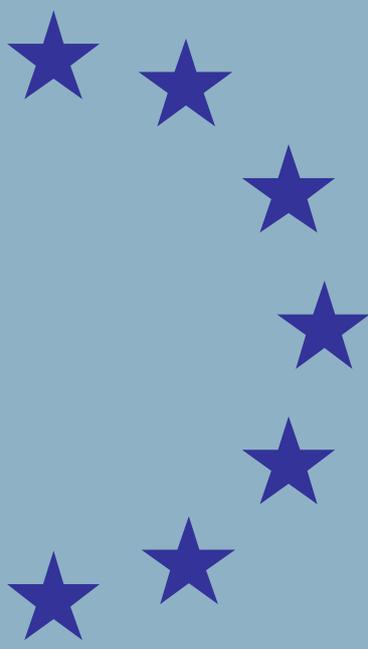




# Germany

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## Health Care & Long-Term Care Systems



An excerpt from  
the Joint Report on Health Care  
and Long-Term Care Systems  
& Fiscal Sustainability,  
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## Germany

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Health care systems

## 1.11. GERMANY

### General context: Expenditure, fiscal sustainability and demographic trends

#### General statistics: GDP, GDP per capita; population

In 2013, GDP per capita (31,700 PPS) in Germany was one of the highest in the EU. GDP grew with positive rates from 2010 onwards, after a record negative growth rate in 2009. Current population is estimated at 82.0 million. Over the decades to come, the German population is projected to shrink significantly from 82 million in 2013 to 70.8 million in 2060.

#### Total and public expenditure on health as % of GDP

Total expenditure on health was one of the highest in the EU at 11.3% of GDP in 2013 (EU: 10.1%). Public spending on health was at 8.7% of GDP (EU: 7.7%). Spending relative to GDP was quite constant between 2003 and 2008, with a sharp increase due to falling GDP in 2009, and has stayed on this level in 2013. In 2012, 15.7% of total government expenditure was channelled towards health spending (EU: 14.9%). In per capita terms, total (3,742 PPS) and public spending (2,860 PPS) are well above the respective EU averages (2,988 PPS and 2,208 PPS).

#### Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 0.6 pps of GDP, below the average growth level expected for the EU (0.9 pps of GDP), according to the "AWG reference scenario".<sup>(107)</sup> When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.3 pps of GDP from now until 2060 (EU: 1.6). Overall, projected health care expenditure increase is expected to add to budgetary pressure. However, no sustainability risks appear over the long run as the favourable initial budgetary position would

mitigate the projected increase in age-related expenditure.<sup>(108)</sup>

#### Health status

Life expectancy at birth is 78.6 years for men and 83.2 years for women, being one of the highest in the EU (EU: 77.6 for men and 83.1 for women). Healthy life years are, however, below the EU average (57.0 vs. 61.8 years and 58 vs. 61.6 years), but due to limited cross-country comparability of the healthy-life years indicator these results have to be treated with caution. Amenable mortality rates, i.e. deaths that should not occur with timely and effective care, are well below EU average. Infant mortality is at the level of 3.3‰ (EU: 3.9‰).

#### System characteristics

##### System financing, revenue collection mechanism, coverage and role of private insurance and out of pocket co-payments

The German health care system provides universal coverage. Insurance is compulsory and provided by either statutory (SHI) (around 90% of the population) or private health insurance (PHI). The membership in the SHI is mandatory for employees with gross income not exceeding a legally defined threshold, covering in most cases also the spouses and children of the insured without additional contributions. High-earners with a monthly income exceeding a specified threshold, the self-employed and civil servants have to contribute towards a private insurance.

SHI provides a standardised benefits package. Premiums are income dependent but do not depend on individual health risks. In contrast, PHI premiums depend on the individuals' health risks and not on income. The benefit package is based on an insurance contract and co-insurance of family members requires additional premiums. Once covered by PHI, the possibility to switch back to SHI is restricted.

SHI is predominately financed through labour-income-dependent contributions accompanied by a

<sup>(107)</sup> The 2015 Ageing Report: [http://europa.eu/epc/pdf/ageing\\_report\\_2015\\_en.pdf](http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

<sup>(108)</sup> Fiscal Sustainability Report 2015: [http://ec.europa.eu/economy\\_finance/publications/eeip/pdf/ip018\\_en.pdf](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf).

complementary government subsidy. Since 2009, a National Health Fund (*Gesundheitsfonds*) is responsible for pooling contributions paid at a uniform rate set by the Federal government. From January 2015 on, the uniform contribution rate is set at 14.6% (7.3% and 7.3% paid by employers (pensioners) and employees (pension fund), respectively). Yet, the SHIs may charge additional surcharges if expenses do not cover expenditures. The introduction of additional surcharges increases competition between SHIs (see explanation of the SHI health financing reform below).

The collected contributions are pooled and complemented by a federal tax subsidy. They are allocated then to the individual sickness funds in the form of: (i) a uniform basic lump-sum per person insured, (ii) payments adjusted for risk, gender, invalidity, age and morbidity from 80 chronic and serious illnesses; and (iii) additional funds to cover other standard expenditure (e.g. administrative costs).

In 2016, the SHI was composed of 116 sickness funds, which are non-profit public law corporations and financially and organisationally independent bodies. The number of SHI funds has decreased from over 1.123 in 1992, mainly as a result of reforms aimed at strengthening the competition among health-care insurers. There is an obligation for sickness funds to insure anybody who is entitled to SHI. A risk adjustment mechanism redistributes funds across SHI funds to better reflect actual morbidity costs.

In 2012, the SHI bore 57% of total health expenditure. Other social insurance schemes bore another 10.7%, the PHI 9.3%, public authorities 4.8% and employers 4.3%. Private out-of-pocket payments amount to 12.9% of total health expenditures (EU: 14.3%). Conversely, private expenditure was slightly above the EU average of 23.2% (EU: 22.6%). Since 2004, patients need to provide certain co-payments limited to 2% of an annual household income, respectively to 1% for the chronically ill. The quarterly fee paid by patients for medical treatment (*Praxisgebühr*) was abolished at the beginning of 2013 on the grounds that it was ineffective.

The health reform (*GKV-Finanzstruktur- und Qualitätsweiterentwicklungsgesetz*), coming into force in January 2015, promotes a quality-based

competition among health funds. Its main elements are the following. The general contribution rate was decreased from 15.5% in 2010 to 14.6%, while freezing the contribution rate paid by employers at 7.3%. The 0.9% employee's contribution surcharge was abolished. Health funds received greater financial autonomy due to the lowering of the uniform contribution rate and the introduction of health insurance fund-specific, income-related surcharges to cover expenditures exceeding risk-adjusted allocations. A full revenue compensation scheme for the income-related surcharges was introduced to avoid incentivising risk selection.

#### *Administrative organisation*

The responsibility for the system is shared between national and regional level (*Länder*). At the national level the legal framework for both tiers of the insurance system is set. The *Länder* are responsible for organising medical education, planning inpatient capacities and financing capital investments in hospitals. Large sections of the German health care system are shaped through contracts between the SHI-funds and various health care providers.

A special feature in the regulation of medical services of the German health care system is the important role, alongside that of the legislature, played by the self-governing bodies of service providers and health insurance funds. In the statutory health insurance system the major decision-making body is the Federal Joint Committee (G-BA). It is formed by the national associations of doctors and dentists, the German Hospital Federation and the National Association of Health Insurance Funds. Thus, the G-BA determines the benefit catalogue of the SHI as well as on binding collective regulations on the quality of health care services.

#### *Treatment options, covered health services*

SHI covers preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, optometry, physical therapy, prescription drugs, medical aids, rehabilitation, hospice and palliative care, pregnancy care, maternal leave and sick leave compensation. SHI preventive services include regular dental check-ups, child check-ups, basic

immunisations, check-ups for chronic diseases, and cancer screening at certain ages. All prescription drugs—including newly licensed ones—are covered unless explicitly excluded by law (mainly so-called lifestyle drugs) or pending evaluation. While the broad contents of the benefits package are legally defined, specifics are decided upon by the Federal Joint Committee.

#### *Types of providers, referral systems and patient choice*

Primary care is provided by private for-profit physicians, most of whom run individual practices, and about 25% share a practice. The majority of doctors are accredited for SHI. They can also take private patients and charge them higher prices. Traditionally, the German health-care system does not have a gate-keeping system and the patients are free to choose any doctor under a contract with their sickness fund. SHI operates with collective contracts covering provision by all doctors of a certain region. There is no affiliation to a single sickness funds. Additionally, there is also the option for selective contracts for a range of services or specific care models. More recently, patients are encouraged to choose a family doctor.

The number of physicians has grown constantly over the recent decade: from 337 per 100000 inhabitants in 2003 to 402 in 2013, above the EU average of 344. Over the same period of time, the number of general practitioners has stayed constant at 66 per 100000 between 2003 and 2013 (EU: 78). The number of nurses is at 1248 per 100000 in 2013, remaining well above the EU average of 837. Total and public expenditure on outpatient care as a % of current health expenditure were at the EU average (around 23%).

Germany has the highest per-capita hospital beds for curative (acute) care in the EU: 529 beds per 100 000 inhabitants in Germany compared to 356 in the EU. Obviously, access to inpatient care is high. This is despite a constant decline of hospital bed capacity in the past, driven by a decrease in the average length of stay, which still remains above the EU average. Contrary to the general trend in the EU, the number of hospital inpatient discharges is rising from 21.9 in 2003 to 24.4 in 2013 per 100 inhabitants (EU: 16.5 in 2013). At the same time, the level of day case discharges is very low with 656 discharges per 100 000

inhabitants in Germany, versus 7,031 discharges in the EU. The low number of day case discharges is a consequence of the disintegrated system of care, which basically limits the room for providing day case treatments in German hospitals. Public inpatient care accounts for roughly 32% of public expenditure on health in Germany compared to 34% in the EU. High expenditure levels may be a sign of a modern hospital system providing high-quality services. They may, also, reflect hospital centrism, an overprovision of inpatient services, a focus on costly high-technology treatments and an undervaluation of (cheaper) ambulatory care services (at the same level of quality of care).

#### *Price of healthcare services, purchasing, contracting and remuneration mechanisms*

Physicians and other health professionals working in hospitals or institutions for nursing care or rehabilitation are paid salaries. Public and non-profit providers usually pay public service tariffs to their employees, while private, for-profit providers may pay lower or higher wages or additional payments to their employees. Services provided by the ambulatory care providers, as well as by private physicians, dentists, pharmacists, midwives and other health professionals are subject to predetermined price schemes or price ranges.

Medical billing is based on the standard schedule of fees (*Einheitlicher Bewertungsmaßstab - EBM*). It is the fee schedule that applies to outpatient care and, in the form of fees-for-service or flat rates, comprises all services that panel doctors can bill for reimbursement by the statutory health insurance funds. Patients covered by PHI pay out-of-pocket on a fee-for-service basis. Doctors may charge higher fees for private patients – based on a medical fee schedule for private patients.

Hospital expenditures are financed using two different mechanisms. Investment is financed by the regions (*Länder*), mainly through regional taxes, while recurrent expenditure (thus, mainly cost of care) is reimbursed by the SHI-funds and PHI. Recurrent expenditures of acute hospitals are reimbursed by the SHI-funds according to the Diagnosis-Related Group (DRG) system, with some exceptions.

### *The market for pharmaceutical products*

Until 2011, prices of medicines were mainly determined by internal reference pricing for generics and therapeutic substitutes. Internal reference prices are price limits on certain pharmaceutical substance groups. The G-BA specifies the groups of active ingredients. The National Association of Health Insurance Funds sets the reference prices, considering that enough medicines are available at that price. Patients have to bear the price difference for any drug whose price exceeds the reference level. This sets strong incentives to producers not to set prices above the reference price. In contrast, prices of newly invented drugs were unilaterally set by the producer.

Since 2011, the AMNOG obliges producers to verify the additional therapeutic benefit of new patented medicines. If an additional benefit is proven, the National Association of Statutory Health Insurance Funds negotiates the price for the medicine with the pharmaceutical company. If an additional benefit is not proven, new active pharmaceutical ingredients are subject to reference pricing. If this is not possible the price must not be higher than the price of the therapy standard.

AMNOG aims at ensuring fair prices that balance the interests of both, the statutory health insurance as well as the pharmaceutical companies. As a further cost-containment measure, the SHI-Amendment Law (in force since August 2010) introduced a mandatory discount of 16% on pharmaceuticals and freeze of prices of pharmaceuticals until 2013. With the 13<sup>th</sup> and 14<sup>th</sup> SGB V-Amendment Law (in force since December 2013 respectively April 2014) the price freeze was extended until 2017 and while the mandatory discount of 16 % ran out by the end of 2013, there is still a remaining mandatory discount of 7 % (16 % for generics). However, the prize freeze does not apply for medicines that have been subject to internal price referencing and it is not relevant for medicines that have a negotiated price after the AMNOG-procedure.

Pricing policies are supplemented by financial incentives and the monitoring of prescription patterns of physicians vis-à-vis prescription guidelines and prescription targets.

### *Use of Health Technology Assessments and cost-benefit analysis*

Health Technology Assessment (HTA) is increasingly used in Germany to inform health-care decision-making. Quality and efficiency are two deciding factors in maintaining the performance of the German health care system. To achieve this aim, it is important to examine objectively the advantages and disadvantages of medical services for patients. This is the responsibility of two German Institutes: the German Agency for Health Technology Assessment (DAHTA), which runs the HTA information system and the Institute for Quality and Efficiency in Health Care (IQWiG). IQWiG is an independent scientific institute that investigates the benefits and harms of medical interventions for patients.

### *eHealth (e-prescription, e-medical records)*

One of the most important eHealth projects in the German health care system is the adoption of an eHealth card and a telematics infrastructure. The eHealth card is meant to contribute to better medical care provision, to improve communication among all of the parties involved and ensure greater efficiency in health care processes. To this end, the application possibilities for the eHealth card are to be expanded step by step, whereas the eHealth card has been distributed to the ca. 70 million publicly insured persons in Germany by almost 100%.

A new act on eHealth, which came into force in December 2015, accelerated the deployment of the applications to the eHealth card, setting clear deadlines and further specifications to the entrusted company (Gematik). In addition the act on eHealth set out further incentives with regard to telemedicine as well as supporting interoperability. Gematik is responsible for the national telematics infrastructure and the applications of the eHealth card and supported by the self-administration. The act on eHealth also supported Gematik's continued work to support interoperability on the EU-level.

As set out in the act on eHealth, from 2018 onwards patients in Germany can choose to have the relevant emergency data stored on their health card. Also an electronic medication plan is planned to be available by 2018, including a verification of

drug treatment safety among care providers. The Electronic Patient Health Records, which will be on the one hand managed by health professionals, but also on the other hand through a so called electronic patient folder manageable by the patients, are to be introduced by beginning of 2019. The design of the German telematics infrastructure fulfils the highest of safety standards: there are clear rights of access and the accessing of data by physicians is recorded. Medical data is encrypted. At all times, patients have control over their data and decide whether and which medical data may be stored and who is entitled to read them.

#### *Health and health-system information and reporting mechanisms*

The planning of measures on health care provision is based on a range of information and research made available by various actors at the federal, state and corporatist levels. For example, the Federal Association of Sickness Funds and the Federal Association of SHI Physicians are obliged by law to provide and publish statistics on their financial performance and activities and about the structure of their membership. Additionally, these and other stakeholders are financing health services research, health policy research and publish related reports and statistics. A large number of health statistics is published by the Federal Statistical Office. An Advisory Council on the Assessment of Developments in the Healthcare System reports every two years to the Federal Ministry of Health on current developments in the health care system.

#### *Health promotion and disease prevention policies*

Health promotion and disease prevention activities have received more emphasis than in other countries in the EU, as seen by its pattern of expenditure. Total and public expenditure on prevention and public health services as a % of total current health expenditure were well above the EU average. The German Preventive Health Care Act (*Präventionsgesetz*) has given a further boost on health prevention. SHI-funds are obliged to provide more disease prevention and health promotion activities especially in the settings and spend more money in this sector (See section 3).

#### *Transparency and corruption*

The task of supervising whether doctors, dentists, pharmacists and psychotherapists fulfil their professional obligations is incumbent on the specific professional organisations and the professional disciplinary tribunals. Professional obligations include the observance of specific prohibitions regarding inadmissible business relations and forms of cooperation, or relations that are prone to corruption, with other benefit and care providers. Statutory disclosure obligations apply, for example, to fees and remuneration received within the framework of surveys and observational non-interventional trials in the context of medicinal products supply. The health insurance funds, together with the panel doctors' associations and/or the associations of the other care providers, are responsible for verifying the observance of the rules applicable in the statutory health care system regarding the cost-effectiveness of care provision and the mathematically and factually accurate settlement of claims for benefits and services by the care providers. Furthermore, offices responsible for combating misconduct in the statutory health insurance have been set up at all health insurance funds and panel doctors' associations as well as their associations at Land and federal level.

#### *Recently legislated and/or planned policy reforms*

The increase in the elderly population will result in a greater need for health and long-term care benefits. The federal government addresses these challenges in its recent reforms to the health care system and has implemented several structural health care reforms to strengthen competition in the health care system in order to improve efficiency in health care provision. A sustainable funding for health care provision was emphasised in particular as part of this process.

The "Reform of the Market for Pharmaceutical Products" (AMNOG) in 2011 was a far-reaching structural reform that aimed at curbing expenditure growth of medicines. The AMNOG obliges producers to verify the additional therapeutic benefit of new patented medicines. The AMNOG also allows for the possibility of price negotiations for patented medicines instead of unilateral price setting by the producers.

The health financing reform (*Act on the further development of the Statutory Health Insurance System's Financial Structure and Quality*), which came into force in January 2015, promotes quality-based competition among providers and health funds. Health funds received greater financial autonomy due to the lowering of the uniform contribution rate and the introduction of health insurance fund-specific, income-related surcharges to cover expenditures exceeding risk-adjusted allocations. The idea behind the surcharges is to foster competition among statutory health funds. Through increasing the financial autonomy of health funds and by implementing a consistent quality focus in health care provision, the cost-effectiveness of public spending should be improved. At the same time, freezing the share of employers' health insurance contributions at 7.3% aims at containing wage related costs.

The establishment of an Institute for Quality Assurance and Transparency in the healthcare sector (IQTIG), as specified in the "*Act to Further Develop the Financial Structure and Quality of the Statutory Health Insurance System*", strengthens competition in terms of quality in the statutory health insurance system. The aim is for patients to have a set of transparent criteria which they can use to ascertain which specific hospitals offer the best quality for a specific treatment, for instance. Over the medium to long term, a better quality of service leads to the more efficient use of resources. Better in-patient treatment, in turn, will mean fewer complications and re-admissions, and thereby less subsequent expenditure. Higher quality in health care leads, in the medium to long term, to a more efficient use of resources and to greater sustainability in the German health care system.

Representatives of the federal government and the *Länder* agreed for structural reform measures in the hospital sector that came into force in January 2016 (KHSG – Krankenhausstrukturgesetz). The aim is to boost the efficiency of hospital care – ranging from nationwide care provision to high-end medical care – by improving the efficient use of resources. Important goals include strengthening the quality of care as a criterion, when it comes to hospital planning and the remuneration of services, and establishing a promotion programme for nursing homes. A structural fund will be set up to finance measures to improve existing care

structures. To this end, a one-time disbursement of 500 million euros will be made from the liquidity reserve of the national health fund. This money will be used to finance projects proposed by the *Länder*, if the latter contribute an equal amount. Thus, a maximum of 1 billion euros funding volume will be made available in order to promote the reduction of excess capacity and the specialisation and concentration of hospital centres.

The federal government introduced a "*Preventive Health Care Act*" that entered into force in July 2015. At the core of this law is the strengthening of prevention and health promotion in the settings in which people live, for example in child day-care centres, schools, workplaces, neighbourhoods or in long-term care facilities. The intention is to achieve this through a much better fine-tuning of efforts undertaken by persons responsible for these settings at federal, *Land* and municipal level. Expenditure by the health insurance funds on prevention and health promotion is to be almost doubled. The additional expenditure shall be offset in the medium and long term by cost savings achieved through avoided costs of diseases. Additionally, early detection screening among children, young persons and adults will continue to be developed and important measures shall be taken to close vaccination gaps.

In order to ensure a needs-based, universal and easily accessible supply of medical care, the federal government introduced the "*Act to Strengthen Care Provision in the Statutory Health Insurance System*" (Care Provision Strengthening Act) that came into force in July 2015. The primary objective of this law is to ensure a proper supply of physicians both in the cities and in the rural areas. The role of family doctors is to be strengthened. The strain on doctors is to be reduced by allowing them to delegate selected medical services to qualified non-physician personnel, for example, practice assistants. Moreover, in the future, hospitals in underserved areas will be able to assume more responsibility for medical care. In order to promote innovative care structures, to facilitate inter-sectoral cooperation among health care providers and to stimulate research on health care provision, an innovation fund will be set up at the *Federal Joint Committee*, endowed with EUR 300 million annually – initially from 2016 to 2019.

Telemedicine and digital technologies can provide vital support in organising the supply of healthcare. In order to make these advantages available nationwide as soon as possible a new act on eHealth was introduced by the federal government and came into force in December 2015. The act on eHealth contains an overall plan to accelerate the deployment of the telematics infrastructure and the applications to the eHealth Card such as electronic emergency data, medication plan and electronic health records and as well as to set out further incentives with regard to telemedicine. Digital technologies are meant to contribute to better medical care provision, improves communication among all of the parties involved and ensure greater efficiency in health care processes (See above on eHealth: e-prescription, e-medical records)

- To extend the possibilities of hospitals to provide ambulatory and day care as well as to transfer more health care services into the ambulatory sector in order to reduce the number of inpatient care treatments.
- To promote further the process of modernisation and specialisation among hospitals and to stimulate the further reduction of excess capacities.
- To strengthen further the role of health promotion and disease prevention in the overall health care system as well as in society in general.

### Challenges

The analysis above shows that a wide range of promising reforms has been implemented in recent years to strengthen financial sustainability, efficiency and quality of health care provision. The main challenges for the German health system are as follows:

- To continue increasing the efficiency of health care spending, promoting quality and integrated care against the background of rising health care expenditure over the coming decades, due to population ageing and non-demographic factors.
- To improve further the coordination among care providers and to reduce inter-sectorial borders between inpatient and outpatient care and to promote new models of health care delivery.
- To promote further telemedicine and digital technologies in the health care sector for a better medical care provision, for improving communication among all of the parties involved and to ensure greater efficiency in health care processes.
- To enhance primary care provision through promoting the number and the use of GPs' services.

Table 1.11.1: Statistical Annex – Germany

General context												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
GDP, in billion Euro, current prices	2220	2271	2301	2393	2513	2562	2460	2580	2703	2755	2821	9289	9800	9934
GDP per capita PPS (thousands)	26.9	27.8	28.8	30.1	31.3	31.3	28.6	30.8	32.1	32.1	31.7	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	-0.4	1.2	0.7	3.8	3.4	1.3	-4.9	4.2	3.3	0.5	0.2	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	2.6	-1.1	2.0	2.2	1.8	3.4	4.4	2.5	0.5	0.7	0.5	3.2	-0.2	-0.4
<b>Expenditure on health*</b>												<b>2009</b>	<b>2011</b>	<b>2013</b>
Total as % of GDP	10.9	10.7	10.8	10.6	10.5	10.7	11.8	11.6	11.3	11.3	11.3	10.4	10.1	10.1
Total current as % of GDP	10.5	10.3	10.3	10.1	10.0	10.2	11.1	11.0	10.7	10.8	10.9	9.8	9.6	9.7
Total capital investment as % of GDP	0.4	0.4	0.6	0.5	0.5	0.5	0.6	0.6	0.6	0.5	0.4	0.6	0.5	0.5
Total per capita PPS	2814	2813	2889	2960	3066	3194	3378	3493	3564	3635	3724	2828	2911	2995
Public as % of GDP	8.6	8.2	8.3	8.1	8.0	8.2	9.0	8.9	8.6	8.6	8.7	8.1	7.8	7.8
Public current as % of GDP	8.3	7.9	7.8	7.7	7.6	7.8	9.3	9.2	9.0	9.0	9.2	7.9	7.7	7.7
Public per capita PPS	2065	2018	2070	2120	2197	2289	2426	2516	2726	2788	2860	2079	2218	2208
Public capital investment as % of GDP	0.3	0.3	0.4	0.4	0.4	0.4	-0.3	-0.3	-0.3	-0.3	-0.5	0.2	0.2	0.1
Public as % total expenditure on health	78.5	76.8	76.6	76.4	76.4	76.4	76.8	76.7	76.5	76.7	76.8	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	14.4	14.0	14.3	14.6	14.9	15.2	15.1	15.0	15.5	15.7	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	99.7	99.8	99.8	99.8	99.8	99.9	99.9	99.9	99.9	99.8	99.8	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	11.4	12.8	12.7	12.9	12.8	12.6	12.3	12.3	12.3	12.2	12.9	14.1	14.4	14.1

Note: \*Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												2009	2011	2013
Population, current (millions)	82.5	82.5	82.5	82.4	82.3	82.2	82.0	81.8	81.8	81.8	82.0	502.1	504.5	506.6
Life expectancy at birth for females	81.3	81.9	82.0	82.4	82.7	82.7	82.8	83.0	83.2	83.3	83.2	82.6	83.1	83.3
Life expectancy at birth for males	75.8	76.5	76.7	77.2	77.4	77.6	77.8	78.0	78.4	78.6	78.6	76.6	77.3	77.8
Healthy life years at birth females	64.7	:	54.8	58.3	58.6	57.7	58.1	58.7	58.7	57.9	57.0	:	62.1	61.5
Healthy life years at birth males	65.0	:	54.5	58.7	59.0	56.4	57.1	57.9	57.9	57.4	57.8	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	69	63	60	56	52	51	50	47	102	99	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	4.2	4.1	3.9	3.8	3.9	3.5	3.5	3.4	3.6	3.3	3.3	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Inpatient curative and rehabilitative care	2.93	2.91	2.85	2.81	2.71	2.75	3.04	3.02	2.97	3.00	3.03	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.07	0.07	0.08	0.09	0.10	0.10	0.11	0.11	0.10	0.10	0.11	0.18	0.18	0.19
Out-patient curative and rehabilitative care	2.46	2.46	2.32	2.29	2.26	2.32	2.54	2.50	2.46	2.47	2.50	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.57	1.48	1.58	1.52	1.53	1.56	1.70	1.65	1.53	1.53	1.54	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.58	0.50	0.52	0.53	0.52	0.53	0.57	0.57	0.56	0.58	0.60	0.31	0.31	0.32
Prevention and public health services	0.35	0.34	0.35	0.35	0.37	0.38	0.41	0.39	0.36	0.36	0.34	0.25	0.25	0.24
Health administration and health insurance	0.67	0.66	0.66	0.63	0.60	0.61	0.67	0.67	0.65	0.64	0.61	0.42	0.41	0.47
<b>Composition of public current expenditure as % of GDP</b>														
Inpatient curative and rehabilitative care	2.63	2.60	2.55	2.52	2.43	2.46	2.91	2.89	2.85	2.88	2.91	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.07	0.07	0.08	0.09	0.10	0.10	0.11	0.11	0.10	0.10	0.11	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.84	1.73	1.61	1.59	1.56	1.59	2.04	2.00	1.96	1.97	2.05	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	1.17	1.05	1.17	1.14	1.16	1.19	1.42	1.36	1.26	1.24	1.26	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.33	0.28	0.27	0.26	0.26	0.27	0.29	0.28	0.27	0.28	0.29	0.13	0.12	0.13
Prevention and public health services	0.30	0.29	0.30	0.30	0.32	0.33	0.35	0.33	0.30	0.30	0.29	0.25	0.20	0.19
Health administration and health insurance	0.44	0.43	0.43	0.41	0.39	0.40	0.44	0.45	0.42	0.43	0.43	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.11.2: Statistical Annex - continued – Germany

Composition of total as % of total current health expenditure												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Inpatient curative and rehabilitative care	27.9%	28.3%	27.8%	27.8%	27.2%	27.1%	27.3%	27.5%	27.8%	27.9%	27.7%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	0.7%	0.7%	0.8%	0.9%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	23.4%	24.0%	22.6%	22.7%	22.7%	22.9%	22.8%	22.7%	23.0%	23.0%	22.9%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	15.0%	14.4%	15.4%	15.0%	15.4%	15.4%	15.3%	15.0%	14.3%	14.2%	14.1%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	5.5%	4.9%	5.0%	5.2%	5.3%	5.2%	5.1%	5.2%	5.3%	5.4%	5.4%	3.2%	3.3%	3.3%
Prevention and public health services	3.3%	3.3%	3.4%	3.5%	3.7%	3.7%	3.7%	3.5%	3.4%	3.3%	3.1%	2.6%	2.6%	2.5%
Health administration and health insurance	6.4%	6.4%	6.4%	6.2%	6.0%	6.0%	6.0%	6.1%	6.1%	5.9%	5.6%	4.2%	4.3%	4.9%
<b>Composition of public as % of public current health expenditure</b>														
Inpatient curative and rehabilitative care	31.8%	32.8%	32.5%	32.7%	32.0%	31.7%	31.2%	31.4%	31.8%	32.0%	31.7%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	0.8%	0.9%	1.0%	1.2%	1.3%	1.3%	1.1%	1.2%	1.2%	1.1%	1.2%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	22.2%	21.8%	20.5%	20.6%	20.5%	20.5%	21.8%	21.7%	21.9%	21.9%	22.3%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	14.1%	13.3%	14.9%	14.8%	15.3%	15.3%	15.2%	14.8%	14.1%	13.8%	13.7%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	4.0%	3.5%	3.4%	3.4%	3.4%	3.4%	3.1%	3.0%	3.1%	3.1%	3.1%	1.6%	1.6%	1.6%
Prevention and public health services	3.6%	3.7%	3.8%	3.9%	4.2%	4.3%	3.7%	3.6%	3.4%	3.3%	3.2%	3.2%	2.7%	2.5%
Health administration and health insurance	5.3%	5.4%	5.4%	5.3%	5.2%	5.2%	4.7%	4.9%	4.7%	4.7%	4.6%	1.4%	3.5%	3.5%
<b>Expenditure drivers (technology, life style)</b>														
MRI units per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	0.6	0.7	0.7	0.8	0.8	:	:	:	:	:	:	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	0.1	0.1	0.1
Proportion of the population that is obese	12.9	:	13.6	:	:	15.8	14.7	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	24.3	:	23.2	:	:	22.8	21.9	:	:	:	20.9	23.2	22.4	22.0
Alcohol consumption litres per capita	11.9	11.8	11.7	11.8	11.5	11.4	11.2	11.2	11.2	11.2	10.9	10.3	10.0	9.8
<b>Providers</b>														
Practising physicians per 100 000 inhabitants	337	339	341	345	350	356	364	373	382	389	402	329	335	344
Practising nurses per 100 000 inhabitants	1095	1106	1123	1135	1151	1174	1204	1216	1229	1238	1284	840	812	837
General practitioners per 100 000 inhabitants	66	66	67	66	66	65	65	66	66	65	66	:	78	78.3
Acute hospital beds per 100 000 inhabitants	582	568	559	543	538	535	535	533	531	528	529	373	360	356
<b>Outputs</b>														
Doctors consultations per capita	7.6	7.4	8.1	7.9	8.1	8.6	9.2	9.9	9.7	9.7	9.9	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	21.9	21.4	21.3	21.5	22.1	22.7	23.1	23.4	23.7	24.1	24.4	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	834	710	591	576	578	596	613	629	647	655	656	6368	6530	7031
Acute care bed occupancy rates	78.0	76.0	76.0	77.0	79.0	79.1	79.2	79.0	79.0	79.2	79.3	72.0	73.1	70.2
Hospital curative average length of stay	9.3	8.9	8.8	8.7	8.5	8.3	8.2	8.1	7.9	7.8	7.7	6.5	6.3	6.3
Day cases as % of all hospital discharges	:	:	:	2.6	2.5	2.6	2.6	2.6	2.7	2.6	2.6	27.8	28.7	30.4
<b>Population and Expenditure projections</b>														
<b>Projected public expenditure on healthcare as % of GDP*</b>	2013	2020	2030	2040	2050	2060	Change 2013 - 2060				EU Change 2013 - 2060			
AWG reference scenario	7.6	7.9	8.1	8.3	8.4	8.2	0.6				0.9			
AWG risk scenario	7.6	8.2	8.5	8.9	9.1	8.9	1.3				1.6			
Note: *Excluding expenditure on medical long-term care component.														
<b>Population projections</b>	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %				EU - Change 2013 - 2060, in %			
Population projections until 2060 (millions)	81.3	80.6	79.7	77.7	74.5	70.8	-12.9				3.1			

Sources: EUROSTAT, OECD and WHO

## Germany

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Long-term care systems

## 2.11. GERMANY

### General context: Expenditure, fiscal sustainability and demographic trends

GDP per capita in PPS is at EUR 31,700 and far above EU average of EUR 27,900 in 2013. Germany has a population of 80.8 million inhabitants. <sup>(377)</sup> During the coming decennia the population will steadily decrease, from 80.8 million inhabitants in 2013 to 70.3 to 73.1 million inhabitants in 2060 depending on the migration rate. Thus, Germany is facing a considerable decrease of its population by 9.5 to 13%, while the EU average population is estimated to increase by 3%.

### Health status

Life expectancy at birth for both women and men is respectively 83.2 years and 78.6 years in 2013 and is around the EU average for women and men (83.3 and 77.8 years respectively). Healthy life years at birth are with 57.0 years (women) and 57.8 years (men) below the EU-averages (61.5 and 61.4 respectively). The percentage of the German population having a long-standing illness or health problem is considerably higher than in the Union (38% in Germany versus 33% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 10.4%, which is higher than the EU-average (8.7%); these figures are subjective and differ between cultural backgrounds and countries (from 2.7 in Malta up to 11.3 in Slovenia). <sup>(378)</sup>

### Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 7.4 <sup>(379)</sup> million residents living with (self-assessed) strong

limitations due to health problems in 2013, an increase of 11% is estimated until 2060 with nearly 8.2 million. <sup>(380)</sup> That is a less steep increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 10.6% to 14.1%, an increase of 33% (EU: 36%).

### Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing in most scenarios. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 1.5 pps of GDP by 2060. <sup>(381)</sup> The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, which is strongly depending on subjective self-assessments, projects an increase in spending of 3.1 pps of GDP by 2060. Overall, projected long-term care expenditure increase for these two scenarios is expected to add to budgetary pressure. However, no sustainability risks appear over the long run as the favourable initial budgetary position would mitigate the projected increase in age-related expenditure. <sup>(382)</sup> In Germany, long-term care benefits are indexed to prices (whereas they are indexed to GDP per hours worked in the displayed scenarios), which is relevant for budgetary surveillance purposes. In Germany, long-term care benefits are indexed to prices (whereas they are indexed to GDP per hours worked in the AWG reference scenario), which is relevant for budgetary surveillance purposes. Assuming constant unit costs in real terms, the long-term care

<sup>(377)</sup> This is according to the German statistical office, see: <https://www.destatis.de/DE/ZahlenFakten/GesellschaftStaat/Bevoelkerung/Bevoelkerung.html>

According to Eurostat, population stands at 80.8 million in 2014.

<sup>(378)</sup> This data (EU-SILC) is based on subjective assessment of care needs. The comparability of cross-country data is more limited than would be the case for objective measures of care needs, which are however not available on a comparable basis for all EU countries. The German Ministry of Health perceives the numbers for Germany as a significant overestimation of the number of dependent people.

<sup>(379)</sup> The number of dependent population is estimated for those insured under social health insurance only.

<sup>(380)</sup> According to the AWG report the robustness of dependency rates calculated on the basis of the EU-SILC survey has been improved, by using a 5 year average (where available) of the dependency rates for each of the age-gender groups.

<sup>(381)</sup> The 2015 Ageing Report: [http://europa.eu/epc/pdf/ageing\\_report\\_2015\\_en.pdf](http://europa.eu/epc/pdf/ageing_report_2015_en.pdf)

<sup>(382)</sup> Fiscal Sustainability Report 2015: [http://ec.europa.eu/economy\\_finance/publications/eeip/pdf/ip018\\_en.pdf](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

public expenditure is projected to increase not by more than 0.1 pps of GDP, with a spending level of around 1.5% of GDP in 2060.

### System Characteristics

Social long-term care insurance (LTC) insurance is compulsory. All members of the social health insurance are covered by the public and members of the private health insurance (PHI) are covered by the private LTC insurance. Both parties are entitled to the same benefits, which is basically covering a portion of long-term nursing care costs. If costs of care exceed benefits, the person in need of care has to bear the difference, also including support from their children or near relatives, or ultimately social assistance.

Premiums for social LTC insurance are calculated as a fixed proportion of the labour income (2.35% for insured with and 2.60% for insured without children in 2015). Employers bear one half of it and children and spouses with no substantial individual labour income are co-insured without extra costs. Private LTC insurance premiums are related to (income independent) premiums of PHI.

Since 2012, employees with a family member in need of home care are entitled to reduce their weekly working time to 15 hours for up to two years. Their employers can top up the reduced salary by half of the difference between old and new salary with an interest free credit from the *Kreditanstalt für Wiederaufbau*. Afterwards, the employee has to work full-time until the credit is paid back. The uptake of this policy was very low so far.

Since 2013, for informal carers getting sick or taking holidays, LTC insurance pays benefits for up to four weeks of respite care or short-term residential care, but not more than EUR 1,550 once a year. This is conditional on the informal carer having taken care of the recipient for at least six months prior to application. Also, benefits for people with dementia have been increased. Benefits are given, even if eligibility is not established within the 3 levels of care (see below), and additional benefits within given levels of care are possible. Also, an additional optional private LTC insurance is now subsidised with a maximum of EUR 60 per year.

Public spending on LTC reached 1.4% of GDP in 2013 in Germany, below the average EU level of 1.6% of GDP.<sup>(383)</sup> 69% of the benefits were in-kind, while 31% were cash-benefits (EU: 80 vs 20%). Private co-financing of formal LTC services is important in Germany. According to OECD data 25% of LTC services are co-financed privately.

In the EU, 53% of self-perceived dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 34% lower in Germany. Overall, 3.6% (including disabled persons) of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional services makes up 57% of public LTC expenditure (EU: 61%), 43% being spent for LTC services provided at home (EU: 39%). Thus, relative to other Member States Germany seems might have some potential to focus more on home care, which may be cost-efficient. As institutional care is relatively costly, Member States with shares well above the EU levels may benefit from efficiency gains by shifting some coverage (and thus expenditure) from institutional to other types of care.

### Types of care

Recipients of LTC services can choose between cash benefits, home care (in kind), and institutional care. Cash benefits allow for informal care, allowing the recipient to live at home and be taken care of typically by his relatives. Home care (in

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<sup>(383)</sup>This is according to the Ageing Report 2015. Due to agreements taken with the Member States delegates in the AWG-EPC, definition of LTC expenditure may deviate from expenditure levels as reported in other publications. Specifically, cash benefits include period economic integration of handicapped from ESSPROS disability function, and are projected with age specific probability. Expenditure on this item amounts 0.4 to 0.54% of GDP for Germany. The number of disabled persons in Germany is increasing and will continue for about the next ten years. In this projection the number of disabled persons is assumed to increase with the age specific LTC need probabilities, which is not relevant for this group, since (older) disabled persons are covered by the LTC system and not by the integration of handicapped anymore.

kind) allows for a professional care, paid directly by the recipient to the provider. Institutional care refers to either short-term or long-term stay in a nursing home.

#### *Eligibility criteria and user choices: dependency, care needs, income*

The LTC insurance has defined three levels of care based on the severity of the health condition. Level I provides for extensive care of at least 90 minutes per day. This care duration is extended to at least 3 hours in level II (severe care) and at least 5 hours in level III (most severe care). Even more severe cases may receive additional care assistance. Recipients in need of care should/must be insured for at least six months prior to the application of care allowance. Eligibility and the level of care are assessed by an independent Medical Review Board of the Statutory Health Insurance Funds (MDK) for the social LTC insurance or an equivalent body for the private LTC insurance.

#### *Prevention and rehabilitation measures*

Since 2016 social LTC insurance contributes to the prevention efforts in institutions of the health insurance with estimated 21 million Euro each year; the amounts in the following years depend on the reference figure and the number of recipients of formal care in institutions. Rehabilitation measures are not defined as (part of) LTC in Germany; i.e. rehabilitation is part of health care.

#### *Recently legislated and/or planned policy reforms*

The Ministry of Health has strengthened LTC with two laws strengthening long-term care 'Pflegestärkungsgesetz' (PSG I and PSG II). PSG I has significantly increased services for dependants from January 2015 onwards and has increased the number of caregivers in institutional care; besides that a 'fund for demographic sustainable financing' (Pflegevorsorgefonds) has been created.

PSG I and PSG II increase premiums in two steps by 0.5% starting from 2015. Each year EUR 1.2 billion of these additional funds are invested in the sustainable financing fund until 2034, the rest (EUR 3.8 billion per year) in improved services for

dependents; this will increase services by 20%.<sup>(384)</sup>

PSGII was introduced within this legislature period (2013-2017). It redefines care levels and care assessment methods based on individual care demands; especially dementia is now part of the assessment.

The German government plans to continue the improvements for people in need of care further with the PSG III law in 2017. PSG III strengthens local support for people in care especially by improving local coordination cooperation and steering.

In order to make the job of formal carers more attractive and to increase the quality of care, the government plans to pass the carer education law (Pflegerberufsgesetz).<sup>(385)</sup>

As described under section 2, new measures have also been taken recently to strengthen prevention.

#### **Challenges**

Germany has taken significant steps to establish a coherent financing mix, ensure the fiscal sustainability of LTC expenditure and provide adequate coverage to the population. The main challenges of the system appear to be:

- **Improving the governance framework:** To establish good information platforms for LTC users and providers;
- **Encouraging independent living:** To provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.
- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care; To improve recruitment efforts, including through the migration of LTC

<sup>(384)</sup> <http://www.bmg.bund.de/pflege/pflegestaerkungsgesetze/pflegestaerkungsgesetz-i.html>

<sup>(385)</sup> <http://www.bmg.bund.de/ministerium/meldungen/2016/160113-pflegerberufsgesetz.html>

workers and the extension of recruitment pools of workers;

- **Ensuring coordination and continuity of care:** To establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.
- **To facilitate appropriate utilisation across health and long-term care:** To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system;
- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.11.1: Statistical Annex – Germany:

GENERAL CONTEXT																
GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	2,220	2,271	2,301	2,393	2,513	2,562	2,460	2,580	2,703	2,755	2,821	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	26.9	27.8	28.8	30.1	31.3	31.3	28.6	30.8	32.1	32.1	31.7	26.8	27.6	28.0	28.1	27.9
Population, in millions	82.5	82.5	82.5	82.4	82.3	82.2	82.0	81.8	81.8	81.8	82.0	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.9	0.9	0.9	0.9	0.9	0.9	1.0	1.0	1.0	1.0	:	1.0	1.0	1.0	1.0	:
Per capita PPS	375.0	389.5	403.9	411.1	421.9	433.5	445.0	486.6	504.9	526.4	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	3.3	3.3	3.3	3.3	3.4	3.4	3.4	3.5	3.6	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	81.3	81.9	82.0	82.4	82.7	82.7	82.8	83.0	83.2	83.3	83.2	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	75.8	76.5	76.7	77.2	77.4	77.6	77.8	78.0	78.4	78.6	78.6	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	:	:	54.8	58.3	58.6	57.7	58.1	58.7	58.7	57.9	57.0	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	:	:	54.5	58.7	59.0	56.4	57.1	57.9	57.9	57.4	57.8	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	36.2	38.2	37.9	36.2	36.0	36.2	36.8	37.0	38.3	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	8.5	8.3	8.2	10.6	10.1	10.2	10.0	10.9	10.4	:	8.1	8.3	8.6	8.7
SYSTEM CHARACTERISTICS																
Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	561	610	658	707	726	743	740	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	1,028	1,188	1,349	1,509	1,537	1,565	348	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.9	2.2	2.4	2.7	2.8	2.8	1.3	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	3,163	:	3,256	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	511	:	556	:	595	:	642	:	683	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.11.2: Statistical Annex - continued – Germany

PROJECTIONS								
	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population								
Population projection in millions (Eurostat 2013)	82.0	80.6	79.7	77.7	74.5	70.8	-14%	3%
<b>Dependency</b>								
Number of dependents in millions (2015 Ageing Report)	7.40	8.04	8.30	8.51	8.74	8.18	11%	40%
Share of dependents (% 2015 Ageing Report)	10.6	11.7	12.4	13.2	14.2	14.1	33%	36%
<b>Projected public expenditure on LTC as % of GDP</b>								
AWG reference scenario	1.4	1.7	2.0	2.3	2.8	2.9	105%	40%
AWG risk scenario	1.4	1.8	2.3	3.0	3.9	4.5	223%	149%
Indexation of LTC spending to prices (unit costs constant in real terms)	1.4	1.4	1.4	1.5	1.5	1.5	7%	:
<b>Note: Based on projections from 2015 Ageing Report</b>								
<b>Coverage</b>								
Number of people receiving care in an institution	740253	835632	955660	1045394	1239627	1230541	66%	79%
Number of people receiving care at home	347867	389446	423921	463042	511877	481553	38%	78%
Number of people receiving cash benefits	1391470	1557784	1695685	1852169	2047506	1926212	38%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	3.6	4.1	4.6	5.2	6.2	6.3	76%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	33.5	34.6	37.0	39.5	43.5	44.5	33%	23%
<b>Composition of public expenditure and unit costs</b>								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	69.0	69.0	70.4	71.3	72.3	73.2	6%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	31.0	31.0	29.6	28.7	27.7	26.8	-14%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	57.0	56.9	57.9	57.6	58.6	59.9	5%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	43.0	43.1	42.1	42.4	41.4	40.1	-7%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	51.8	54.7	56.6	58.5	58.2	59.4	15%	-2%
Unit costs of home care per recipient, as % of GDP per capita	82.9	88.7	92.8	97.2	99.6	101.7	23%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	21.7	23.1	23.2	23.0	23.0	23.2	7%	-2%

**Source:** Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".