system. Like all LTC social insurance programs in this era of aging societies, it has had to cope with the often competing challenges of meeting beneficiary care needs, addressing the care workforce shortage, ensuring quality jobs and quality care, and controlling costs (and hence the program contribution rate). Hitherto it has mostly navigated these challenges by privileging meeting beneficiary care needs and controlling costs. It is reliant to a significant extent on a gray market of guest

workers who are paid substandard wages. This is not only morally problematic vis-à-vis the care workforce but also presents quality-of-care challenges, as does the use of cash benefits in general; the use of cash benefits at home is a black box, perhaps intentionally so. Germany faces a workforce shortage in the coming decades both in replacing the gray market workers engaged by families using cash benefits but also in addressing projected shortages in the formal care sector. As the workforce shortage becomes more acute, Germany is showing early indications of an increasing emphasis on quality care jobs as a means of addressing the workforce shortage.

Care leave policy has long been underdeveloped in Germany, and remains so, but policymakers are now beginning to realize that a longer-term wage-replacement benefit for family caregivers could go far in alleviating the care workforce shortage. The larger lesson for LTSS systems in the U.S. is that a multi-pronged approach will be required to meet the scope of the LTSS workforce challenge brought by population aging and the corresponding expansion of public LTSS benefits.

Taking a broader view of universal LTSS systems across the OECD, divergent approaches persist to some system design questions, while for others, best practices – or a degree of convergence – can be observed. Approaches to financing and coverage continue to develop in the three broad lanes of social insurance, universal comprehensive coverage, and residual (means-tested) public provision. Each design architecture is predicated on a set of social-policy cultural preferences that tend to have deep roots in the countries where they obtain. Another axis of divergence across systems is whether cash benefits are included as a significant part of the benefit system. Some countries place great value on cash benefits supporting family care, while others are more concerned with supporting female labor-market participation.

A large degree of convergence across systems can be found with regard to supporting older adults being able to age in place, both because most care recipients prefer this and because it helps control system costs. Related to this, even countries whose systems eschew cash benefits have increasingly developed policies in recent years that ease burdens on family caregivers. Robust care leave policy offers a sweet spot here in that it facilitates family care without requiring an exit by family caregivers from the labor-market.

Finally, all universal LTSS programs across the world face two significant challenges. The first is the shortage of care workers. Even with supportive immigration policy, these systems will be competing for this scarce global resource in the years ahead. Robust domestic workforce and care leave policies will be required to meet this challenge. Second, all LTSS programs abroad are structured as pay-as-you-go systems and as such will face a financing challenge in the coming decades as Boomers age into their peak care years.



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