Implementation Report
by the Advisory Board to Review the Definition of the Need for Long-term Care

20 May 2009

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Preface by the Chairman of the Advisory Board

After submitting its recommendation for a new definition of the need for long-term care and the corresponding assessment procedure in its final report in January 2009, the Advisory Board to Review the Definition of the Need for Long-term Care hereby submits its implementation report.

Anyone making recommendations concerning implementation must expect that they will not always be received in the same manner. In some quarters they will find a positive echo, and in others they will be subject to criticism; for example from those who say how important a well-founded assessment procedure is, but believe that it is even more important to have more money in the system; or from those who regret the lack of attention devoted to the care of the elderly in our society, because one turns a blind eye to the fact that one is also growing older.

The Advisory Board did not adopt either of these positions. It again emphasises the suitability of the New Assessment Procedure and accepts the challenge of carefully evaluating possible scenarios based on it, while avoiding the arbitrary shuffling of funds. The situation in terms of the economy and labour market policy prohibits favouring short-term variations; it is essential to create sustainable mid- and long-term solutions. It is essential that the diversity of our images of the elderly as well as of the need for long-term care are recognised in order to react appropriately to the living situations of people in need of long-term care. The increased number of people with limited abilities to cope with everyday activities presents a particular challenge in this context.

I thank the members of the Advisory Board for not simply presenting standard solutions, but for instead proposing models that could be examined from the standpoint of nursing sciences, and which sounded out possibilities and framework conditions, and clearly illustrated the existing limits and, thirdly, considered opportunities from the viewpoint of social policy. For the Advisory Board there is a connection between the New Assessment Procedure and the need to ensure a secure infrastructure for long-term care, if we are to succeed in avoiding or delaying the event of the need for long-term care and stand by people who wish to grow old while being cared for in a dignified manner.

With this implementation report, the Advisory Board hopes to provide impulses for a public discussion concerning the value of good long-term care and to increase the acceptance for funding it.

I thank the members of the Presidium for supporting this work, the working groups and their chairpersons, Klaus Dumeier, Sabine Jansen, Harald Kesselheim and Paul-Jürgen Schiffer, for their contributions, the participating experts and institutions, namely Dr. Klaus Wingenfeld, Dr. Andreas Büscher, Dr. Barbara Gansweid, Dr. Ulrich Heine, Prof. Heinz Rothgang, Prof. Stefan Görres, Dr. Peter Pick and Prof. Jürgen Windeler.

The editorial group (chaired by Dr. h. c. Jürgen Gohde) took on the task of formulating the results. I thank Klaus Dumeier, Sabine Jansen, Harald Kesselheim, Gert Nachtigal, André Necke and Dr. Irene Vorholz. Christine Wilcken provided excellent support for our work.

Dr. h. c. Jürgen Gohde

Chapter 1: Starting Point

On 29 January 2009, the Advisory Board for the Review of the Definition of the need for Long-term Care submitted its final report to the Federal Minister of Health Ulla Schmidt.[1] With this final report, the Advisory Board presented its conceptual considerations on the establishment of a new definition of the need for long-term care and a new, nationally uniform and reliable assessment instrument for the determination of the need for long-term care according to the SGB XI. In this context, the proposal that was developed for a new definition of the need for long-term care and a New Assessment Procedure illustrates options for action on the part of policymakers in further developing long-term care with a focus on more independence and participation.

At a meeting of the Advisory Board on 15 October 2008, while work on the final report was still underway, the Federal Minister of Health Ulla Schmidt requested that the Advisory Board submit a supplementary report. Answers to the following questions were to be provided within the framework of an implementation study:

1. Which preparatory and accompanying measures are needed in the Advisory Board's view in order to introduce a new definition of the need for long-term care and the new assessment procedure? Will additional administrative preconditions need to be met, and if so, which?

2. Is it possible to introduce the New Assessment Procedure gradually and how could this be done? Is a coexistence of the "old" and the "new" assessment procedures–under certain circumstances at the discretion of the applicant–possible, and what would the consequences be?

3. What possibilities are there, within the framework of an implementation concept, to differentiate the point in time at which the New Assessment Procedure is introduced in order to take various criteria into consideration (e.g. regional variations in the introductory and testing phases; differentiation between cer-

[1] Published under http://www.bmg.bund.de/cln_110/SharedDocs/Downloads/DE/Pflege/Bericht__zum__Pflegebed_C3_BCrftigkeitsbegriff,templateId=raw,property=publicationFile.pdf/Bericht_zum_Pflegebedürftigkeitsbegriff.pdf.

tain groups of persons applying for or entitled to benefits, e.g. gradual introduction initially only for those over ninety years of age or for all applicants under sixty-five years of age)?

4. In which form and for which period of time should and can preserved rights be recognised for previous recipients of social or private insurance benefits? What might the effects of new assessments be in this conjunction?

5. How can the benefits of the long-term care insurance be adjusted to the new differentiation of the Degrees of Need? Should the claims to benefits be uniformly differentiated according to the new Degrees of Need, or does a differentiation according to how the impairment of independence manifests itself make more sense?

6. What other possibilities are there to limit the risk of unwanted costs, particularly for the social and private long-term care insurance systems?

7. What influence will the measures and scenarios developed on the basis of the questions 1 to 6 have on costs incurred by the social and private long-term care insurance systems (expenditures for benefits, administrative expenditures by the long-term care insurance funds and the medical advisory services of the health insurance funds)?

In order to answer these questions, the Advisory Board is submitting proposals in this implementation report for possible strategies and concrete implementation steps for the introduction of a new definition of the need for long-term care and the New Assessment Procedure in the SGB XI. The report evaluates possible alternatives in order to make corresponding recommendations, on this basis, for additional instruments and procedures to implement the recommendations made in the final report.

The results submitted here serve the purpose of providing support for policymakers in the decision-making process. They thereby enhance the expectation that a new way of viewing people in need of long-term care and improved long-term care can become reality.

The implementation recommendations were drafted on the basis of the results and the recommendations found in the Advisory Board's final report.[2]

Statutory long-term care insurance is to be viewed as a partial benefit system. In addition to benefits-in-kind or the reimbursement of expenditures, long-term care insurance also provides cash and combination benefits.[3]

In keeping with recommendations already made in the first report, the Advisory Board considers it necessary to adopt a definition of the need for long-term care that encompasses all physical, intellectual and psychological impairments, orients itself in a differentiated manner on living situations, and focuses on the degree of independence. The goal of implementing a new definition of the need for long-term care and the New Assessment Procedure, along with correspondingly restructured benefits, is to ensure that they take the shift from a paradigm in which the extent of long-term care required was the determining criterion to a paradigm in which the degree to which independence is impaired is the determining factor into account. Focussing on the extent to which independence is maintained, allows the living situation of a person in need of long-term care to be understood in a more holistic and context-related manner and thus takes people's impairments into consideration in a more just manner. The consideration of the desire for independence is not only an expression of respect for a person's dignity, it also promotes personal responsibility along with reliable engagement in a spirit of solidarity on behalf of people in risk situations. The orientation on existing resources is just as decisive in this conjunction as the challenge of an ageing society and the accompanying rise in the number of people in need of long-term care.

The recommendations for structures and instruments to implement a new definition of the need for long-term care and the New Assessment Procedure include two basic scenarios with a number of individual calculations. In addition to the scenarios calculated in the Second Main Phase and the corresponding allowance values, an additional scenario was presented which diverged from the present allowance values (alternative solutions for linking Degrees of Need to allowance values depending on the type of benefit). The decision to depict this supplementary scenario was prompted by the realisation of the fact that the current Levels of Care and the Degrees of Need determined by the New Assessment Instrument are spread over

[2] Cf. Final Report of the Advisory Board to Review the Definition of the Need for Long-term Care, January 2009, Chapter 3 Recommendations of the Advisory Board.
[3] Cf. Sections 4 paragraph 1, 28 paragraph 1 SGB XI and Sections 23, 110 SGB XI.

different ranges. Both of the basic scenarios include variations that are, by-and-large, oriented on the present level of benefits.

Chapter 2: Working Procedure

On 8 January 2009, the Advisory Board adopted a working plan and timetable for further work within the framework of the implementation study. It foresaw the establishment of three working groups dedicated to three topics: “scenarios”, “preserved rights” and “preparatory measures”. The members of the working groups were nominated from among the members of the Advisory Board.

The Steering Committee under the direction of Dr. h. c. Jürgen Gohde was responsible for coordinating the Advisory Board’s work. Members of the Presidium and the chairpersons of the Working Groups belonged to the Steering Committee.[4]

The task of Working Group 1, “scenarios”, was to present various scenarios for the implementation of the Advisory Board’s recommendations in the law related to benefits and services and to calculate their effects. The brief of Working Group 1 was based mainly on the recommendation 3.13 in the Final Report concerning the “financial effects”. In concrete terms, various models were to be presented on the effects of five Degrees of Need on the development of benefits and services, the financial consequences, and on considerations related to the structural perspectives.

The Working Group 2 on “preserved rights” was charged with considering how individual and structural benefits can be preserved after the transition from the one system to the other. In addition to the main task of drawing up regulations to protect preserved rights, deliberations focused on clarifying the question as to how assistance to people with dementia-related disorders, intellectual disabilities, and/or psychological conditions in inpatient facilities within the framework of Section 87b SGB XI, and the benefits currently received according to Sections 45a and 45b SGB XI and structural measures (low-threshold offers) according to Sections 45c and 45d SGB XI can be maintained.

[4] Members of the Steering Committee were Dr. h.c. Jürgen Gohde (Chairman of the Advisory Board), K.-Dieter Voß (Central Associations of the Statutory Health Insurance Funds), Sabine Jansen (German Alzheimer Society), Klaus Dumeier (Central Associations of the Statutory Health Insurance Funds), Harald Kesselheim (National Association of Statutory Public Health Insurance Funds), Paul-Jürgen Schiffer (Association of Substitution Health Insurance Funds.

Working Group 3 on “preparatory measures” was charged especially with the presentation of necessary administrative provisions, including guidelines and training programmes. Furthermore, corresponding problem areas were to be identified and – if possible – solutions proposed.

Considerable impetus and insight for the finding was provided within the framework of a conference staged by the German Association for Public and Private Welfare on 9 March 2009.[5]

[5] The findings of the conference were published under http://www.deutscher-verein.de/03-events/2009/gruppe4/f-410-09/ .

Chapter 3: Progress in Reaching Findings / Results

3.1 Meeting the Challenges and Opportunities

The demographic development and financial framework conditions of long-term care require a sustainable orientation in long-term care insurance. The new definition of the need for long-term care can contribute to mastering this task.

Considerations of how to ensure that the necessary infrastructure and personnel is available to provide long-term care are now increasingly included in concepts of active ageing, which is now characterised by an ever more diverse images of old age. This diversity also characterises the situation in long-term care to a far greater extent than previously. The need for long-term care is, in this conjunction, also part of a self-determined process of ageing marked by the desire to participate in social and cultural life. The goal of remaining in one's own home for as long as possible is foremost in this context. Hence, there is an obvious preference for living and receiving benefits as an outpatient. It is, however, equally clear that quality ensured inpatient care will continue to be necessary for many people, due to changing lifestyle options and private support situations, particularly as a result of changes in the structure of families and their reduced ability to provide support and care.

The Advisory Board emphasises the conclusion, reached in its final report, that the effects of changes in the law related to benefits and services in the wake of an expanded definition of the need for long-term care on other social benefits systems (e.g. care assistance and integration assistance according to the SGB XII) need to be examined. The object of the calculations presented here is the expenditures under the laws regarding benefits and services by the social and private long-term care insurance systems. Not taken into consideration are possible effects of the new definition of the need for long-term care on overall expenditures for long-term care and their distribution. The question therefore remains open as to whether and to what extent individual contributions by those in need of long-term care, and the costs incurred by the social welfare system, will change.[6]

[6] Cf. Final Report of the Advisory Board to Review the Definition of the Need for Long-term Care, January 2009, Chapter 3 Recommendations 3.12.

Among the central challenges with regard to housing and caring for people in old age in the coming years will be the increase in the number of people whose competence in coping with everyday activities is impaired. Furthermore, the prognoses regarding available personnel must be considered; in the event of continued growth in demand it must be assumed a greater number of full-time employees will be needed. In addition, changes in conditions on the economic and labour markets represent a further challenge.

In view of these challenges, an enhanced orientation on the neighbourhood context, increased engagement on the part of civil society and self-organised activities by members of the older generation, better networking between assistance providers, and greater efforts to ensure that assistance is available close to home are all essential.

All of these challenges should be viewed as an opportunity to modernise the structures of long-term care insurance in order to ensure that it better suits the new conditions: as an opportunity, in light of limited funds and human resources, to make more subsidiarity and solidarity, greater dignity for people in need of long-term care, and, not least of all, more equality in meeting their needs a real possibility.

3.2 The New Definition of the Need for Long-term Care as an Instrument of Change

The implementation of a new definition of the need for long-term care opens up the possibility of effecting the necessary paradigm shift in long-term care insurance towards a holistic view of people in need of long-term care, towards more self-determination and participation under conditions of reliable solidarity, and, thus, better long-term care geared more towards people’s needs.

The present system will presumably be unable to meet the challenges of the increasing number of people with cognitive impairments and the overall number of cases without a marked increase in financial resources or extensive intervention into the benefit profile of the long-term care insurance system. It would not be possible to provide care in an appropriate manner for people with dementia under the current conditions.

New challenges require new strategies, concepts, and instruments. With the New Assessment Procedure, an instrument and assessment procedure have been developed that meet these challenges. The new definition of the need for long-term care and the new assessment instrument require altered framework conditions in order to be fully effective and which allow for, or promote, a paradigm shift.

3.2.1 Advantages of a New Assessment Procedure and the New Definition of the Need for Long-term Care on which it is Based

The New Assessment Procedure (*Neues Begutachtungsassessment*, Ger. abbr. = NBA) was developed in order to implement the definition of the need for long-term care. It offers, as was demonstrated in the Report by the Advisory Board to Review the Definition of the Need for Long-term Care of 26 January 2009, a convincing alternative to the current assessment procedure. It not only overcomes the weaknesses of the current system. It also creates the basis that will be needed in order to better meet future challenges posed by demographic change.

- Unlike the present assessment instrument, the New Assessment Procedure takes all of the essential aspects of the need for long-term care into consideration. It is thereby more successful in taking the everyday problems and experience of people in need of long-term care into consideration.

- The New Assessment Procedure creates more equality. The special situation of people with mental impairments (e.g. dementia) and psychological problems is now addressed in a differentiated manner. It is expressly included in the process of determining the degree of need for long-term care.

- The New Assessment Procedure is also the better alternative for the assessment of children with health conditions or who are disabled. The assessment now often leads to classifications in the case of children that parents are unable to comprehend. This will change with the new procedure, because the New Assessment Procedure takes the areas into consideration that decisively characterise the everyday living and care situations of chronically ill children and their families (e.g. dealing with the serious consequences of illness, demands of extensive therapy, communication, behavioural disorders).

- Because the new procedure eliminates the restrictions of the current definition of the need for long-term care, it will meet with greater acceptance by insured persons and by their families. This has already been seen in the testing phase for the new procedure.

- The problematic, and often criticized, criterion of the time required to provide care will no longer be used. The New Assessment Procedure works with the criterion of "independence", which represents a clearly better and, above all, more reliable solution from the viewpoint of nursing sciences. By doing so, the New Assessment Procedure follows many well-recognised international models.

- The New Assessment Procedure offers, in the view of many experts who have had the opportunity to become familiar with it, a good alternative to the current procedure. It has indeed proved itself in practice and avoids a number of methodological problems that have been part of the everyday experience with the current assessment procedure.

- The new assessment procedure opens up new ways for the further qualitative development of long term care, which is desperately needed. The expanded definition of the need for long-term care is a prerequisite of a modern understanding of long-term care. The new assessment procedure thus contributes to overcoming obstacles encountered in efforts to adapt the provision of nursing care to the growing and changing demands of the future.

- The introduction of the new definition of the need for long-term care and the New Assessment Procedure also contributes to the elimination of scientifically questionable methodological shortcuts that result from the orientation on what are classified as activities of daily living in nursing care practice in the SGB XI. Paradoxically, many problems and situations of need that currently characterise everyday experience in long-term care will not trigger targeted support. Assessments undertaken with the New Assessment Procedure will give rise, in this conjunction, to a reorientation that has been called for by many experts.

- Because the need for long-term care is comprehensively reflected by the new assessment procedure, the assessment findings that it provides are a suitable basis for planning individual care and services. This not only applies to outpatient care services and inpatient long-term care facilities. Comprehensive long-term care counselling in the sense of Sec-

tion 7a SGB XI, in which explicit reference is to be made to the results of the assessment by the Medical Advisory Services of the Health Insurance Funds (Ger. abbr. = MDK), can also only be provided on the basis of a comprehensive assessment. The new assessment instrument is intended to improve the quality of long-term care and can provide a contribution to the appropriate calculation of necessary staffing levels oriented on the Degrees of Need.

- The evaluation of the need for medical rehabilitation provides more transparency in comparison to the current procedure, even if the new assessment procedure still requires further development in this regard. The results of this evaluation can also be used for additional purposes. They provide, for example, important information on long-term care measures that are intended to help people maintain or regain independence.

3.2.2 New Long-term Care Requires New Structures

The Advisory Board recommends linking the implementation of the Final Report and the introduction of a new definition of the need for long-term care to the discussion concerning the provision of care and services for people in need of long term care. An altered definition of the need for long-term care, which determines the degree to which a person's independence is impaired and their dependence upon personal assistance, poses different expectations both on the self-determination and the responsibility of people in need of long-term care and their relatives, as well as on their neighbours and civil society. This does not represent an attempt to privatise the risk of long-term care. It is virtually impossible to overestimate the contribution made by many families and caregivers.

The need for long-term care according to the new definition differs recognisably from what is found in the present system. The definition takes the often-simultaneous occurrence of the impairment of physical and cognitive functions into consideration and prevents, by viewing people holistically, the dominance of any one form of impairment. Defining the term not on the basis of deficits, but through a person's potential, thus requires strategies to preserve a person's independence, call attention to existing resources, and thus help to avoid the emergence or the exacerbation of the need for long-term care for as long as possible.

As today, the long-term care insurance will also in the future define insured persons' access to benefits to cope with the need for long-term care. It will, however, not be able to cover all

forms of need. It is feared, from the viewpoint of those affected, that for certain individuals specific and structural disadvantages could emerge in comparison to the old system. These fears must be taken into careful consideration within the framework of planning the implementation of the assessment procedure.

The distribution of funding adheres to proven principles of subsidiarity and solidarity and seeks to take appropriate account of individuals' living situations. The principle of giving outpatient measures priority over inpatient measures is to be further enhanced, as are prevention, rehabilitation, and rights to express preferences and make choices, whilst the special situation of people with a considerable need for long-term care is being recognised.

The framework conditions for long-term care as defined by policymakers not only determine chances of participation for people in need of long-term care, they also determine the long-term viability of professional options and the chances of establishing a secure infrastructure for long-term care, particularly in the family and non-professional context. In light of the demographic challenge, ensuring a contribution to the costs of long-term care based on solidarity is still a task for society on the whole.

3.2.3 Adaptation of the Assessment System

The determination of the weight accorded to each of the individual modules and the threshold values[7] for the Degrees of Need was undertaken by the Institute for Nursing Sciences at the University of Bielefeld (Institut für Pflegewissenschaft an der Universität Bielefeld, Ger. abbr. = IPW) and the Medical Advisory Service of the Health Insurance Funds of Westphalia-Lippe (Medizinischer Dienst der Krankenverischerung Westfalen-Lippe, Ger. abbr. = MDK WL) on the basis of scientific and practical considerations. The threshold to the Degree of Need 1 was determined so that people who are considered in need of long-term care from a professional point of view, but who display only a relatively low level of impairment, can also be included. The threshold value for the Degree of Need 2 was defined so that the number of persons entitled to benefits who achieve this threshold, or who exceed it, is roughly the same as the number of those currently entitled to benefits. The threshold value for the Degree of Need 4 is defined so that only persons with severe impairments reach it; this holds true, above

[7] A threshold value is the entrance point value for a given degree of need within the points schedule of the assessment system.

all, for people in need of care with serious cognitive/psychological impairments, but it can also be attained by other persons who are in need of long-term care due to extreme physically impairment. Hence, the threshold to the Degree of Need 3 was defined, with respect to the threshold values for the Degrees of Need 2 and 4, so that, on the whole, an acceptable system of classification, from the viewpoint of nursing sciences, is created. In this conjunction care was also taken to ensure that the threshold value could be reached as a result of certain constellations of impairment in the individual modules.

In keeping with the recommendations made by the Advisory Board in the final report[8], the need for adaptations in the system of classification was examined on the basis of experience with the nation-wide testing of the new assessment instrument in the Second Main Phase. The IPW/MDK WL recommended making fine adjustments in the New Assessment Procedure after this examination was completed, and this recommendation was extensively deliberated within the Advisory Board. It would entail the following changes:

3.2.3.1 Adjustment of the Modules

In the testing phase, it was shown that the new assessment instrument reacted in an overly sensitive manner in relation to persons suffering from low levels of capability loss in modules 1,2,4 and 6. As a consequence, some people whose independence was barely impaired were assessed as being in need of long-term care–albeit only “slightly”. This problem was solved by making appropriate adjustments in the system of classification. Subsequently, inconsequential impairments in the modules 1, 2, 4 and 6 of the New Assessment Procedure determining the Degrees of Need was not taken into consideration.

One of the tasks to be fulfilled in testing the instrument consisted of reviewing details of the design of modules 2 and 3. In the case of module 2, it was a question of the extent to which certain communication impairments could be included in the determination of the degree of impairment in terms of content and method. According to the results of a review by the IPW/MDK WL, this practice can be endorsed. This review also led to the finding that special weighting of individual aspects within the field of behaviour/psychological problems is not necessary and would make the assessment unnecessarily complicated, thus it should not be retained.

[8] Cf. Final Report of the Advisory Board to Review the Definition of the Need for Long-term Care, January 2009, Chapter 3 Recommendations 3.5.

3.2.3.2 Changes in the Threshold Values

Furthermore, the IPW/MDK WL consider it advisable to avoid excessive sensitivity of the instrument by raising the threshold between "not in need of long-term care" and the Degree of Need 1 "slight need of long-term care" slightly. By raising the lower threshold value from 10 to 15, it is possible to avoid insured persons with slight losses of independence being assessed as "in need of long-term care".

In considering the implementation, the Advisory Council also pursued recommendations made in the Second Main Phase and in the Supplementary Study. Thus, it was recommended in the evaluation report on the Second Main Phase that changes be made in the threshold values and, if necessary, a weighting of the modules in order to achieve a cost-neutral solution.[9] In this context, two models were presented which correspond, for the most part, with the demands for a cost-neutral solution.[10]

These models were again thoroughly reviewed with regard to their consequences for individual groups of insured parties and discussed by the Advisory Board. Changing the upper threshold to 75 or 80 points, as was calculated,[11] is not recommended because it was shown to make access to higher Degrees of Need considerably more difficult or impossible for people with physical impairments.

Raising the lower threshold value (to Degree of Need 1) to 20 points was also not recommended. Differentiated evaluations of the data led to the finding that this sort of increase would also keep people who, from the standpoint of nursing sciences, would unquestionably be designated as in need of long-term care from being able to claim benefits. These are, for example, people who show impairments in three or more of the total of six modules of the New Assessment Procedure (e.g. loss of mobility and impairments in the field of self-care and managing illness- and therapy-related demands).

[9] Measures to Establish a New, Reliable Assessment Instrument to Determine the Need for Long-term Care according to SGB XI, Final Report on the Second Main Phase (Windeler/Görres), Institute for Public Health and Nursing Research at the University of Bremen/Medical Advisory Service of the Federal Association of the Health Insurance Funds, October 2008, p. 107, 111.

[10] Measures to Establish a New, Reliable Assessment Instrument to Determine the Need for Long-term Care according to SGB XI, Final Report on the Second Main Phase (Windeler/Görres), Institute for Public Health and Nursing Research at the University of Bremen/Medical Advisory Service of the Federal Association of the Health Insurance Funds, October 2008, Variations1C and 2C, pp. 93-95.

[11] See calculation under 3.3.2.

3.2.3.3 Weighting the Modules

The Advisory Board does not consider it necessary to change the weighting of individual modules in relation to each other. It was convincingly demonstrated that the added value of the new assessment instrument, and the balance between physical and cognitive impairments, would be seriously impaired if the weighting were changed. The Advisory Council espouses the recommendation of the IPW/MDK WL and recommends that the new assessment procedure be employed with the designated modifications.

3.2.4 The New Structure of the Degrees of Need

The Advisory Board accepts the recommendation made by experts that five Degrees of Need be determined under the precondition that these are linked to benefits.[12] Under this premise, the Advisory Board recommends structuring the Degree of Need 1 to maintain independence and avoid the severe need for long-term care and the Degree of Need 5, which encompasses the most severe impairments of independence with special nursing care requirements.

3.2.4.1 Structuring the Degree of Need 1

The Degree of Need 1 could encompass the following benefits:

- Sums of money dedicated to certain purposes for persons in need of long-term care, allowing them to purchase support services such as low-threshold support offers or housekeeping services in a system of reimbursement
- Claim to individual, care counselling regardless of the determination of a need for long-term care
- Application of the expedited application procedure for rehabilitation according to Section 18 SGB XI in connection with Sections 31 and 32 of the SGB XI
- Claim to domestic counselling visits according to Section 37 paragraph 3 article 6 of the SGB XI
- Claim to measures to improve the living environment according to Section 40 paragraph 4 of the SGB XI

[12] Cf. Final Report of the Ad ivory Board to Review the Definition of the Need for Long-term Care, January 2009, Chapter 3 Recommendations 3.7.

- Claim also to nursing aids and appliances (technical and consumptive) according to Section 40 SGB XI
- Long-term care courses according to Section 45 SGB XI

With the exception of the costs for the cash allowances, it is difficult to estimate expenditures, since no reliable indicators of possible claims behaviour are available. Nonetheless, it is possible to make rough estimates by using appraisals and postulating assumptions. A particular difficulty in this conjunction results from the fact that those who will be entitled to benefits due to this Degree of Need and who live in their own domestic environments will, for the most part, be drawn from the group of those who were not previously entitled to benefits, or never previously submitted applications. The Advisory Board assumes a figure of 650,000 persons in its calculations. The scientific experts who participated consider this a reasonable assumption.[13]

Calculated on this basis, the annual expenditures would be as follows:

Annual Expenditures for 650,000 Persons with the Degree of Need 1 (in millions of €)

	Without dedicated allowance	**Dedicated allowance = 50 euros**	**Dedicated allowance = 100 euros**
Dedicated allowances (0 / 50 / 100 Euro)*	0	312	624
Care counselling	97.5	97.5	97.5
Domestic counselling visits	14	14	14
Improvements to the living environment	8.5	8.5	8.5
Nursing aids and appliances	7	7	7
Technical nursing aids and appliances	16	16	16
Sum	**143**	**455**	**767**

* An 80% utilisation rate is assumed.

[13] Cf. Appendix 5, Methodological Notes on the Determination of the Future Number of Persons Entitled to Benefits in the Degree of Need 1.

3.2.4.2 Structuring the Degree of Need 5

The Degree of Need 5 encompasses cases of extreme impairment of independence, which are accompanied by special nursing-care requirements. Two options for structuring the Degree of Need 5 were examined:

The first possibility is similar to the current criteria for what are considered hardship cases. Accordingly, this Degree of Need would be assigned to people who are not only found to have a high point value (at least 90 points), but also a certain constellation of need.[14] The additional expenditures, in comparison to those under the present hardship case regulations, would be on the order of 75 million euros in the Scenarios I, II and IV.

The alternative allows for defining the Degree of Need 5, like all other Degrees of Need, solely on the basis of the threshold value. Correspondingly, the Degree of Need 5 would be accorded to persons who reach a point value of at least 90. As a result, the problems and uncertainties connected with the current hardship regulation could be avoided. In this case, additional expenditures of some 400 million euros would result; these are taken into consideration in Scenario 3.

3.3 Implementation Scenarios

The discussion concerning the implementation of the proposed scenarios among members of the Advisory Board showed that a solution oriented largely on the present overall volume of benefits would only be possible under certain conditions.[15] The Research Study on the Second Main Phase defines cost neutrality as a deviation in costs by +/- 2 per cent of the overall volume of costs for long-term care insurance.[16] This amounts to an increase or decrease in required funding of 380 million euros.

[14] This includes the options that were subsequently tested: unusually high degree of need for of support in conjunction with consuming sustenance over more than two hours, unusually high degree of need for support due to spasms and contractions, the occurrence of generalised cramping more than once a day, intensive care at home with the need for permanent observation and vigil coma.

[15] Cf. Final Report of the Advisory Board to Review the Definition of the Need for Long-term Care, January 2009, Chapter 3, Recommendation 3.13.

[16] Measures to Establish a New, Reliable Assessment Instrument to Determine the Need for Long-term Care according to SGB XI, Final Report on the Second Main Phase (Windeler/Görres), Institute for Public Health and Nursing Research at the University of Bremen/Medical Advisory Service of the Federal Association of the Health Insurance Funds, October 2008, Variations1C and 2C, p. 93.

As the final report on the Second Main Phase already illustrated, it does not seem to be possible to generally link the new Degrees of Need to the monetary benefits currently provided without causing an increase in costs and a reduction in benefits due to structural effects and/or increases in the number of cases. The Advisory Board agreed to calculate and present various scenarios.[17] These are to be viewed as model calculations, which demonstrate the leeway that exists in the application of the new instruments. They are not proposals for concrete benefit allowances now already anchored in the laws related to benefits and services. A combination of elements from the scenarios presented here, or the scenarios themselves, is basically possible. The Advisory Board presents the following calculations[18]:

3.3.1 Scenario I – Model New Assessment Procedure with Present Allowances

The Advisory Board requested that the IPW/MDK WL submit a model that corresponds with the assessment instrument, operates with the present allowances, and structures a Degree of Need 1 with benefits to help maintain independence and avoid the need for additional long-term care, and a Degree of Need 5 as a special constellation of need.

This scenario will be referred to as "Scenario I" in the following. It employs the original threshold values of the New Assessment Instrument in determining the boundaries between the Degrees of Need 2 to 4:

Scenario I	Degree of Need 1	Degree of Need 2	Degree of Need 3	Degree of Need 4
	15	30	50	70

In this scenario it is assumed that the benefits for the Degree of Need 2 will be roughly equivalent to the benefits for the Level of Care I. The Degree of Need 3 corresponds to the level of benefits for the Level of Care II, and the Degree of Need 4 corresponds to the Level of Care III. The benefits for the Degree of Need 1 are structured in the manner described in Chapter 3.2.4.1. The Degree of Need 5 (special constellations of need) employs the current

[17] Final Report of the Advisory Board to Review the Definition of the Need for Long-term Care, January 2009, Chapter 3 Recommendation 3.13.
[18] These are model calculations. Statements or estimations with regard to aspects of gender as well as regional differences (North-South/East-West) can therefore not be presented.

benefit allowances for hardship cases and accounts for 75 million euros of assumed additional expenditures (cf. Chapter 3.2.4.2).

The scenarios are based on the assumption of 588,800 nursing home residents entitled to benefits (figures from the Federal Ministry of Health for 2007), for whom the full allowance for full-time institutional care is calculated (1,023 euros, 1,279 euros, 1,470 euros). The number of nursing home residents classified as "not in need of long-term care" in the sense of the SGB XI is estimated to be 50,000 or approx. 8%. This proportion reflects a realistic figure, which agrees with current studies.[19]

Benefits for outpatient and full-time institutional care are taken into consideration. The calculations for the Second Main Phase also included those who receive benefits according to Section 43a SGB XI treating them as nursing home residents. In the meantime, there is more reliable information for these persons based on the supplementary study.[20] The figure of 200 million euros, which was determined in the supplementary study, will be taken into consideration in the scenarios.

The question was introduced into the discussions of the Advisory Board from various sides, particularly from social welfare agencies, as to whether Section 43a SGB XI will be maintained in light of the greater tendency of the new definition of the need for long-term care to overlap with participation benefits. The question regarding a system of regulation free of discrimination also presents itself in view of the UN Convention on the Rights of Persons with Disabilities. This can only be clarified in the wake of a political decision.

The assumptions regarding the cost of outpatient benefits were adopted from the report on the Second Main Phase. The figure used for the number of "persons not in need of long-term care" who would be considered in need of long-term care under the New Assessment Proce-

[19] Cf., for ex. MuG IV or the project "Reference Models" NRW; cf. also the advice concerning the overestimation of the number of persons "not in need of long-term care" in nursing comes in the report on the Second Main Phase–Windeler et al. 2008, p. 105. In the Report on the Second Main Phase persons were also taken into consideration whose applications for inpatient long-term care were rejected, which might be approved this time. However, since there is no reliable information on size of this group of persons, this group was not taken into consideration in the calculations.

[20] Financial Effects of the Implementation of the new Definition of the Need for Long-term Care and the Corresponding Assessment Procedure for the Social Welfare Agencies and the Long-term care Insurance Funds, Supplementary Project to the Model Project "Development and Testing of a new Assessment Instruments to Determine the Need for Long-term Care", (Rothgang/Holst/Kulik/Unger) Center for Social Policy at the University of Bremen, December 2008.

dure was also taken from this report (ca. 530,000 persons). Costs for the benefits provided for persons with "limited abilities to cope with everyday activities" will be integrated as a constant factor; it is therefore assumed that these, or analogous, benefits will continue to be provided.

Financial Effects[21] of Scenario I:

Degree of Need 1	**Degrees of Need 2 to 4**	**Degree of Need 5**	**Benefits according to Section 43a SGB XI**	**Additional Expenditures**
0.143 in the case of an allowance of 0 euros	2.082	0.075	0.200	**2.500**
0.455 in the case of an allowance of 50 euros	2.082	0.075	0.200	**2.812**
0.767 in the case of an allowance of 100 euros	2.082	0.075	0.200	**3.124**

(in billions of euros)

The result would be costs of between 0.143 and 0.767 billion euros for the Degree of Need 1 and of 0.075 billion euros for the Degree of Need 5. Thus, the additional expenditures total 2.500 billion euros or 2.812 billion euros or 3.124 billion euros.

All of the calculations are based on current allowances and utilize the threshold value constellation of the New Assessment Procedure previously cited. A total of 2.082 billion euros of additional expenditures results for the Degrees of Need 2 to 4. Of this, 1.317 billion euros is for outpatient and 0.765 billion euros for full-time institutional care.

Scenario I shows a total increase in expenditures in relation to the present system of 16.3% in outpatient care and 8.6% in inpatient care (total 12.3%). In outpatient care, 48.2% of the recipients receive unchanged benefits, 32.9% higher and 19% lower benefits (data from the testing of instruments). The changes for inpatient care are as follows: there will be no change in benefits for 52.7%, higher benefits for 43.6%, and lower benefits for 3.7%.

[21] Figures indicate the additional expenditures in comparison to the status quo in each case.

In this model, the balance between physical and cognitive impairment is, for the most part, maintained. The results for people with cognitive impairments are considerably better than they are at the moment. The conditions for prevention and quality assurance are also good.

There is in principle a balance between outpatient and inpatient care, however inpatient care still enjoys a preferential status. The calculations made for the supplementary study[22] have shown that with an unchanged system of remuneration, roughly 1.8 billion euros would flow into inpatient care; this would only be justified if the quantity and/or quality of care improved.

Scenario I is a relatively evenly balanced solution with regard to physical and cognitive impairments, but also expensive, thus it exacerbates the problem of sustainable financing due to a considerable increase in overall cost. In addition, Scenario I has a tendency to favour inpatient care, which can be explained as a result of the higher percentage of people suffering from serious dementia, because forms of outpatient care for this group of persons is currently not available in sufficient quantity and quality.

3.3.2 Scenario II – Nearly Cost-neutral Model with Present Allowances

A cost-neutral model corresponding to the New Assessment Procedure and oriented largely on the present level of benefits can only be realised when the threshold values are increased to 60 or 80 points. Thus, in the following Scenario II therefore utilises this setting, i.e. an increase in the threshold values for the Degrees of Need 3 and 4.

Scenario II	Degree of Need 1	Degree of Need 2	Degree of Need 3	Degree of Need 4
	15	30	60 (instead of 50)	80 (instead of 70)

Otherwise, the same conditions apply as in Scenario I.

[22] Cf. Financial Effects of the Implementation of the new Definition of the Need for Long-term Care and the Corresponding Assessment Procedure for the Social Welfare Agencies and the Long-term care Insurance Funds, Supplementary Project to the Model Project "Development and Testing of a new Assessment Instruments to Determine the Need for Long-term Care", (Rothgang/Holst/Kulik/Unger) Center for Social Policy at the University of Bremen, December 2008, p. 59-60.

The financial effects of Scenario II manifest themselves as follows:

Degree of Need 1	Degree of Need 2 to 4	Degree of Need 5	Benefits According to Section 43a SGB XI	Additional Expenditures
0.143 in the case of an allowance of 0 euros	-0.116	0.075	0.200	**0.302**
0.455 in the case of an allowance of 50 euros	-0.116	0.075	0.200	**0.604**
0.767 in the case of an allowance of 100 euros	-0.116	0.075	0.200	**0.926**

(in billions of euros)

The analysis of the calculations shows different effects in outpatient and inpatient care for the Degrees of Need 2 to 4. While additional expenditures for inpatient care total up to 0.247 billion euros, the drop in costs for outpatient care is 0.364 billion euros (in each case for the Degrees of Need 2 to 4). In total, this results in lower expenditures of 0.116 billion euros for the Degrees of Need 2 to 4. Additional expenditures result for the Degrees of Need 5 as well as for the Degree of Need 1.

When there is no allowance for the Degree of Need 1, the model is largely cost neutral.

Scenario II leads to a reduction in expenditures of 4.5% in outpatient care and to an increase of 2.8% in inpatient care for the Degrees of Need 2 to 4, and altogether to lower expenditures of 0.7%. The benefits for outpatient care remain the same for 63.8% of the recipients, they are higher for 10.7% of the recipients, and lower for 25.5%. The benefits for 72.5% of those entitled to inpatient care remain unchanged, they are higher for 18.0%, and lower for 9.5%.

The qualitative assessment of the model shows, however, that it is not able to sufficiently ensure the balance between physical and cognitive impairments. Raising the highest threshold has an exclusionary effect with regard to persons who are only, or for the most part, affected

by physical impairments. This group would–without the protection of preserved rights–have to expect lower benefits in the wake of changes in the effects of classification.

Furthermore, the model exacerbates the situation in outpatient care. The consequence will be increased payments by the insured parties and/or the social welfare system. Overall, however, the model also works to the benefit of people with cognitive impairments.

Similar effects would also result from a change in the threshold values to 55 in the Degree of Need 3 and 75 in the Degree of Need 4.

The Scenario is not able to solve recognizable problems, namely access to Degree of Need 4 for people with physical impairments. Overall, it leads to poorer coverage of outpatient/domestic care.

The Scenarios I and II demonstrate that nearly cost-neutral solution in which the current allowances are maintained can only be realised when the access to benefits for higher Degrees of Need are altered considerably and intervention is undertaken in the structure of benefit provision.

3.3.3 Scenario III – Scenario with Alternative Allowances

The Advisory Board asked the IPW/MDK WL to examine an additional scenario based on the same thresholds but with other allowances. What needed to be clarified was the question as to the criteria according to which new benefit allowances could be defined and how the relationship of the allowances to the Degrees of Need was to be determined.

In this context, the Advisory Board also discussed how and by means of which criteria the relationship between the classifications resulting from the New Assessment Procedure and the determination of benefit allowances for the Degrees of Need can be structured in order to ensure that they are justified from the standpoint of nursing science and comprehensible in terms of social policy. The Advisory Board believes that it is essential, in the wake of the introduction of a new definition of the need for long-term care and the New Assessment Procedure, that benefit allowances in the Degrees of Need are assigned to individual situations of need on a basis that is comprehensible in terms of content and method. The exemplary determination

of the allowances in the Scenarios III and IV took place in a manner that linked them to the benchmark figures in the various benefit areas (outpatient: cash benefits/benefits-in-kind; inpatient) for the benefit allowances in the present Levels of Care. For Scenario IV, by contrast, the benchmark figures were chosen so that a nearly cost-neutral scenario resulted; hence, there is a relatively strong divergence from current benefit allowances.

All of the scenarios take the special function of long-term care insurance into consideration, especially

- in making a (normatively determined) financial contribution to the costs that the person in need of long-term care incurs in covering their needs (individual relief effect),
- and thus in directly reducing the structural dependency on social welfare and in contributing indirectly to the relief of social welfare agencies.

In the further course of implementation it must be determined whether and how a graduated system of benefits for individual Degrees of Need can be related to a typical profile of need for those in need of long-term care. Further transparency of the benefit requirements of those in need of long-term care could thereby be achieved. The financial burdens related to the event of the need for long-term care should also be taken under scrutiny, e.g. in the form of co-payments, as well as the question as to whether and how individually structured informal outpatient care might be suited for classification in typologies.

The Advisory Board also considers it possible that the degree of need for long-term care or the impairment of independence itself could be used as a direct reference point for the level of benefits of a Degree of Need. This is made possible by the relationship between the point values in the New Assessment Procedure. For example, if the point value is double, then a doubling of the benefit allowance would be justified. The Advisory Board opted in this context for two different possible modes of statistical derivation while simultaneously taking aspects of social and long-term care policy into consideration.

If monetary allowances based on the median point values of each of the Degrees of Need were related to each other, they would be relatively close. This is not desired and is therefore not used in the Scenarios.

If the lower threshold values of the Degrees of Need are used instead of their median values, as in the Scenarios III and IV, the intervals are larger. For example, the threshold for the Degree of Need 3 is higher by a factor of 1.67 than the threshold value for the Degree of Need 2 (50 as opposed to 30 points). Analogously, it can be determined that the allowances for the Degree of Need 3 are higher by a factor of 1.67 than the allowances for the Degree of Need 2. If, for example, the level for a certain benefit for the Degree of Need 2 is set at 300 euros, the result for the Degree of Need 3 would be 1.67 times this sum, i.e. an allowance of 500 euros. Other allowances can also be determined in the same manner.

With its decision in favour of the lower threshold value, the Advisory Board made use of the opportunity to take criteria based on social policy into consideration in distributing the existing funds, e.g. preserving independence, and improving the situation of people who are considerably impaired or who require a special combination of benefits. Hence, Scenario III, like the subsequent, nearly cost-neutral Scenario IV, illustrates the possibilities that result from this approach.

As is the case with all of the other scenarios, the parameters of the model must also be clarified:

- It is assumed that the benefits for the Degree of Need 1 will be structured in a manner similar to the one described in Chapter 3.2.4.1.
- The Degree of Need 5 in Scenario III is defined, in contrast to the Scenarios I, II and IV, only by a point value, not by particular criteria (such as special constellations of need).
- Changes in costs must, in this case, be calculated separately for the various types of benefits (benefits-in-kind, cash benefits, combination benefits, full inpatient benefits). The overall result is derived by combining all of the changes that are determined.
- The assumptions concerning the continuation of current benefit expenditures for persons with limited abilities to cope with everyday activities correspond with the assumptions in Scenarios I and II.
- Additional assumptions must be made for the calculation of combination benefits, since exact figures concerning the volume of combined cash benefits and benefits-in-kind are not available. From the statistics on expenditures for the long-term care insurance in 2007, it is possible to calculate that the volume of expenditures for combination benefits per benefit recipient were, on average, roughly 2/3 of the highest individual allowance for in-kind benefits. The following figures are based on this share.

- A basic allowance is defined for full-time institutional care, which remains constant in all of the Degrees of Need. Firstly, this is intended to avoid distortions that could result from benefit allowance sums for which the intervals are much larger than they are today.[23] Secondly, it should be taken into consideration that not all components in full-time institutional care vary with the degree of need for long-term care (especially indirect care services such as care management and organisation). The basic allowance is set at 500 euros. This allowance is somewhat higher than the average share of indirect care services in relation to total expenditures to support long-term care (ca. 38%) (calculated in relation to the average expenditure per resident by the mandatory long-term care insurance system).

Under these conditions, it is possible to present plausible models for linking of Degrees of Need, determined by the New Assessment Procedure, to alternative allowances in Scenarios III and IV.

Scenario III leads to the following results:

Example for the Determination of New Monthly Benefit Allowances and the Definition of a Degree of Need 5

	New Benefit Allowance				
	Degree of Need 2	**Degree of Need 3**	**Degree of Need 4**	**Degree of Need 5**	**Additional Expenditures in billions of euros**
Cash benefits	215	359	501	645	**0.044**
In-kind benefits	490	817	1.143	1.470	**0.103**
Combination benefits*	490	817	1.143	1.470	**0.066**
Full-time institutional care benefits	890	1.150	1.410	1.670	**0.369**
Sum	–	–	–	–	**0.582**

* Calculatory reference values according to Degree of Need.

[23] The intervals between the current benefit allowances for full-time institutional care are very short at €256 (1,023 – 1,279) and €191 (1,279 – 1,470) and are markedly shorter than the intervals of the highest allowances for in-kind benefits in outpatient care.

The determination of a cash benefit allowance of 215 euros per month in Degree of Need 2 is oriented largely on the present allowances and calculated for the other Degrees of Need on the basis of this spread.

Altogether, Scenario III would have the following financial effects:

Degree of Need 1	**Degrees of Need 2 to 5**	**Benefits according to Section 43a SGB XI**	**Additional Expenditures**
0.143 in the case of an allowance of 0 euros	0.582	0.200	**0.925**
0.455 in the case of an allowance of 50 euros	0.582	0.200	**1.237**
0.767 in the case of an allowance of 100 euros	0.582	0.200	**1.549**

(in billions of euros)

Thus, under the condition that benefits are provided for the Degree of Need 1 and a Degree of Need 5 is established, additional costs of 0.925 to 1.549 euros result for Scenario III.

The model leads to twice as many people in need of long-term care receiving the allowance for benefits in kind for the Degree of Need 4 (36,000 as opposed to 17,000 today); it would, however, only entail 1,143 euros instead of 1,470 euros. In comparison to the status quo, in the overall effect on outpatient care is higher volume of funds flowing into the lower Degrees of Need. Consequently, changes are to be expected in financial expenditures by individuals or by the social welfare system as a result of copayments. The shift, in absolute terms, mainly favours persons with more strongly manifested cognitive impairments, who are at a disadvantage under the current system. In addition, the enhancement of long-term care prevention measures in the lower Degrees of Need will be realised.

If one were to choose the current benefit allowance in the Level of Care III as a basis for determining the benefit allowance for outpatient care in the Degree of Need 4, one would come to the following, alternative, results:

	New Benefit Allowance*				
	Degree of Need 2	**Degree of Need 3**	**Degree of Need 4**	**Degree of Need 5**	**Additional Expenditures in billions of euros**
Cash benefits	290	484	675	869	**1.283**
In-kind benefits	630	1051	1470	1890	**0.557**
Combination benefits*	630	1051	1470	1890	**0.461**
Full-time institutional care benefits	890	1,150	1,410	1,670	**0.369**
Sum	–	–	–	–	**2.670**

* Calculatory reference values according to Degree of Need.

The financial effects of this determination can be represented as follows:

Degree of Need 1	**Degrees of Need 2 to 5**	**Benefits According to Section 43a SGB XI**	**Additional Expenditures total**
0.143 in the case of an allowance of 0 euros	2.670	0.200	**3.013**
0,455 in the case of an allowance of 50 euros	2.670	0.200	**3.325**
0,767 in the case of an allowance of 100 euros	2.670	0.200	**3.637**

(in billions of euros)

For this example of the determination of benefit allowances within the framework of Scenario III, additional expenditures of 3.013 to 3.637 billion euros result, under the condition that benefits are provided for the Degree of Need 1 and that a the Degree of Need 5 is structured in the manner described above.

In the case of this model, higher overall expenditures may be incurred as a result of structural and volume effects. In the event that the current benefit allowances for outpatient care in the Level of Care III are used as a starting point for the Degree of Need 4, slightly higher additional expenditures result, in comparison to Scenario I, but, by the same token, a considerable share of the expenditures for the regulation of preserved rights in outpatient care would become redundant, because many benefit recipients would receive allowances that were higher or at least equal to those received now. Adopting slightly reduced allowances for inpatient care would then not necessarily lead to higher copayments if the remuneration system is readjusted and the more numerous recipients in the higher Degrees of Need are taken into consideration.

The calculations illustrate the higher degree of flexibility in the process of structuring the benefits. Thus, the effects of outpatient and inpatient care can be better managed. This could be of importance with regard to the goal of avoiding structural distortions during the transition to a new definition of the need for long-term care. Fundamentally, other benefit levels with slight additional expenditures could also be determined according to this principle.

Introducing alternative allowances makes it easier – in comparison to a model with the present benefit allowances – to refer to this as a new model. It is also considerably easier to realise and administer the fundamental principle of outpatient care over inpatient care. Depending upon the amount of the benefit allowance chosen, it also presents particular challenges, to the extent that the ensuing benefit migration will necessitate an explanation of the connection between the degree of need and the volume of benefits. A considerable need for its implementation in laws related to benefits and services will result.

Furthermore, the Scenario III consistently classifies the Degree of Need 5 as a Degree of Need for persons with a particularly severe level of need for long-term care. This model completes the transition into the new system of long-term care insurance without any gaps. It will no longer seem plausible to equate the Levels of Care with the Degrees of Need even when viewed cursorily. The problems and obstacles related to the current regulations for hardship cases, are excluded from the start. Overall, there is a higher degree of flexibility in structuring the benefits profiles.

3.3.4 Scenario IV – Nearly Cost-neutral Scenario with Alternative Allowances

Principally, the same parameters apply in Scenario IV as in Scenario III. The differences are

- that the benefit allowances are defined so that a nearly cost-neutral scenario results, and
- that the Degree of Need 5 is defined as in the Scenarios I and II (hardship regulations) and assumed to result in additional expenditures of 75 million euros.

In this conjunction, Scenario IV represents a variation with a nearly cost-neutral benefit volume structure.

Scenario IV: Examples for the Determination of New Benefits Allowances

	New Benefit Allowances (in Euro)			
	Degree of Need 2	**Degree of Need 3**	**Degree of Need 4**	**Additional Expenditures in billions of euros**
Cash benefits	215	359	501	**-0.024**
In-kind benefits	480	800	1,120	**0.027**
Combination benefits*	480	800	1,120	**-0.024**
Full-time institutional care benefits	880	1,133	1,387	**-0.058**
Sum	–	–	–	**-0.079**

* Calculatory reference values for each Degree of Need; assumption: 2/3 of the highest allowances will be claimed.

The financial effects of the Scenario IV present themselves as follows:

Degree of Need 1	Degrees of Need 2 to 4	Degree of Need 5	Benefits According to Section 43a SGB XI	Additional Expenditures
0.143 in the case of an allowance of 0 euros	-0.079	0.075	0.200	**0.339**
0.455 in the case of an allowance of 50 euros	-0.079	0.075	0.200	**0.651**
0.767 in the case of an allowance of 100 euros	-0.079	0.075	0.200	**0.963**

(in billions of euros)

Thus, additional costs of 0.339 to 0.963 billion euros result for the Scenario IV under the condition that benefits are provided for the Degree of Need 1 and that a Degree of Need 5 is established. Scenario IV and/or variations of its realisation (for example the variation with total costs of 0.339 billion euros) can therefore be realised with nearly the same level of benefits as is presently the case. Altogether, there is a shift in benefits for outpatient care from the higher to the lower classifications. This is also not compensated by the fact that more people reach the highest Degree of Need than previously reached the highest Level of Care.

With regard to the need for explanation, the comments on Scenario III apply to an even greater extent to Scenario IV. In particular, the existing flexibility in structuring the benefits profiles becomes, in turn, particularly clear from this model.

Therefore, with Scenario IV the Advisory Board presents policymakers with an additional model with alternative allowances, which corresponds to the New Assessment Procedure and can be realised with nearly the present volume of benefits.

3.4 Preserved Rights

The consideration given to the problem of ensuring individual and structural benefits in the event of the transition from one system to the other in long-term care insurance is related to persons in need of long-term care who are receiving benefits at the time when the systems change or who have submitted applications by that time. There is no need to regulate the protection of preserved rights for those who have simply been paying contributions. In light of decisions handed down by the Federal Constitutional Court on changes in positions in social insurance law in the wake of reforms in the social insurance system, it can be ascertained that lawmakers are fundamentally entitled to exercise considerable leeway in this context.[24]

This notwithstanding, the politically important expectations of those affected should still be taken into consideration. Fundamentally, it can be assumed that benefit recipients expect that their positions will be improved by the transition to the new system, or at least not worsened.

However, it must be determined whether this expectation is related to a fundamental claim to assistance as of a certain level of need for long-term care, or whether the expectation with regard to the level of benefits previously received warrants protection. The need to take people's expectations with regard to the level of benefits into consideration could play a lesser role, if it is made clear that changes in the legal situation are to be expected at the time that benefits are originally granted.

The period of time for which preserved rights will be protected, and the period of time and the circumstances in which a new assessment will be conducted, must still be clarified. The decision concerning the point in time at which the transition will take place, and, thus, at which all people in need of long-term care will be covered under the new system, and, consequently loose all preserved rights, is a question of political discretion. In this conjunction, consideration should also be given to the fact that, on grounds of practicality, two parallel assessment systems should not exist. Despite the fact that a large number of new applications are to be expected at the time when the new system is being introduced, long delays in implementing

[24] Cf. the Federal Constitutional Court, Decision of 17 February 1997 – Az.: 1 BvR 1903/96; cf. Federal Constitutional Court, Decision of 7 October 2008 – Az.: 1 BvR 2995/06, 1 BvR 740/07.

the New Assessment Procedure must be avoided. For this reason, the regulation of preserved rights and administrative regulations must be coordinated with each other.

3.4.1 The Translation of the Old Levels of Care into the New Degrees of Need

3.4.1.1 Determining a Cut-off Date

An initial option for the transition from the old to the new system is a cut-off date according to which lawmakers would determine a certain date after which the new legal situation would take effect. In the past, cut-off date regulations of this type were generally adopted in relation to claims for benefits that were triggered by circumstances that were dependent upon the occurrence of certain events. In view of the event of the need for long-term care, a cut-off date regulation would result in people who were in need of long-term care before the cut-off date and who submitted an application at this time being covered according to the old legal situation. For people whose need for long-term care arose after the cut-off date, the new legal situation would apply. Within the framework of a later assessment, e.g. due to fundamental changes in the need for assistance, the new legal situation should apply regardless of the existence of a cut-off date regulation.

3.4.1.2 Translating the Levels of Care into Degrees of Need

Another conceivable possibility is the complete conversion of the current Levels of Care into the new Degrees of Need for all of those in need of long-term care. Levels of Care and Degrees of Need are, however, not comparable to each other. In the case of a general conversion, the transition would have to be prescribed by lawmakers. It is, however, hardly conceivable that persons would then be classified according to their actual need for long-term care. Hence, the Advisory Board considers a conversion based on purely formal criteria inappropriate.

3.4.2 Financial Effects of the Protection of Preserved Rights

The transition to a new understanding of the need for long-term care and to a new assessment procedure will lead to changes for insured persons who are currently entitled to benefits.

The model calculates the additional costs that result from the protection of preserved rights over a period of three years. It pursues the question as to which costs could result for guaran-

teeing the claims of those entitled to benefits during this period. This model calculation also serves to illustrate the possible costs resulting from regulations to protect preserved rights. The assumption of a maximum of three years as the length of the period in which preserved rights would be protected should not be viewed as a stipulation introduced by the Advisory Board.

There is no representative data on the course of the need for long-term care on the individual level. Reasonable assumptions on the course of long-term care careers can, however, be derived from various empirical studies.[25] Correspondingly, the model assumes that during the course of a period of three years, 80 % of the persons for whom a regulation to protect preserved rights takes effect will either pass away or will reach a higher Degree of Need, due to a progressing need for long-term care, which in turn leads to the suspension of the need to protect preserved rights. The model calculation hereby assumes an ongoing reduction (by 2.22 % per month or 80/36 % – s. above).

The calculations must be undertaken for each of the presented scenarios individually, since both the amount of the benefits and the number of persons with preserved rights varies. An additional complication results from the fact three different variations for structuring the Degree of Need 1 must be taken into consideration (characterised in the following by the given "allowance"). The following table presents the results of the calculations per scenario.

In Scenario I, the additional expenditures total a sum of between 1.830 and 2.092 billion euros, depending on how the benefits in the Degree of Need 1 are structured. In this case, 14.1% of the insured persons who are currently entitled to benefits (roughly 265,000 persons)[26] would be among those with preserved rights (3,7% of those in inpatient care, or 22,000 persons, and 18.8% of those in outpatient care, or 243,000 persons).

[25] For example from the Infratest Study on the "Möglichkeiten und Grenzen selbständiger Lebensführung" (Possibilities and Limits of Leading an Independent Life) (MuG III and MuG IV) or an assessment of date by the Gmünder Ersatzkasse.
[26] Without persons entitled to benefits from facilities for the disabled.

Table 1: Additional Expenditures for Preserved Rights during a Period of Three Years: Scenario I – Model New Assessment Procedure with Present Allowances

Configuration DoN 1	Outpatient	Inpatient	Total
Allowance 0 euros	1.797	0.295	2.092
Allowance 50 euros	1.666	0.295	1.961
Allowance 100 euros	1.535	0.295	1.830

(in billions of euros)

In Scenario II the additional expenditures lie between 2.751 and 3.014 euros, i.e. clearly higher than in Scenario I. In comparison to Scenario I, clearly more people, namely 21.0% of the insured persons now entitled to benefits (roughly 396,000 persons), would be among those with preserved rights[27] (9.6% of those in inpatient care, or 56,000 persons, and 26.2% of those in outpatient care, or 340,000 persons).

Table 2: Additional Expenditures for Preserved Rights during a Period of Three Years: Scenario II – so-called Cost-Neutral Model with Present Allowances

Configuration DoN 1	Outpatient	Inpatient	Total
Allowance 0 euros	2.535	0.478	3.014
Allowance 0 euros	2.405	0.478	2.883
Allowance 0 euros	2.273	0.478	2.751

(in billions of euros)

In Scenario III the additional expenditures total between 2.672 and 2.938 billion euros or 1.907 to 2.172 billion euros for the alternative determination in which cash benefits and in-kind benefits at the level of current benefit allowances in the Level of Care III were chosen as a starting point in the Degree of Need 4.[28]

[27] Without persons entitled to benefits and living in special support institutions for persons with disabilities.

[28] The share of persons who will be affected by the changes is not enumerated, since this would exceed the framework of this report. Because, unlike in the Scenarios I and II, there are nearly countless variations in the allowances individually required in order to protect preserved rights in the wake of a change in allowances (for example 58, 117, 159, 169, 197, 203, 215, 313, 322, 364, 402 and 458 euros, i.e. twelve different values alone for the recipients of monetary benefits.

Table 3: Additional Expenditures for Preserved Rights during a Period of Three Years: Scenario III - Scenario with Alternative Allowances

Configuration DoN 1	Outpatient	Inpatient	Total
Allowance 0 euros	2.011	0.927	2.938
Allowance 0 euros	1.878	0.927	2.805
Allowance 0 euros	1.745	0.927	2.672

(in billions of euros)

Table 4: Additional Expenditures for Preserved Rights during a Period of Three Years: Scenario III - Scenario with Alternative Allowances, Using the Present Benefit Allowances in Level of Care III for Degree of Need 4 as a Point of Departure for Determining Cash and In-kind Benefits

Configuration DoN 1	Outpatient	Inpatient	Total
Allowance 0 euros	1.245	0.927	2.172
Allowance 50 euros	1.113	0.927	2.040
Allowance 100 euros	0.980	0.927	1.907

(in billions of euros)

Finally, Scenario IV leads to additional expenditures of between 3.046 and 3.310 billion euros.[29] The differences between the additional expenditures for outpatient and inpatient care are similar in magnitude to those in Scenario III.

Table 5: Additional Expenditures for Preserved Right during a Period of Three Years: Scenario IV – so-called Cost-Neutral Scenario with Alternative Allowances

Configuration DoN 1	Outpatient	Inpatient	Total
Allowance 0 euros	2.300	1.010	3.310
Allowance 50 euros	2.169	1.010	3.179
Allowance 100 euros	2.036	1.010	3.046

(in billions of euros)

In summary, it can be ascertained that additional expenditures for preserved rights are closely related, as was expected, to the additional expenditures for the benefits that are ultimately determined for the Degrees of Need.

[29] For the same reason as in Scenarios III, the share of persons who are affected by changes are not named.

3.4.3 Remuneration in Inpatient Care

While it is possible to imagine the coexistence of people in need of long-term care who were assessed according to the old and the new systems in outpatient care, this presents greater difficulties in inpatient care. While it would indeed be possible to continue paying allowances at the rate of the present Level of Care until a new assessment has been undertaken, the existence of two systems of remuneration alongside each other would be far more problematic in inpatient care. Instead of the parallel application of two remuneration systems, a conversion using equivalency factors is conceivable, as was the practice in 1996. The most practical solution would be to regulate the procedure by law.

3.5 Care of Persons with Limited Abilities to Cope with Everyday Activities

Introduced through the Supplementary Long-term Care Benefits Act (Pflegeleistungsergänzungsgesetz, Ger. abbr. = PflEG) and the Long-term Care Further Development Act (Pflege-Weiterentwicklungsgesetz, Ger. abbr. = PfWG), benefits from long-term care insurance are available to persons with limited abilities to cope with everyday activities according to Section 45b SGB XI and Section 87b SGB XI. The expansion of the definition of the need for long-term care to include cognitive impairments requires that consideration be given to how the objectives and contents of these benefits can be translated into the new law.

The claim to supplementary benefits for supervision and care in outpatient care (regulated in Sections 45a and 45b SGB XI) was justified mainly by the fact that the assistance requirements of those affected were not, or not sufficiently, met by the system in effect. The equal consideration given to all somatic and intellectual/psychological impairments by the new assessment instrument also leads to a greater number of people with limited abilities to cope with everyday activities being able to participate equally in the benefit system. A considerable share of the affected persons will be entitled to general benefits from the long-term care insurance system for the first time as a result of the new classification in a Degree of Need according to the New Assessment Procedure.[30]

[30] Cf. Final Report of the Advisory Board to Review the Definition of the Need for Long-term Care, January 2009, p. 49.

3.5.1 Benefits of Sections 45b to 45d SGB XI

The existing self-help structures and the diverse offers for people with limited abilities to cope with everyday activities are viewed positively. The Advisory Board is therefore of the opinion that

- the promotion of infrastructure according to Section 45c and 45d SGB XI and
- accountable cash benefits corresponding to the present stipulation of Section 45b SGB XI should be maintained in terms of their objectives and content in the new system.

Various approaches to implementation were discussed. During the transition to the new system, services presently offered under Section 45b SGB XI could become a form of service offered on equal footing, i.e. part of the long-term care benefits-in-kind offered within the framework of Section 36 SGB XI. This can be applied as a disposable budget for the purchase of low-threshold services from approved service providers within the benefit allowance or from outside of the approved service providers through cost reimbursement. As an alternative, these benefits can still take the form of different types of offers. The objective in both cases must be to maintain and enhance what was offered up until now through low-threshold services in order to continue to supplement outpatient services and their offers on the market.

An argument in favour of including Section 45b SGB XI benefits in the in-kind benefits system of Section 36 SGB XI is the flexibility it would provide for those in need of long-term care and their relatives in structuring individual long-term care and supervision arrangements. In this context, however, it will still be necessary to ensure that low-threshold offerings do not require the conclusion of long-term care supply contracts or remuneration agreements.

An argument in favour of retaining Section 45b SGB XI services outside of the in-kind benefits system according to Section 36 SGB XI is the fact that existing, approved offers will not be abandoned and that the expansion of these offers can be maintained in keeping with regional needs.

Notwithstanding these two fundamentally conceivable approaches, the question as to the extent of the benefits and the group of persons entitled to benefits must still be clarified. Firstly, the benefits of Section 45b SGB IX could be retained as additional benefits for the group of

persons presently designated in Section 45a SGB XI. In this context, a complete or only partial deduction of the allowance provided according to Section 45b SGB XI from the benefits-in-kind according to Section 36 SGB XI and the long-term care allowance according to Section 37 SGB XI would be possible. To the extent that an accumulation of the benefits is to be allowed, the level of the present allowances, up to 200 euros per month, does not seem justified. The intention of the new definition of the need for long-term care is specifically the elimination of discrimination against people with cognitive deficits.

On the other hand, it is also possible that the type of benefits provided according to Section 45b SGB XI could be made available to everyone in need of long-term care depending on their situation of need. As a result of the evaluation of the degree of independence in the areas of communication and psychological behaviour patterns in the new system of classification, it already determines a corresponding need for care as an independent set of care services in addition to basic care and care of the household within the framework of in-kind benefits according to Section 36 SGB XI. In this conjunction, low-threshold offers should be completely or partially deducted from the in-kind benefits or long-term care allowance.

A combination of supplementary care and supervision with the objective of allowing greater flexibility is also conceivable. When the offers can be taken advantage of by additionally claiming a separate benefit allowance, it would be possible to arrange for a more extensive use of such services by people with limited abilities to cope with everyday activities within the framework of a cost reimbursement agreement with the long-term care insurance funds. This should, however, only be undertaken in combination with the deduction of in-kind benefits according to Section 36 SGB XI and/or the long-term care allowance according to Section 37 SGB XI.

At any rate, a supplementary benefit allowance should, as was previously the case, only support taking advantage of care and supervision and not be available as a cash allowance or for in-kind benefits. In addition, fundamental consideration must be given to the adequacy in allocating funds. Furthermore, the support for structural development according to Sections 45c and 45d SGB XI should also be a component of long-term care insurance in the future.

3.5.2 Benefits According to Section 87b SGB XI

In the new system it can still be expected that people with dementia with high Degrees of Need will live in inpatient facilities. The additional care and activation of nursing home residents in need of long-term care with considerable need for general supervision and care should be retained in terms of the objective and content, in order to ensure better structure in everyday activities and to make the transition and networking between inpatient and outpatient care easier.

3.6 Preparatory Measures

The implementation of the new definition of the need for long-term care and the New Assessment Procedure requires, above all, the revision of the existing guidelines as well as a series of additional administrative provisions.

3.6.1 Revision of Guidelines

3.6.1.1 Guidelines for Assessments and for the Need for Long-term Care

The Guidelines Issued by the Central Associations of Long-term Care Insurance Funds for the Assessment of the Need for Long-term Care According to the Eleventh Book of the Social Code (Assessment Guideline) in 21 March 1997 in the version of 11 May 2006) and the Guideline of the Central Associations of the Long-term Care Insurance Funds on the Delineation of the Characteristics of the Need for Long-term Care and the Levels of Care as well as a Procedure for Determining the Need for Long-term Care (Guideline on the Need for Long-term Care) of 7 November 1994 in the version of 11 May 2006 must be adapted in terms of their content in view of the new definition of the need for long-term care and the New Assessment Procedure. A revision should be undertaken as soon as possible.

3.6.1.2 Guideline on the Determination of Persons with Severely Limited Abilities to Cope with Everyday Activities

The content of the Guideline to Determine Persons with Severely Limited Abilities to Cope with Everyday Activities will be included in the Assessment and Need for Long-term Care Guideline drafted in the wake of the new definition of the need for long-term care. It is there-

fore not necessary for a specific guideline to be drafted for these circumstances. However, it must be ensured that the characteristics related to persons with severely limited abilities to cope with everyday activities can continue to be identified as such.

3.6.1.3 Hardship Case Guideline

Hardship Case Guidelines will no longer be necessary once the Degree of Need 5 is adopted as a system-compatible Degree of Need for people with special long-term care needs.

3.6.2 Staffing Requirements / Additional and Further Training

The testing during the second Main Phase showed that the time required for an assessment using the New Assessment Procedure, 60 minutes, was within the same timeframe as the current procedure. In practice, the time required is also a function of the concrete configuration of the forms that must be filled out, whereby the possibility of electronically registering the data represents a possibility for saving time. Higher staffing requirements are therefore not to be expected in the long run.

Initially, there will be a considerable need for additional training both on the part of the benefit agencies (insurance funds) and the Medical Advisory Service of the Health Insurance Funds as well as among caregivers. Care facilities must make themselves familiar with the requirements of the new definition of the need for long-term care. In addition, it should also be kept in mind that the new procedure would require a complex software solution as well as people who are well trained in its use. The implementation of the new definition of the need for long-term care and the New Assessment Procedure will therefore require a sufficient period of preparation.

3.6.3 Further Adjustments

Social long-term care insurance statistics (financial statistics, PV45 or PJ1 / benefits statistic PG1, PG2, PG4 as well as PG5) and other statistics, including social welfare statistics, must be examined in order to determine the need for adjustments.
In addition, the joint circulating letter issued by the Central Association of Long-term Care Insurance Funds and the National Association of Statutory Health Insurance Funds of 15 July

2008 on the stipulations related to long-term care benefits and services in the Act Providing Social Protection of Persons in Need of Long-term Care (Ger. abbr. = PflegeVG) must be revised depending upon the future structure of the benefits (Sections 14 to 18, 33 – if necessary in connection with the regulation of preserved rights - 36 to 45d in connection with 87b SGB XI; Art. 45 PflegeVG; Sections 82 to 85 and 87 to 89 SGB XI).

Chapter 4: Recommendations for Implementation

4.1 Implementation of the New Assessment Procedure

4.1.1 Modification of Modules

The Advisory Board hereby decides to make changes based on considerations of nursing science in the Modules 1, 2, 3, 4 and 6, because of the increased sensitivity that became obvious during the evaluation process (Second Main Phase) and recommends their implementation.

4.1.2 Testing the Weighting of Modules

The testing of how the modules are weighted in relation to each other, which was called for by the Advisory Board, showed that changes could only be undertaken in the event of a threat to the balance between physical and cognitive impairments. The Advisory Board therefore recommends that the weighting of the modules defined in the First Main Phase and evaluated in the Second Main Phase be left unchanged.

4.1.3 Changes in the Threshold Values

The Advisory Board recommends changing the entry-level threshold value from 10 to 15 points. Other changes, especially of the higher threshold values, could make it difficult or impossible for people whose impairments are mainly physical to gain access to higher Degrees of Need and are therefore not considered appropriate.

4.2 New Structure of the Degrees of Need 1 and 5

The Advisory Board accepts the proposal submitted by experts in favour of the establishment of five Degrees of Need under the precondition that they are all linked to benefits. Under this premise, the Advisory Board recommends structuring the Degree of Need 1 so that it helps to maintain independence and avoids severe need of long-term care and inpatient care, and Degree of Need 5 that includes particularly severe situations of need. The proposals that were

made with regard to structuring the Degrees of Need 1 and 5 (3.2.4.1 and 3.2.4.2) should be examined and, if found acceptable, adopted.

4.3 Preserved Rights

The Advisory Board recommends the examination of the advice expressed with regard to preserved rights in 3.4.1 and, if it is found convincing, that it be heeded.

4.4 Care of People with Limited Abilities to Cope with Everyday Activities

The Advisory Board recommends that the care of people with limited abilities to cope with everyday activities, which was introduced through the Supplementary Long-term Care Benefits Act and the Long-term Care Further Development Act, be retained in terms of their objective and content and that advice expressed under 3.4.2. be considered and, if found convincing, adhered to.

4.5 Recommendations for Preparatory Measures

The Advisory Board recommends that the advice expressed under 3.5 pointing out the necessary changes required in the guidelines etc. be adopted, that existing regulations be examined to determine whether they are expendable and, depending on the results, to adjust them.

The Advisory Board recommends that the new assessment procedure and the adjustments that are connected with it be introduced in one step nationwide and that sufficient time is foreseen for this step.

4.6 Outlook

The Advisory Board recommends combining the implementation of the final report and the introduction of the new definition of the need for long-term care with the discussion of new structures for providing benefits.

Changes in the infrastructure for providing care is required by all of the scenarios. It is not only an essential prerequisite in the cost-neutral scenarios, but also for proposals that call for greater financial resources. It is only possible to ensure that changes in the individual benefit claims, whether increases or decreases, resulting from changes in the determination of need in the wake of structural and volume effects, can be undertaken through intervention in the structures in an acceptable manner, when they allow for personal, well-targeted assistance. Synergies etc. can result from changes in structures.

Objectives of the Orientation:

1. Stronger support for outpatient care and care close to home
2. Ensuring crosslinking between outpatient and inpatient care. Overcoming the rigid boundaries between the two areas
3. Enhancement of the infrastructure through benefits and services from statutory long-term care insurance (e.g. by further developing long-term care counselling)
4. Increased orientation on the social context and better cooperation between social security systems
5. Stronger orientation on the individual

Contents of Implementation:

1. Enhancement of the willingness of families to provide long-term care and of arrangements for care in civil society through benefits geared towards avoiding inpatient care: security and protection in cases of risks that overtax individuals. Promotion of the compatibility of working life with long-term care
2. Crosslinking of outpatient and inpatient benefits and services

3. Preserving the balance between physical and cognitive impairments of independence requires the recognition of the equal weight of impairments. At the same time, the unique nature of each case must be recognised.

4. Stronger development of structures that make a mixture of assistance possible, e.g. through:
    - The modularisation of benefits in inpatient care and/or
    - Reduction of compensation payments or copayments, when relatives provide services in inpatient care and assume responsibility,
    - Low-threshold, self-organised assistance.
5. Promotion of an orientation on the community, care counselling and accompaniment (case management)
6. Enhancement of the existing incentives to reduce the need for long-term care through activating care
7. Primacy of prevention and rehabilitation before long-term care.
8. Enhancement of consumer sovereignty with regard to services for long-term care, room and board

Appendices

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Appendix 5 Methodological Notes on Determining the Future Number of Persons Entitled to Benefits with the Degree of Need 1

(H. Rothgang and K. Wingenfeld)

The model calculations to determine the future number of persons entitled to benefits in the new Degrees of Need are all based on two types of data:

a) The transition probabilities from the old Levels of Care to new Degrees of Need, which are a result of the Second Main Phase (n = 1.490) and
b) The number of persons who are currently in each of the (old) Levels of Care.

One of the problems results from the fact that there is no information in the official statistics on the existing number of persons whose applications were rejected. Although it was also possible to calculate the transition probabilities for this group of persons from the data of the Second Main Phase, there is no reliable number of existing cases to which it can be related. Hence, for the calculations undertaken in the Second Main Phase, the incidence found in the assessments was used as an approximation of the prevalence. It was assumed that there were 530,000 persons whose applications for outpatient care had been rejected. It is also possible to determine a corresponding number of existing cases from the MuG-Studies by TNS Infratest. This figure was 577,000 cases in outpatient care, which confirms the assumption from the Second Main Phase by virtue of its magnitude.

The persons in Category of Need 1 will be derived from two sources in the future:

1. Those, who have also submitted an application under the old system and
2. Those, who never submitted an application under the old system, but may now be able to submit a successful application due to the New Assessment Procedure and the new definition of the need for long-term care.

It is possible to make model calculations for the group first cited analogous to those for the other Degrees of Need. For this purpose, contingency tables were constructed for the incidence using the New Assessment Procedure, which has in the meantime been modified (old Levels of Care vs. new Degrees of Need), these were converted into indicators of prevalence by means of the method of calculation presented in the report on the Second Main Phase and

applied to all existing applicants (with both successful and unsuccessful applications). A figure of 530,000 or 577,000 (s. above) was assumed for the number of persons who submitted unsuccessful applications.

This leads to the finding that roughly 330,000-350,000 persons are to be expected in the Degree of Need 1 who are drawn from those persons designated under 1. This figure is therefore to be viewed as the minimum number of people to be expected in the Degree of Need 1 and is considered reliable.

What is more difficult, on the other hand, is the determination of the group of persons designated under 2. There is no data on the size of this group of people. Since this is a group of insured persons who have, up until now, never submitted an application for benefits from long-term care insurance, they may not be taken into consideration within the framework of the national testing of the New Assessment Procedure. However, there is no experience with the deployment of the New Assessment Procedure outside of this testing, thus, no empirically reliable information is available for this group of persons. The size of the group must, therefore, be assessed in order to be able to calculate what additional expenditures may be incurred after the introduction of the new assessment procedure.

An assessment is, however, also dependent upon empirical evidence. Therefore, it was recommended that the Advisory Board use other data–namely the data from the studies on “Possibilities and Limits of Leading an Independent Life in Private Households” (*Möglichkeiten und Grenzen selbständiger Lebensführung in privaten Haushalten*, Ger. abbr. = MuG III) in order to establish a reasonable approximation. TNS Infratest, the company that conducted the MuG studies, was commissioned to examine the viability of these data. The MuG data encompass various aspects of the need for long-term care by people in private households, so that it seemed to make sense to use them to derive indicators for the group cited. For this purpose, the modules from the new assessment procedure had to be recreated from the MuG data as accurately as possible. Uncertainty emerges in this conjunction, so that the results are not as reliable as those of the model calculations, which are related to the applicants for SGB XI benefits.

The original Infratest calculations were related to the version of the New Assessment Procedure used in the Second Main Phase. However, subsequent adjustments were made. TNS In-

fratest was therefore asked to adjust their own estimates in light of these modifications. As a result, Infratest ascertained that the number of persons in the Degree of Need 1 totalled roughly 450,000 persons. If this number were augmented by the minimum figure of 330,000-350,000 cited above, the result would be a value of roughly 800,000. However, it cannot be ruled out that an overestimation of the number of persons who have never previously submitted applications for SGB XI benefits, but who would now be classified in the Degree of Need 1, resulted from methodological difficulties. This can be verified to some extent, since Infratest also undertook its modelling for those who have already submitted applications. Comparing the results of the modelling with the results that were attained on the basis of data from the Second Main Phase shows a tendency to overestimate the Degree of Need 1 in the Infratest calculations. At the same time, the number of persons in the Degree of Need 2, and above, is underestimated.

The figure of 800,000 persons in the Degree of Need 1 may therefore be more of a maximum, while the figure of 330,000-350,000, on the other hand, a minimum. In light of the unsatisfactory data situation, and after extensive discussions within the Advisory Board, it seems justified from a scientific standpoint to assume a figure of 650,000 persons classified in the Degree of Need 1 for the purpose of the model calculations.