Germany

Health Care & Long-Term Care Systems

An excerpt from

the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability,

published in June 2019
as Institutional Paper 105
Country Documents - 2019 Update

Economic and Financial Affairs
Economic Policy Committee

Germany

Health care systems

From: *Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability*, prepared by the Commission Services (Directorate-General for Economic and Financial Affairs), and the Economic Policy Committee (Ageing Working Group), Country Documents – 2019 Update

2.11. GERMANY

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

GDP per capita in PPS is at 33,200 and above the EU average of 29,600 PPS in 2015. Germany has a population of 81.2 million inhabitants. During the coming decennia the population will steadily decrease, from 82.1 million inhabitants in 2016 to 79.3 million inhabitants in 2070, depending on the migration rate. Thus, Germany is facing a decrease of its population by 3%, while the EU average population is estimated to increase by 2%.

Total and public expenditure on health as % of GDP

Total expenditure on health was one of the highest in the EU at 11.2% of GDP in 2015 (EU: 10.2%). Total public spending on health was at 9.4% of GDP (EU: 8.0%). Looking at health care without long-term care ([154]) reveals a similar picture with public spending above the EU average (DE: 8.1% vs. EU: 6.8% in 2015). 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 2015. In 2015, 16.0% of total government expenditure was channelled towards health spending (EU: 15.0%). In per capita terms, total (3,981 PPS) and public spending (3,365 PPS) are well above the respective EU averages (3,305 PPS and 2,609 PPS) ([155]).

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure for the insured in the Statutory Health Insurance is projected to increase by 0.7 pps of GDP ([156]), below the average growth level expected for the EU (0.9 pps of GDP), according to the "AWG reference scenario" ([157]). When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure for the insured in the Statutory Health Insurance is expected to increase by 1.5 pps of GDP from now until 2070 (EU: 1.6). Overall, projected health care expenditure increase is expected to add to budgetary pressure. However, no fiscal sustainability risks appear over the long run as the favourable initial budgetary position would mitigate the projected increase in age-related expenditure ([158]).

Health status

Life expectancy at birth is 78.3 years for men and 83.1 years for women, being one of the highest in the EU (EU: 77.9 for men and 83.3 for women). Healthy life years are also above the EU average (65.3 vs. 62.6 years and 67.5 vs. 63.3 years) 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: 3.6‰).

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

([154]) To derive this figure, the SHA aggregate HC.3 for LTC (health) is subtracted from total health spending.

([155]) Note that these PPS figures reflect current plus capital health expenditure in contrast to Eurostat data series, which reflect only current expenditure.

([156]) Due to some institutional specificities, the projections for Germany include solely expenditure of the Statutory Health Insurance Funds and the State, and exclude expenditure of the mandatory Private Health Insurance Funds. Thus, the projections for Germany cover approx. 87% of the population insured at the Statutory Health Insurance.

([157]) The 2018 Ageing Report, https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf.

([158]) European Commission, Fiscal Sustainability Report (2018), https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

dependent 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 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 2018, the SHI was composed of 110 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 2015, the SHI bore 58% of total health expenditure. Other social insurance schemes bore another 10.6%, the PHI 8.39%, public authorities 4.6% and employers 4.2%. Private out-of-pocket payments amount to 12.5% of total health expenditures (EU: 15.9%). Private expenditure with 16.5% was below the EU average of 21.6%. 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, after having been assessed as ineffective.

The health reform (*GKV-Finanzstruktur- und Qualitätsweiterentwicklungsgesetz*), that came 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 fund. 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 340 per 100,000 inhabitants in 2005 to 414 in 2015, well above the EU average of 344. Over the same period of time, the number of general practitioners has stayed nearly constant at 66 per 100,000 between 2005 and 2015 (EU: 78). The number of nurses is at 1,334 per 100,000 in 2015, remaining well above the EU average of 833. Total and public expenditure on outpatient care as a % of current health expenditure were at the EU average (around 22%).

Germany has the highest per-capita hospital beds for curative (acute) care in the EU: 611 beds per 100,000 inhabitants in Germany in 2015 compared to 402 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 21.3 in 2005 to 24.9 in 2015 per 100 inhabitants (EU: 16.2 in 2015). At the same time, the level of day case discharges is very low with 677 discharges per 100,000 inhabitants in Germany, versus 7,635 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 31% of public expenditure on health in Germany compared to 32% 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, midwifes 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 outpatient 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 Reform of the Market for Pharmaceutical Products (*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 13th and 14th 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). With the Pharmaceutical Care Strengthening Act (*AMVSG*) the price freeze was extended until 2022, though from 2018 onwards price increases in line with inflation will be allowed. 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.

A new act on eHealth, which came into force in December 2015, accelerated the deployment of the applications of 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 at EU-level.

As set out in the act on eHealth, from the end of 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 end of 2018, including a verification of drug treatment safety among care providers. The implementation of Electronic Patient Health Records will follow and should be completed by 2021. They will be managed by health professionals, but also patients will be able to store data and access the information stored by health professionals. The design of the German telematics infrastructure fulfils the highest 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

Total and public expenditure on prevention and public health services as a % of total current health expenditure were at EU average in 2015. 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 on recently legislated reforms).

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 outpatient 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 outpatient doctors' associations as well as their associations at Land and federal level.

In 2016, the *Act to Combat Corruption in Healthcare* entered into force, whereby active and passive bribery in the health care sector were added as criminal offences to the Criminal Code (sections 299a, 299b). This goes back to a decision by the Federal Supreme Court from 2012 that had identified criminal liability loopholes in regards to

the application of the bribery provisions in the Criminal Code to healthcare professionals, specifically doctors working in the field of statutory health insurance.

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% aimed at containing wage related costs. The latter measure, however, will be reversed as of January 2019 (*GKV-GEK*).

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. Higher quality in hospital care, should translated in fewer complications and re-admissions and will lead, 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 was 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 included 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 was set up to finance measures to improve existing care structures. To this end, a one-time disbursement of 500 million euros was made from the liquidity reserve of the national health fund. This money was supposed to be used to finance projects proposed by the *Länder*, if the latter contribute to an equal amount. Thus, a maximum of 1 billion euros funding was made available in order to promote the reduction of excess capacity and the transformation and concentration of hospital capacities. Presumably, all of the available funds will be used until the end of 2018.

In addition to that a legislation is planned which focusses on the further improvement of hospital care. This legislation is supposed to enter into force in the year 2019 and contains for example measures to improve the reconciliation of work and family and financing measures in order to improve the current staff situation in hospital care. Furthermore, the above mentioned structural fund will be continued for four more years with a disbursement of one billion euros per year. Such amount is to be contributed by the liquidity reserve of the national health fund and the *Länder* in equal shares. Finally, the German federal government

recently submitted draft legislation providing for minimum nurse to patient ratios in selected fields of hospital services in order to improve patient security, quality of services and working conditions in the hospitals.

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, such as 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, regional *(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 has been set up at the *Federal Joint Committee*, endowed with EUR 300 million annually – initially from 2016 to 2019.

The coalition agreement from February 2018 calls for further amendments to improve the access to healthcare with action focusing on minimising waiting times for outpatient care appointments and on improving outpatient medical care.

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 as well as to set out further incentives with regard to telemedicine. Digital technologies are meant to contribute to better medical care provision, improve communication among all parties involved and ensure greater efficiency in health care processes (See above the section on eHealth: e-prescription, e-medical records).

Further legal adaptations to the eHealth framework are foreseen in 2018, so that patients will be able to access eHealth applications via their mobile phones and health insurances will be obliged to introduce Electronic Health Records by 2021 at the latest.

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.

- 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.

Table 2.11.1: **Statistical Annex – Germany**

General context												EU- latest national data			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	2,301	2,393	2,513	2,562	2,460	2,580	2,703	2,758	2,826	2,932	3,044	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	29.1	30.2	31.5	31.3	28.9	30.5	31.9	32.1	31.7	32.6	33.2	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	0.9	3.9	3.5	1.4	-5.3	4.3	3.7	0.3	0.2	1.5	0.9	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	2.3	1.9	3.5	4.0	2.6	0.9	0.5	-0.8	2.8	-0.2	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	10.8	10.6	10.5	10.7	11.8	11.6	11.3	11.3	11.2	11.3	11.2	10.2	10.1	10.1	10.2
Total current as % of GDP	10.3	10.1	10.0	10.2	11.2	11.0	10.8	10.8	11.0	11.1	11.2	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.5	0.5	0.5	0.5	0.6	0.5	0.5	0.5	0.2	0.3	0.0	0.9	0.6	0.2	0.3
Total per capita PPS	2,866	2,936	3,041	3,169	3,351	3,466	3,603	3,678	3,723	3,900	3,981	2,745	2,895	2,975	3,305
Public total as % of GDP	7.9	7.7	7.6	7.8	9.4	9.2	9.0	9.0	9.2	9.3	9.4	8.0	7.8	7.8	8.0
Public current as % of GDP	7.8	7.7	7.6	7.8	9.3	9.2	9.0	9.0	9.2	9.3	9.4	7.7	7.6	7.6	7.8
Public total per capita PPS	2,084	2,131	2,212	2,304	2,668	2,768	2,875	2,940	3,075	3,223	3,365	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.02	0.01	0.02	0.02	0.01	0.02	0.03	0.03	0.03	0.03	0.02	0.2	0.2	0.2	0.2
Public as % total expenditure on health	72.7	72.6	72.7	72.7	79.6	79.9	79.8	79.9	82.6	82.6	84.5	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	14.3	14.7	15.2	15.5	15.2	14.9	15.4	16.1	16.4	15.9	16.0	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	99.8	99.8	99.8	99.9	99.9	99.9	99.9	99.9	100.0	100.0	100.0	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	14.2	14.3	14.2	14.0	13.8	13.9	13.9	13.9	13.2	12.7	12.5	14.6	14.9	15.9	15.9

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

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	82.5	82.4	82.3	82.2	82.0	81.8	80.2	80.3	80.5	80.8	81.2	502.1	503.0	505.2	508.5
Life expectancy at birth for females	82.0	82.4	82.7	82.7	82.8	83.0	83.1	83.1	83.1	83.6	83.1	82.6	83.1	83.3	83.3
Life expectancy at birth for males	76.7	77.2	77.4	77.6	77.8	78.0	77.9	78.1	78.4	78.7	78.3	76.6	77.3	77.7	77.9
Healthy life years at birth females	54.8	58.3	58.6	57.7	58.1	58.7	58.7	57.9	57.0	56.5	67.5	62.0	62.1	61.5	63.3
Healthy life years at birth males	54.5	58.7	59.0	56.4	57.1	57.9	57.9	57.4	57.8	56.4	65.3	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	60	56	52	51	50	47	120	118	118	113	116	64	138	131	127
Infant mortality rate per 1 000 live births	3.9	3.8	3.9	3.5	3.5	3.4	3.6	3.3	3.3	3.2	3.3	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	2.9	2.8	2.7	2.8	3.1	3.0	3.0	3.0	3.0	3.1	3.1	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	2.3	2.3	2.3	2.3	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.6	1.5	1.5	1.6	1.7	1.7	1.5	1.5	1.5	1.6	1.6	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.3	0.3	0.4	0.4
Prevention and public health services	0.3	0.3	0.3	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.3	0.3
Health administration and health insurance	0.6	0.6	0.5	0.5	0.6	0.6	0.6	0.6	0.5	0.5	0.5	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	2.6	2.5	2.4	2.5	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	1.6	1.6	1.6	1.6	2.0	2.0	2.0	2.0	2.1	2.1	2.1	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	1.2	1.1	1.2	1.2	1.4	1.4	1.3	1.2	1.3	1.3	1.3	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.1	0.1	0.2	0.2
Prevention and public health services	0.3	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.3
Health administration and health insurance	0.4	0.4	0.4	0.4	0.6	0.6	0.5	0.5	0.5	0.5	0.5	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.11.2: **Statistical Annex - continued – Germany**

												EU- latest national data			
Composition of total as % of total current health expenditure	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	27.8%	27.8%	27.3%	27.1%	27.3%	27.5%	27.8%	27.8%	27.6%	27.6%	27.4%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	0.8%	0.9%	1.0%	1.0%	1.0%	1.0%	0.9%	0.9%	1.0%	1.0%	1.0%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	22.5%	22.5%	22.5%	22.7%	22.6%	22.6%	22.8%	22.8%	22.6%	22.4%	22.3%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	15.4%	15.0%	15.3%	15.3%	15.2%	15.0%	14.2%	14.1%	14.0%	14.4%	14.3%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	5.1%	5.2%	5.2%	5.1%	5.1%	5.2%	5.2%	5.4%	5.5%	5.5%	5.5%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	3.1%	3.2%	3.4%	3.4%	3.4%	3.2%	3.1%	3.1%	2.9%	3.0%	3.0%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	5.5%	5.4%	5.2%	5.2%	5.2%	5.3%	5.2%	5.1%	4.9%	4.7%	4.8%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	32.7%	32.7%	32.0%	31.7%	31.2%	31.4%	31.8%	32.0%	31.6%	31.5%	31.1%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	1.0%	1.2%	1.3%	1.3%	1.2%	1.2%	1.1%	1.1%	1.2%	1.2%	1.2%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	20.5%	20.6%	20.5%	20.5%	21.8%	21.7%	21.9%	21.8%	22.3%	22.0%	21.9%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	14.9%	14.8%	15.3%	15.3%	15.2%	14.8%	14.1%	13.8%	13.7%	14.3%	14.2%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	3.4%	3.5%	3.4%	3.5%	3.3%	3.3%	3.4%	3.3%	3.4%	3.7%	3.6%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	3.6%	3.8%	4.1%	4.1%	3.7%	3.5%	3.4%	3.3%	3.2%	3.2%	3.2%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	5.4%	5.2%	5.0%	5.0%	5.9%	6.0%	5.9%	5.8%	5.5%	5.3%	5.2%	4.1%	4.0%	3.6%	3.4%

												EU- latest national data			
Expenditure drivers (technology, life style)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
MRI units per 100 000 inhabitants	:	:	:	:	:	2.70	2.83	2.81	2.87	3.05	3.36	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	0.7	0.8	0.8	:	:	:	:	:	:	:	:	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	3.0	2.9	3.0	3.1	3.1	3.2	3.3	3.3	3.3	3.5	3.5	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	0.1	0.1	0.2	0.2
Proportion of the population that is obese	13.6	:	:	15.8	14.7	:	:	:	15.7	16.4	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	23.2	:	:	22.8	21.9	:	:	:	20.9	:	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	11.7	11.8	11.5	11.4	11.2	11.2	11.2	11.2	10.9	11.0	:	10.4	10.3	10.1	10.2

Providers	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Practising physicians per 100 000 inhabitants	340	344	349	354	362	371	380	387	400	411	414	324	330	338	344
Practising nurses per 100 000 inhabitants	1116	1128	1150	1174	1204	1214	1229	1238	1290	1324	1334	837	835	825	833
General practitioners per 100 000 inhabitants	67	66	66	65	65	66	66	65	66	67	66	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402

Outputs	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Doctors consultations per capita	8.1	7.9	8.1	8.6	9.2	9.9	9.7	9.7	9.9	9.9	10.0	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	21	21	22	23	23	23	24	24	24	25	25	17	16	16	16
Day cases discharges per 100 000 inhabitants	591	576	578	596	613	629	647	655	656	676	677	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	76.0	77.0	78.7	79.1	79.2	79.0	79.0	79.2	79.3	79.7	79.8	77.1	76.4	76.5	76.8
Hospital average length of stay	8.8	8.7	10.1	9.8	9.7	9.5	9.3	9.2	9.1	9.0	9.0	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	:	2.6	2.5	2.6	2.6	2.6	2.7	2.6	2.6	2.6	2.7	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**
AWG reference scenario	7.4	7.5	7.6	7.7	7.8	8.0	8.1	8.2	8.1	8.1	8.1	8.1
AWG risk scenario	7.4	7.6	7.8	8.0	8.2	8.5	8.7	8.8	8.9	8.8	8.9	8.9

Change 2016-2070, in pps.	
Germany	**EU**
0.7	0.9
1.5	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**
Population projections until 2070 (millions)	82.1	83.8	84.4	84.6	84.5	84.1	83.5	82.7	81.8	80.8	80.0	79.3

Change 2016-2070, in %	
Germany	**EU**
-3.5	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Germany

Long-term care systems

3.11. GERMANY

General context: Expenditure, fiscal sustainability and demographic trends

GDP per capita in PPS is at €33,200 and above EU average of €29,600 in 2015. Germany has a population of 82.7 million inhabitants. During the coming decennia the population will steadily decrease, from 82.1 million inhabitants in 2016 to 79.3 million inhabitants in 2070 depending on the migration rate. Thus, Germany is facing a decrease of its population by 3%, while the EU average population is estimated to increase by 2%.

Health status

Life expectancy at birth for both women and men is respectively 83.1 years and 78.3 years in 2015 and is around the EU average for women and men (83.3 and 77.9 years respectively). Healthy life years at birth in 2015 are with 67.5 years (women) and 65.3 years (men) above the EU-averages (63.3 and 62.6 respectively). The percentage of the German population having a long-standing illness or health problem is higher than in the Union (42.5% in Germany versus 34.2% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 7.1%, which is lower than the EU-average (8.1%); however, it should be noticed that these figures are based on self-reported indicators and therefore can be influenced among others by cultural factors.

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 7.0 million residents living with (self-assessed) strong limitations due to health problems in 2016 ([483]), an increase of 8% is estimated until 2070 with nearly 7.6 million ([484]). That is a less steep increase than in the EU as a whole (25%). Also as a share of the population, the dependents are becoming a bigger group, from 10.0% to 11.7%, an increase of 17% (EU: 21%).

([483]) The number of dependent population is estimated for those insured under social health insurance only.

([484]) 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.

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 ([485]) 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 1.9 pps of GDP by 2070 ([486]).

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, the latter being dependent on self-assessed measure people experiencing severe limitations in daily activities, projects an increase in spending of 3.4 pps of GDP by 2070. Overall, projected long-term care expenditure increase for these two scenarios is expected to add to budgetary pressure. However, no fiscal sustainability risks appear over the long run as the favourable initial budgetary position would mitigate the projected increase in age-related expenditure ([487]).

In Germany, currently long-term care benefits are indexed to prices. To account for this legislation and the financial precaution principle while preserving the realism of the projections, in the displayed scenarios 2/3 of the public expenditure on in-kind benefits are indexed to GDP per hours worked and 1/3 of the cash benefits to GDP per capita.

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

([485]) Public expenditure on LTC in Germany refers to the Statutory Health Insurance Funds only.

([486]) The 2018 Ageing Report, https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf.

([487]) European Commission, Fiscal Sustainability Report (2018), https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

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 (2.55% for insured with and 2.80% for insured without children in 2017). 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.

For informal carers getting sick or taking holidays, LTC insurance pays benefits for up to six weeks of respite care or eight weeks short-term residential care, but not more than €1,612 each 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. An additional optional private LTC insurance is now subsidised with a maximum of €60 per year.

Public spending on LTC ([488]), encompassing expenditure of statutory health insurances only, reached 1.3% of GDP in 2016 in Germany, below the average EU level of 1.6% of GDP ([489]). The share of the in-kind benefits was 67.7%, while 32.3% were cash-benefits (EU: 84.4% vs 15.6%). Private co-financing of formal LTC services is important in Germany. According to 2016 Eurostat data, 29% of expenditure on LTC services are co-financed privately, either through a voluntary insurance scheme or out-of-pocket payments.

In the EU, 50% of self-perceived dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 54.7% higher in Germany. Overall, 6.4% (including disabled persons) of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.6%). 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 70.7% of public LTC expenditure on in-kind services (EU: 66.3%), 29.3% being spent for LTC services provided at home (EU: 33.7%). Thus, relative to other Member States Germany seems to might have some potential to focus more on home care, which may be more 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 recipients to live at home and be taken care of typically by their relatives. Home care (in-kind) allows for a professional care, paid directly by the recipients to the providers. 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 five degrees of care based on the assessment of independence and abilities. Factors included in the assessment are mobility, cognitive and communicative abilities, self-supply, illness or therapy related activities, daily life and social contacts. 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

([488]) Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with IADL tasks).

([489]) This is according to the Ageing Report 2018. 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.

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 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 improved LTC with three interlaced laws strengthening long-term care (*Pflegestärkungsgesetz [PSG] I-III*). 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 LTC provident fund for demographic sustainable financing has been introduced.

PSG I-III increased LTC premiums in two steps by 0.5 pps starting from 2015 (0.3 pps in 2015 and 0.2 pps in 2017). From the additional revenues, €1.3 billion will be transferred yearly to the LTC provident fund until 2034. The remaining €3.7 billion per year will be spent on additional and improved services for dependents (services will increase by 20%) ([490]). As of 2019, LTC premiums will be increased by 0.5 pps to strengthen measures of the care personnel law (*Pflegepersonal-Stärkungsgesetz*).

PSG II and III were introduced within the legislature period 2013-2017. PSG II redefines care levels and care assessment methods based on individual care demands; especially dementia is now part of the assessment. PSG III strengthens the local coordination and provision of care and focuses on counselling.

([490]) Source: https://www.bundesgesundheitsministerium.de/service/gesetze-und-verordnungen/guv-18-lp.html.

In order to make the job of formal carers more attractive and to increase the quality of care, the government has passed the carer education law (*Pflegeberufsgesetz*) ([491]).

As described in the preceding sections, 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 publicly funded LTC 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 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

([491]) Source: http://www.bmg.bund.de/ministerium/meldungen/2016/160113-pflegeberufsgesetz.html.

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 3.11.1: **Statistical Annex – Germany:**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	2,301	2,393	2,513	2,562	2,460	2,580	2,703	2,758	2,826	2,932	3,044	12,451	13,213	13,559	14,447
GDP per capita, PPS	29.1	30.2	31.5	31.3	28.9	30.5	31.9	32.1	31.7	32.6	33.2	26.8	28.1	28.0	29.6
Population, in millions	82.5	82.4	82.3	82.2	82.0	81.8	80.2	80.3	80.5	80.8	81.2	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.1	1.2	1.2	1.3	1.1	1.2	1.2	1.2
Per capita PPS	281.6	286.7	298.7	305.8	318.6	343.0	365.0	387.7	405.8	428.0	464.9	264.1	283.2	352.1	373.6
As % of total government expenditure	2.2	2.2	2.3	2.3	2.3	2.4	2.5	2.6	2.7	2.7	2.9	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	82.0	82.4	82.7	82.7	82.8	83.0	83.1	83.1	83.1	83.6	83.1	82.6	83.1	83.3	83.3
Life expectancy at birth for males	76.7	77.2	77.4	77.6	77.8	78.0	77.9	78.1	78.4	78.7	78.3	76.6	77.3	77.7	77.9
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	56.5	67.5	62.0	62.1	61.5	63.3
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	56.4	65.3	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	38.2	37.9	35.3	35.2	35.2	35.4	35.7	36.8	37.2	42.5	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	8.3	8.2	10.6	10.1	10.2	10.0	10.9	10.4	10.7	7.1	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	561	610	658	707	726	743	740	751	764	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	1,028	1,188	1,349	1,509	1,537	1,565	348	352	358	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	1.9	2.2	2.4	2.7	2.8	2.9	1.4	1.4	1.4	2.0	2.2	2.2	2.2
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	:	3,256	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	628	:	695	:	746	:	792	:	864	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.11.2: **Statistical Annex - continued – Germany**

PROJECTIONS

Population	2016	2020	2030	2040	2050	2060	2070	MS Change 2016-2070	EU Change 2016-2070
Population projection in millions*	82.1	83.8	84.6	84.1	82.7	80.8	79.3	-3%	2%
*Note: The LTC projections are based on the SHI insured part of the population									
Dependency									
Number of dependents in millions	7.04	7.31	7.61	7.76	8.11	7.72	7.61	8%	25%
Share of dependents, in %	10.0	10.2	10.7	11.1	11.9	11.7	11.7	17%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	1.3	1.5	1.7	1.8	2.0	2.0	1.9	48%	73%
AWG risk scenario	1.3	1.6	1.9	2.3	2.8	3.1	3.4	164%	170%
Coverage									
Number of people receiving care in an institution	775,005	833,929	979,597	1,060,364	1,278,885	1,313,781	1,300,496	68%	72%
Number of people receiving care at home	379,049	404,324	453,139	493,629	557,253	545,339	549,287	45%	86%
Number of people receiving cash benefits	1,595,152	1,701,518	1,906,949	2,077,347	2,345,098	2,294,958	2,311,576	45%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	3.9	4.1	4.7	5.2	6.1	6.3	6.4	64%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	39.0	40.2	43.9	46.8	51.5	53.8	54.7	40%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	67.7	68.1	69.8	71.0	72.5	73.9	74.8	10%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	32.3	31.9	30.2	29.0	27.5	26.1	25.2	-22%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	68.2	68.3	69.1	69.1	70.1	71.1	70.7	4%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	31.8	31.7	30.9	30.9	29.9	28.9	29.3	-8%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	53.9	59.2	58.4	57.8	54.2	52.0	50.3	-7%	10%
Unit costs of home care per recipient, as % of GDP per capita	51.5	56.8	56.4	55.7	53.0	51.1	49.4	-4%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	18.3	19.9	18.8	17.4	16.0	14.8	13.5	-26%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).