CHAPTER 7

LESSONS ON LONG-TERM CARE FROM GERMANY AND JAPAN

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Introduction

The international data and literature on long-term care (LTC) now available through international governmental and non-governmental organizations as well as individual countries forms a rich but largely untapped resource for scholars, policy analysts, and others in the United States. With some notable exceptions, such as the US, policy changes that move toward universal LTC benefits have occurred in most other developed nations within the last two decades. Close examination of their experiences will give U.S. stakeholders a clearer picture of what drives policy change and the lessons learned after changes are implemented, both positive and negative.

The focus in this chapter is on Germany and Japan, which have implemented mandatory social insurance programs in which eligibility is not based on income, assets, or availability of family caregivers. Germany began implementing its program in 1995 and Japan in 2000. Both countries also have recently made important changes in their programs, Germany in 2008 and 2012 and Japan in 2006 and 2012.

The 2010 health care reform legislation in the US included the recently suspended Community Living Assistance Services and Support Act (CLASS), a significant and unexpected step in LTC financing reform. Although not comprehensive in benefits or universal in coverage, it would have provided cash benefits to eligible persons with disabilities who enrolled without means-testing or medical underwriting. Without international counterpart, it was a national voluntary system with some characteristics of public insurance, some of private insurance, and a continuing key role for Medicaid in LTC financing (Gleckman 2010). Especially in light of the fate of CLASS, it is important to examine the experiences of countries that have successfully implemented mandatory social insurance programs, such as Germany and Japan.

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Why Examine Germany and Japan?

With higher rates of fertility and immigration, the US population is considerably younger than that of Germany, which is one of Europe's oldest countries as well as the most populous, and of Japan, which is the world's oldest nation. The proportion of people age 65 or older in the US will not reach that in Germany and Japan today until 2050 (Table 1). Moreover, by 2050, the share of persons age 80 or older in the US will still be only about half that in Germany and Japan.

Table 1: Percent of Population ages 65+ and 80+ in Germany, Japan, and the U.S., 2010-2050

	Age 65+			Age 80+		
	2010	2030	2050	2010	2030	2050
Germany	20.5	28.2	32.5	5.1	8.0	14.1
Japan	22.6	30.8	37.8	6.3	12.9	15.6
U.S.	13.0	19.8	21.6	3.8	5.2	7.8

Source: United Nations Population Division (2009)

Germany's universal LTC legislation passed in 1994, when 15.8 percent of its population was age 65 older. Japan's legislation passed in 1997, when 15.7 percent were age 65 or older. In the US, the share of the older population age 65 or older will cross that same line toward the end of this decade (Campbell, Ikegami, and Gibson 2010).

Prior to reform, Germany and Japan faced problems similar to those in the US today, including:

- Burdens on family caregivers; aging of family caregivers
- Benefits targeted to persons with low income and limited family support
- Stigma of using means-tested services
- Fears of the increasing burdens of LTC spending on other social programs
- Widely disparate benefits depending upon where one lives
- Fragmentation across programs and levels of government
- Concerns about quality of care

In enacting contributory social insurance programs, the German and Japanese experiences seem more consonant with the US history with Social Security and

Medicare than a Scandinavian-style program funded through general taxation. In addition, Germany and Japan's broad social policies are more similar to those in the US than those of many other Western European countries. Also, they have strong private market LTC delivery systems, in which services are provided primarily by private sector providers rather than by government agencies.

Gender and LTC

Women in Germany, Japan, and the US, as well as in many other countries, are more likely than men to provide long-term care, either as unpaid family caregivers or as part of the paid LTC workforce, and to need long-term care. With longer lives, higher rates of disability and lower incomes than men on average, women in all three countries typically face greater challenges in obtaining and paying for long-term care. Economic insecurity among older women, especially those 75 or older who live alone, remains a problem today even in rich countries such as Germany, Japan, and the United States.[1] Public long-term care insurance (LTCI) can help to reduce the risk of falling into poverty in order to receive means-tested LTC and buffer the financial and health risks faced by unpaid family caregivers.

Purpose and Method

The purpose of this chapter is to identify key implications of the evolution of the German and Japanese mandatory LTC systems for the United States.[2] It discusses Germany and Japan's decisions about LTC goals and policies, as well as the debates before their programs were implemented. It also examines the results thus far, including discussion of recent reforms. The scope of the chapter includes: (1) coverage, eligibility, and benefits; (2) financing; and (3) family caregiving policy. Workforce and quality policies are critically important but beyond the chapter's scope. Each section concludes with "lessons for the US", which identify the broad policy principles that Germany and Japan's experiences imply for the US, and briefly compares provisions in the German and Japanese systems with those of the recently suspended CLASS Act in the US.[3] The findings in the chapter are based on an extensive review of the English language literature on the German and Japanese LTC systems. National experts on LTC in Germany, Japan, and the US have reviewed the chapter for factual accuracy**.**

We now turn to some of the sharp contrasts between LTC policy heritage, design and debate in Germany and Japan.

Germany: Building on Tradition

LTCI (*Pflegeversicherung*) was the fifth building block of Germany's social insurance system, which began with Bismarck's health insurance act of 1883, followed by mandatory accident, pension, and unemployment insurance (Geraedts, Heller, and Harrington 2000).

As pressure grew on state (Laender) social assistance budgets,[4] multiple LTC reform proposals emerged, leading to a protracted debate of almost twenty years prior to enactment of reform legislation in 1994. The key political stakeholders' proposals generally fell into three broad categories: the employer-oriented Liberal party favored private insurance; employee-oriented Christian Democrats favored social insurance, and the trade union-oriented Social Democrats favored a tax-funded approach but later threw their support behind social insurance (Heinieke and Thomsen 2010). In the end, a social insurance approach, consistent with Germany's long tradition, won out. Substantial opposition by employers to increased payroll taxes was resolved when the Laender agreed to give up one paid holiday, the day of repentance, in all states (except Saxony).

From the beginning, reducing reliance on social assistance benefits due to the need for LTC was considered a key policy objective. Encouraging family caregiving and home and community-based services (HCBS) were other important goals. Both official and scholarly sources in Germany emphasize that its program always was intended to provide partial coverage of risk, not the comprehensive coverage available under its health insurance program.

The guiding principle of Germany's LTC program, then and now, is captured in its slogan: *Prevention and rehabilitation before long-term care. Home care before institutional care.*

Japan: A Break with Tradition

In contrast to Germany, Japan's mandatory LTCI, *Kaigo Hoken* (care insurance), represents a sharp break with tradition. According to John C. Campbell and Naoki Ikegami, "Japan's implementation of its mandatory LTCI insurance program in 2000, came as a surprise in light of its strong tradition of family care for the elderly, its reputation as being 'laggardly' as a welfare state, " and its economic troubles at that time (Campbell and Ikegami 2000). Indeed, few Western observers would have expected Japan to initiate what is one of the world's most generous LTC programs under the slogan *kaigo no shakaika* (the socialization of care)—underscoring that the responsibility of providing care, traditionally borne by daughter-in-laws, should be spread among the entire society.

Although the policy design of Japan's program broke with tradition, the "problem of an aging society" had been high on Japan's policy agenda for several decades. Since 1973, health care for the elderly, including hospital care, had been first a free and then very low cost entitlement. LTC services under its social welfare program[5] were means-tested based on the income of both care recipients and their children, with the burden especially high for middle income users (Japanese Ministry of Health, Labor and Welfare 2008). Coupled with the limited supply of nursing homes and home care, the much lower cost of hospital care to consumers led to the overuse of hospitals providing long-term institutional care. Such hospitals became like nursing homes, with about one-third of hospital inpatients age 65 or older being hospitalized for more than one year (Ikegami 1997).

Not surprisingly, Japan was interested in reining in rapidly growing health care costs, especially hospital costs for older persons (Matsuda and Yamamoto 2001). Other problems included limited service availability and choice of providers available through the social welfare program, in which services were provided directly or contracted out by municipal governments. Broader societal forces, such as increasing numbers of nuclear rather than extended families, as well as cutbacks in social spending, also set the stage for reform.

The most hotly debated issue was whether to include a cash option. Arguments by Japanese feminists, who feared that the cash would disappear in family budgets and family caregivers would continue to be exploited, were influential in its rejection. Other arguments against cash were that (1) formal services would not expand sufficiently if cash were offered; and (2) it would not cost-effective because everyone eligible would enroll immediately, with no time to phase-in funding. Japanese feminists with the help of favorable media coverage, successfully argued that family caregivers wanted liberation, not recognition (Eto 2001).

The Japanese LTC program was a major shift in Japanese social policy toward what has been described as a new "social contract " based on mandatory contributions, uniform and explicit entitlements and consumer choice (Izuhara 2003). In doing so, Japan opted for a social insurance system similar to Germany's rather than a Scandinavian model of broad entitlement to social services funded at the local level, financed by national and local taxes (Campbell and Ikegami 2000).

Coverage, Eligibility and Benefits

Germany's LTC program provides universal coverage for persons of all ages. Its benefits are basic, with individuals expected to bear a large share of the costs. In contrast, Japan's program provides comprehensive benefits but coverage is universal

only for persons age 65 or older. This distinction helps to highlight some of the crucial policy decisions made in both countries.

Consonant with coverage under Germany's other social insurance programs, the decision to cover persons with disabilities of all ages was not controversial. In contrast, in Japan some thought all workers should pay, while others worried about the reaction of younger people to paying a new premium. In the end, the compromise was to start contributions at age 40, and to give 40-64 year olds coverage for age-related disorders only (Campbell and Ikegami 2003). Older people receive 96 per cent of total expenditure from the long-term care insurance program while people aged 40-64 with age-related disabilities receive only four per cent (Glendinning and Moran 2009).

Eligibility Criteria

Both nations determine disability levels as measured by functional impairment and the length of time help is needed each day. Eligibility criteria are nationally uniform in both countries, with Germany basing benefit amounts on three levels of disability and Japan on seven. Germany's eligibility criteria are stricter than Japan's, largely because Germany's disability thresholds are higher. At least half of those receiving benefits in Japan would not be eligible for benefits in Germany (Campbell, Ikegami, and Gibson 2010). For several years, Germany has been studying the effects of making major revisions in its definition of who needs care, which has been repeatedly criticized as being heavily oriented toward persons with physical disabilities, e.g., by excluding persons with dementia who need supervision and persons with serious mental illnesses. An Advisory Board has recommended new criteria organized in five degrees of need for long-term care (Implementation Report May 2009). A draft tool, based on the degree to which a person's independence is impaired, has undergone national testing and eventually may be adopted as the new eligibility assessment tool for LTCI (Buescher, Wingenfeld, and Schaefer 2011). However, calculations of the cost of adopting the new definition of need for care indicated that expenditures would be expected to increase (Rothgang et al. 2008). The political debate on the implementation of this new assessment procedure is still underway (Theobald, 2011).

In late June 2012, Germany enacted reform of some aspects of its LTCI program, primarily by increasing access to home and community -based services for persons with dementia (German Federal Ministry of Health 2012). Beginning in January 2013, there will be higher benefits for persons with dementia and additional support for family caregivers, such as a greater financial incentive to use respite services, which are typically underused by caregivers. The bill also includes subsidies to develop small group homes and shared apartments for persons with disabilities.

In Germany, in-home assessments are conducted by units of the health insurance funds, by geriatric trained nurses. The 2012 reform requires that these assessments be timely, and that eligibility decisions also be made more quickly. In Japan, assessments are conducted by municipal officials, using a computer-based classification based on 74 items. The final classification is made by a local committee with a doctor, usually a social worker, and other personnel.

Table 2: Monthly Benefit Ranges and Cost-Sharing in Germany and Japan, 2008[6]

	Germany	Japan
Benefit Range		
Cash allowance	$250-$794	NA
Formal home care	$490-$1,790	$1,440-$3,400
Nursing home care	$1,200-$1,730	$1,680-$3,670
Cost-sharing		
Nursing home care	Room and board not covered	One-third of room and board costs covered (100% for low-income people); residents in AL pay all room and board costs.
Personal care/home help	No coinsurance	10% coinsurance

Benefits in Germany

The differences in the benefit ceilings between the two countries are substantial, as shown in Table 2. In Germany, LTC benefits cover about 50 percent of the average cost of institutional care and roughly the same for home care (Rothgang 2007). In Japan, benefits cover 90 percent of formal caregiving costs in both institutions and in the community (Campbell, Ikegami, and Gibson 2010).

HCBS benefits under Germany's LTCI program provide a choice of cash benefits that can be used to pay relatives or, for example, migrant workers, agency- provided home care, or both cash and services, up to a ceiling at each level of care. The ceiling on the unrestricted cash allowance is roughly 50 percent lower than that for direct services. Other covered benefits include assistive aids, such as a special bed; and home modifications. Benefit levels were increased in the 2008 reforms, the first benefit increase since the program was implemented. The increases, which are being phased in between 2008 and 2012, are proportionately larger for HCBS than for institutional

care. As of 2009, all individuals receiving LTC became entitled to comprehensive care management to arrange for necessary LTC services, provided by a care counselor (European Commission 2008). Some benefit increases, especially for persons with dementia, are also part of a 2012 reform discussed briefly above.

LTCI is administered by non-profit “care insurance funds," regulated by the government, under the umbrella of Germany’s health insurance funds. These funds are independent self-governing corporations under public law; their health insurance and LTC functions are carried out separately. They collect contributions and contract with providers to deliver LTC services. Persons who elect agency services can choose among the various agencies with which their LTCI fund has contracted. The 2008 reforms also made it possible for individuals to select “approved" independent providers who are contracted with funds, which had only been possible in exceptional cases prior to the reforms (German Federal Ministry of Health 2009).

Fees are negotiated regionally by the LTC funds and providers for HCBS and nursing home care, based on approximately 20 specific bundles of service packages. The LTC funds are able to review providers’ quality results during negotiation (Cuellar 2003).

Trends in Use of Home and Community-based Services

The cash allowance continues to be by far the most popular choice, despite its lower value. However, the share of those choosing formal home care services, either alone or in combination with cash, has been growing modestly, i.e., from 24 percent in 1998 to 30 percent in 2008. Compared to some countries, use of formal home care services by Germany’s older population is relatively low. In 2000, the rate of home help use in Germany among persons 75 or older was 6 percent compared with 33 percent in Norway and Israel (Daatland and Herlofson 2008).

Trends in Institutional Care

The share of all German beneficiaries in nursing homes increased from 25.7 percent in 1998 to 27.6 percent in 2008, and from 3.2 percent to 3.4 percent among younger persons with disabilities in full-time residential care (German Federal Ministry of Health 2010). The supply of nursing homes in Germany is generally perceived as adequate, with little waiting time, although there are regional variations. Relatively few nursing homes offer specialized care for dementia, although the qualifications of staff have been improving. The 2008 reforms addressed quality in particular, including requiring that nursing homes be inspected at least once a year and the results publicized using an easily understood school grading system (Rothgang 2010; Schulz 2012).

Benefits in Japan

Preventive Benefits

Because benefit use by persons with lighter care needs was expanding rapidly in the early years of the program, Japan encouraged benefits for these persons aimed at prevention of further functional decline in its 2006 reforms. This policy is intended to encourage the use of day care services and to contain the use of home help services that provide IADL support. The preventive benefits, provided in adult day care centers, focus on strength, exercise and nutrition training. However, home help service users were found to have a lower risk of functional decline than day care service users in one recent study (Ishibashi and Ikegami 2010).

LTC Benefits

Japan offers a wide range of services in the home and in institutions. Some services from both health care and social services were transferred to LTCI. Visiting nurses, in-home and day-care rehabilitation, and some LTC hospitals were transferred from health care, while home help services, some day care, nursing homes, bathing services, assistive equipment, and home modifications were transferred from social services.[7]

Care management services have been available to all beneficiaries without cost since the program began and are widely used. Care management is seen as a key to providing more integrated medical and LTC services and helping to assure care quality. Care managers provide advice and coordinate with other providers (Tamiya et al. 2011). Clients make the decision about which services to use, how much (up to ceilings) and who will provide them. At the inception of the program, care managers had high case loads, which were subsequently lowered from 50 to 35 clients.

Trends in Use of Services and Residential Care

More people were eligible initially than had been predicted—about 16 percent of persons age 65 or older in 2005 versus the 12 percent expected (Glendinning and Moran 2009). LTCI permitted for-profit HCBS providers to enter the market for the first time, and the volume of home help service providers increased substantially even in the first year of implementation. Clients use only about half of the maximum amount of HCBS for which they are eligible, a proportion that has not changed much since the program began (Campbell, Ikegami. and Gibson 2010).

Demand for institutional care increased immediately, in part because so many individuals had become newly eligible and because all “room and board “ charges in nursing homes were covered. In addition, nursing homes seem to have something of a

halo in the eyes of reporters and the public, with reports of poor quality being less common than for acute hospital care (Wiener et al. 2007). The continuing high demand for institutional LTC has resulted in long waiting lists and greater demand for housing alternatives, such as assisted living. LTCI also has led to rapid growth of Alzheimer's group homes, small residences serving nine residents each with five to six staff, for which residents pay about $1,000 a month (Campbell 2010).

Lessons for the U.S.: Coverage, Eligibility and Benefits

Provide universal coverage through social insurance rather than means-tested coverage

The inequities and cost of Germany and Japan's former means-tested systems were driving forces in providing universal coverage. Their mandatory systems, which provide universal benefits, regardless of income or family support, have garnered political and public support and reduced pressures on social assistance and health care budgets. Coverage under CLASS would not have been means-tested. Participation would have been voluntary and therefore not universal. Indeed, everyone would not have been eligible. Only persons who were actively employed would have been eligible to enroll, not their dependents.

Middle class Americans are increasingly caught between two tiers of care depending upon income: Medicaid for the poor, often in nursing homes, and privately financed residential or home care for the wealthy, with wide disparities in access and quality. While not universal in coverage, CLASS would have provided cash benefits to broaden the options available to middle income persons and diminish the need for them to impoverish themselves in order to receive help.

Provide universal coverage rather than selective coverage by age

Germany's decision to provide coverage for persons of all ages was never controversial because of the legacy of its other social insurance programs. Japan's decision to provide unconditional coverage solely for persons age 65 or older reflects its demography, culture, and institutional structures, which include a separate disability program for persons under age 65. Nonetheless, periodic debate occurs in Japan about extending coverage to younger persons.

In the US, persons under age 65 with disabilities represent about half of the broadly defined LTC population in the community (Kaye, Harrington, and LaPlante 2010). Another reason to cover persons of all ages is that preferences for long-term services and supports and for having more control over services were not found to vary

substantially by age, at least when comparing persons ages 50-64 to those ages 65 and over (Gibson et al. 2003).

Participation in the CLASS program would have been open to full-time students and employed adults age 18 or older but not to those fully retired. A "vesting " period would have been required in which enrollees paid premiums for at least five years and worked for at least three of those years before becoming eligible for benefits.[8] The earnings requirement was only $1,120 per year.

Start with basic benefits and expand to more comprehensive benefits over time

Japan's program covers 90 percent of formal caregiving costs, far more than Germany's. Germany's decision to provide basic benefits while encouraging private responsibility seems more consistent with US history and parsimonious social policies than Japan's decision to implement an expansive program. Japan has modestly cut back benefits over time, although only for people with such light care needs they would not be covered at all in most countries, while Germany has modestly expanded benefits.

Today, only a small proportion of persons age 65 or older with disabilities (11 percent) in the community in the US are receiving any type of publicly funded home care, alone or in combination with family care, as are only 23 percent of those with severe disabilities (Houser, Gibson, and Redfoot 2010). What is clearly important is to first ensure that persons with severe levels of disability receive appropriate services, which requires careful attention not only the needs of persons with physical disabilities but also those with dementia, other cognitive impairments, and severe mental disabilities.

As a cash allowance, the CLASS benefit would have averaged at least $1,500 a month in 2012, when benefits were to be designated, about double that of the German cash allowance at the highest level of disability. However, it would have been considerably lower than formal home care and nursing home benefits in Japan. In terms of its buying power, average prices for home care and nursing home care may be lower in Germany and Japan than the US because prices are negotiated annually with providers by the German LTCI program and set by the Japanese LTCI program.

CLASS was intended to provide basic protection against the risks of disability to eligible enrollees. Costs not covered under CLASS were to be the responsibility of the private sector, either through private insurance or out-of-pocket. Persons with low incomes who had exhausted their assets would have continued to be protected through Medicaid. As in Germany and Japan, enrollees would have been able to receive lifetime benefits if they met eligibility requirements, with no lifetime caps on benefits

like those typically found in private LTC insurance policies in the US (See Gleckman, this volume).

Promote consumer choice and flexibility through options for both cash and formal services

Both Germany and Japan provide greater consumer choice and flexibility in benefits than the U.S. today because they cover an impressive array of formal home care and institutional care benefits in their public programs, with Japan's being less costly for consumers because of higher benefit ceilings. They both also include benefits for assistive technology, and home modifications. A range of home care services and institutional care were included in the original benefit packages adopted in each country, as was respite care and day and night care. Care management, not originally provided in Germany, is now an entitlement in both countries, suggesting it may be essential to meeting needs of some (not all) beneficiaries.

Germany provides greater flexibility in offering the option of cash or a combination of cash and services. In contrast, Japan does not provide cash partly because women's groups in Japan feared that any cash benefit would trap daughters-in-law in "caregiving hell", in part because co-residence between families and older persons was common (Eto 2001). Other arguments against cash were that family caregivers benefit most from direct services (Tamiya et al. 2011), and that cash could deter caregivers from entering the formal labor force. The cash allowance in Germany, however, is relatively low compared to average wages and seems unlikely to serve as a financial incentive for family caregiving.

Real choice depends not only on affordability but also on the supply of direct care workers and good quality services. Major improvements are needed in the US in both areas. (See Stone, this volume.) Some European experts have argued that the impact of LTCI in stimulating new HCBS in Germany has been limited, and that the presence of the cash allowance restricts consumer pressure for a wider range of formal services (Glendinning and Moran 2009). However, the majority of German beneficiaries continue to choose the cash allowance despite other options. In addition, a cash option is consistent with the evolution of consumer-directed service options in state Medicaid programs.

Use uniform national eligibility standards determined by an objective process

Both Germany and Japan have uniform national eligibility standards that are published, reviewed, and changed periodically if problems are discovered. In the US, Medicaid eligibility standards for HCBS vary widely by state and often are not easily transparent to consumers.

Germany's new draft assessment tool for persons of all ages, which has been tested and may eventually be adopted nationally, is worth examining. The criteria go beyond those typically used in the US today. For example, the draft includes difficulties in communication, behavior, and caring for oneself when ill, all of which often require help from family caregivers. Conducting in-home functional assessments, as is done in both Germany and Japan, may also be a practice worth adopting.

Financing

Germany is a mixed public-private system of financing, with about 90 percent of the population covered under public LTCI, and 10 percent of the population covered under private LTCI that is required for the categories of people permitted to "opt out " of the public system. (The cost of services exceeding benefit amounts are paid either out-of-pocket or through social assistance.) Until the 2008 reforms, benefits were not increased to adjust for inflation, resulting in serious erosion of their purchasing power. Now, benefits are to be reviewed every three years for adjustments to keep pace with increases in the cost of living.

Germany has been described as a "capped" entitlement; maximum benefit levels are set by federal law in order to contain spending within premium levels. In contrast, Japan's financing system was designed to increase expenditures in the early years as services became more available

As shown in Table 3, Germany's system is entirely financed by premiums, while Japan's is funded half by premiums and half by taxes.[9] Germany does not adjust premiums by regions, resulting in regional variations. In contrast, Japan makes regional adjustments. For Japanese age 65 or older, premiums are linked to local government spending levels, and hence vary some. For those 40-64, premiums are pooled at the national level and redistributed to municipalities so that those with more low- income residents and persons age 75 or older receive more funding.

Private LTCI

In Japan, the private LTCI market is quite small (OECD 2011). Germany's private *mandatory* LTCI covers about 9 percent of the population (OECD 2011). As with health insurance, German civil servants, high- income employees, and the self-employed may opt out of the public program but must obtain private insurance. This market is much more heavily regulated than private LTCI in the US. Private insurance plans are required to offer equivalent coverage, terms and benefits to the public program. In addition, premiums may not exceed contribution levels for the public program.

Table 3: Financing Provisions for LTCI in Germany and Japan

Germany, 2010	Japan, 2010
Mandatory social LTCI premiums: Workers pay 1.95% of income up to ceiling ($51,882 in 2009) split equally between employers and employees at 0.975 percent each. (Childless adults pay 2.2% of income.)	Half by mandatory premiums; half by taxes
Dependent spouses and children are covered at no cost if their income does not exceed a ceiling	1/3 of premium revenue from 65+; six levels based on income. Deducted from pensions
Childless individuals pay an additional 0.25 of gross income	2/3 from those ages 40-64 at 1% of income, up to a ceiling ($46,800 in 2009) split equally between employers and employees; paid as supplement to health insurance
Retirees pay full contribution rate of 1.95% of income, up to ceiling	
Private mandatory LTCI: premiums are based on purchase age, but cannot exceed the maximum contribution for public LTCI	

While social LTCI is designed on a pay-as-you-go basis, private LTCI in Germany has been described as a "prospective entitlement", in which provisions are kept separately for each individual. Employers contribute a subsidy equaling half of the total premium. Premiums are primarily based on age at purchase; there is no underwriting. The vast majority of the policies provide a daily cash benefit, not services. Germany also has a small private voluntary supplementary insurance market to cover out-of-pocket costs, such as room and board charges in nursing homes. The Federal Cabinet recently decided to introduce public support for voluntary private long-term care insurance policies as part of the 2012 reform (Federal Ministry of Health, 2012). The subsidy will be 60 € per year regardless of income.

Reforms to Enhance Sustainability

Germany has introduced a series of modest steps to improve financial sustainability. In 2004, pensioners began paying the full contribution of 1.70 percent, which formerly had been shared between retirees and the pension funds.[10] As of 2005, those who are childless began paying a supplement of 0.25 percent. One rationale was that the childless, on average, will receive higher benefits. The 2008 reforms raised premium contributions across the board from a rate of 1.70 to 1.95 percent of income, an increase intended to be sufficient until 2014, although this may not be the case, especially in light of the economic recession (Rothgang 2010).

Japan reduced fees to providers in 2003 and 2006, leading to an overall four percent reduction in institutional care fees and one percent for community care. It also increased consumer payments for room and board costs in institutional care. In 2006, Japan made further reforms, including moving "lighter " need clients to preventive care with lower ceilings and more limited services. Fees were slightly raised in 2012 in order to raise careworker wages.

Trends in Expenditures

The German goal of reducing social assistance for LTC appears to have been largely met. According to a recent assessment by the Federal Ministry of Health, LTCI clearly reduced the level of dependence on social assistance by individuals. Today, about 5 percent of those who receive LTC at home, and about 25 percent of those in institutions, require additional social assistance benefits. Prior to the introduction of LTCI, roughly 80 percent of those in need of care in nursing homes received social assistance. In addition, social assistance budgets have been spared expenditures of roughly $6 billion euros annually due to LTCI (German Federal Ministry of Health 2009). Since the introduction of the program, expenditures by the social assistance program for nursing home care have been reduced by roughly two-thirds (Rothgang and Igl 2007). Nonetheless, out-of-pocket spending for LTC services remains significant, representing about one fourth of all LTC spending for nursing homes and seven percent for home care.

By requiring contributions for five years before benefit eligibility began[11], Germany built up financial reserves for several years. Later, expenditures per beneficiary remained basically stable, although spending exceeded revenues by about two percent in almost all years (Gibson and Redfoot 2007). This imbalance was due in part to decreased revenue because of high unemployment, especially in the former East Germany, along with low wage and pension growth.[12]

Given the growth in Japan's "old old" population, it is not surprising that total expenditures for LTC have been growing every year, rising from 3.6 trillion yen in 2000 to 7.4 trillion yen in 2008. Premiums for persons age 65 or older have increased by about 44 percent over the same period (Japanese MHLW 2008). These premiums, which are income-related, averaged about $420 per year in 2010.

The Japanese cost containment measures discussed above have substantially slowed the rate of spending growth. In the first implementation phase (2000-2002), spending increased by 44 percent; in the second phase (2003-2005), by 12 percent, and in the third phase (2006-2008), by 7 percent (Japanese MHLW 2008). Spending growth after the 2006 reforms has been the "sole result of increased spending in the size of this (75 or over) age group" (Tamiya et al., 2011). Japan reviews its spending and benefits every three years. Municipal governments set premiums for older persons based on projected service costs so that financial conditions can be balanced throughout each three year period.[13] Because the premium increases get lots of attention, they create pressure to hold down spending.

Future Financing Reforms

Germany will need to make further financing reforms in the near future, which it recognizes in its planning efforts. Its goal has been to provide stable real benefits with stable contribution rates. However, demographic shifts make meeting this goal problematic because contribution amounts will decrease while expenses will increase with population aging. The increase in contributions by 0.25 percentage points (to 1.95) in its 2008 reforms is expected to be sufficient until about 2015. However, according to the Council of Economic Experts, demographic and revenue trends mean that the contribution rate will have to be increased to 2.5 percent by 2050, i.e., by 0.55 percentage points over a 35-year period (European Commission 2008).

Almost all German financing reform proposals seek to increase contributions.[14] Merging the private insurance and social LTCI systems also has been suggested because the better risk profile of persons in the private system would ease pressure on the social LTCI funds. However, the most actively discussed options are to add some tax funding (for example, to cover costs for children) and to increase contribution rates and the income base upon which they are levied (Rothgang, 2010). The recent 2012 reform will raise premium contributions across the board by 0.1 percentage points, or to 2.05 percent of income beginning in 2013, as part of the expansion of benefits for persons with dementia and other cognitive impairments.

Japan continues to have one of the higher institutional rates in the world (if people in hospitals for long periods, under health insurance, are included), reflecting its legacy

of extended hospital benefits for long-term care. Further increases in room and board costs for institutional care paid by consumers are still under discussion. In addition, the government may eliminate many chronic hospital beds and tighten standards, trying to eliminate "social" admissions (Campbell 2010).

As part of its 2012 reform to strengthen the LTC service infrastructure, Japan is developing more community-based supports for people living at home, especially those with dementia, such as small-scale centers for day care, home visits available 24 hours a day, 365 days a year, and greater access to respite care (MHLG 2011). More radical proposals to either expand or cut back LTCI often appear in the press, but neither seems likely. Many municipal governments are calling for increasing the proportion paid by taxes, claiming that the premiums charged to their elderly residents have reached their limit (Campbell 2010). The 2012 reform is intended to help slow increases in the premiums (MHLG 2011).

Comparative Financing Data

Public spending on LTC appears to be similar in the Germany, Japan, and the US as a percent of GDP at about 1 percent in 2005 (Gleckman 2010). However, because Germany and Japan's populations are much older than that in the US, aggregate measures are less useful than more discrete measures that compare spending by age. Public LTC spending in 2005 in the US per person age 65 or older was recently found to be higher than in Germany ($1,605 versus $1,185), and almost as high as in Japan ($1,605 versus $1,751) (Campbell, Ikegami, and Gibson 2010). At the same time, fewer Americans age 65 or older receive publicly-funded care—about 4.5 percent in the US compared with 10.5 percent in Germany and 13.5 percent in Japan. The reasons for the differences in spending have yet to be examined. Because the US spends more on nursing home care than either other country, its high cost in the US is likely a factor. Private LTC spending on a per capita basis is also likely far higher in the US than in either other country, although precise estimates are not available.

One factor that is often overlooked in LTC financing discussions is the degree to which revenues depend upon other broad macroeconomic trends, including unemployment and limited wage growth. In Germany, deficits in some years arose primarily due to declining revenues rather than to growth in spending.

Lessons for the US: Financing

Make financing sustainable over time

Germany and Japan have fiscally responsible LTC financing systems that permit them to plan for and implement cost containment measures as the need arises. They also

share demographic characteristics that are likely to make financial sustainability even more difficult in the coming decades. Notably, projections in both countries point toward stable or declining fertility rates, increasing life expectancy, increased female labor force participation, and increasing numbers of single person households. Placed in comparative perspective, the dependency/support ratios in the US, both today and in the future, look much more manageable than often thought.

Germany and Japan both require premiums for workers, which are split equally between employees and employers, a provision likely to be opposed by the US business community, as also occurred in Germany and Japan. Both countries also require premium contributions from older persons/retirees. While Germany's program is funded exclusively by premiums, Japan's combines premiums with general revenue funding, an approach more similar to Medicare financing in the US.

Germany only recently began adjusting benefits for inflation. Without inflation protection, the erosion in benefit values in the US might be greater than in Germany and Japan, which negotiate or set fees with providers respectively. CLASS benefits would have been indexed to the consumer price index.

Public expenditures in the US, with its fragmented, means-tested system, are more per person age 65 or older than those in Germany, and almost as much as in Japan. Unlike Germany and Japan, CLASS would have been a voluntary program entirely funded by individual premiums, which also would have been the only source for generous low-income subsidies for full-time students and workers with incomes below the federal poverty level. By law, tax funding was prohibited and CLASS was required to be self-sustaining for 75 years.

Premium projections for CLASS varied rather widely prior to its enactment. After extensive analysis, the Department of Health and Human Services estimated in 2011 that premiums would have been from $235 to $391 per month, a key factor in the suspension of the program. Premiums are much lower in Germany and Japan (Table 4), and are not age-based, although retirees in both countries make contributions based on income. In the US, premiums would have been based on the age at which one first enrolled in CLASS.

The most pressing challenge for CLASS would have been to attract sufficient participation by persons unlikely to need benefits relatively soon, in order to prevent serious adverse selection, and to keep premiums affordable. Another challenge in implementing the program was to encourage voluntary participation by employers, whose employees would have been automatically enrolled unless they chose to opt out.

CLASS was to have been to be fully evaluated ten years after implementation. By comparison, Japan evaluates its system every three years. Germany made modest reforms about eight years and more significant reforms about twelve years after its program was implemented.

Table 4. LTC Financing in Germany, Japan, and the US

Germany	Japan	US - CLASS
Maximum annual premium in 2009, $506 each by employer and employee ($1,012 combined)[a]	Income-related premiums (age 65+ average $420 per year)	Voluntary premiums, age-based; no under-writing
	Maximum premium per year ages 40-64, $234 each by employer and employee ($468 combined)	Premium estimates were between $235 and $391 per month (DHSS, 2011)
Those permitted to "opt out" of public program must obtain private LTCI ; private LTCI heavily regulated	No private LTCI market	No mandate to obtain private LTC but room for private market to compete and fill gaps left by CLASS
State funded social assistance nursing home spending decreased	Pressures on health insurance reduced somewhat	Impact on Medicaid spending might have reduced "spend- down"

[a] Converted to $US using the OECD purchasing power parity (PPP) rate of 0.85 euro to the dollar and 115 yen to the dollar in 2009.

Reduce social assistance spending through a social insurance program but maintain the "safety net"

Germany's social insurance program has substantially reduced its social assistance spending, by about two-thirds for nursing home care. CLASS benefits would have been in addition to Medicaid benefits; they could not supplant or replace Medicaid or any other federally funded health benefits. However, the availability of benefits to CLASS enrollees might have helped to delay or prevent nursing home entry as well as

spend down onto Medicaid, thus reducing Medicaid spending over the longer term. Importantly, both Germany and Japan have maintained their social assistance safety-nets for persons with low incomes to meet any LTC costs not covered by their universal programs, such as room and board costs in assisted living residences or nursing homes.

Permit private LTCI but regulate it more extensively

It is unlikely that the US, with its long history of private sector health financing, would adopt a system that does not provide a role for private LTC insurance. (See Cohen, this volume.) Today, about eight million private LTC policies are in force, representing a small share of the adult population. The enactment of CLASS sparked considerable debate about how it would interface with the private LTC market. Germany regulates its private LTCI market quite extensively, e.g., by requiring uniform benefits and premium ceilings, mandatory reserves, and consumer protections in marketing. Such regulations could increase consumer confidence in the US that private LTCI benefits would be paid and that rates would remain relatively stable over time, hence increasing demand. In addition, the German model of permitting certain groups (such as higher income individuals) to opt-out of a public system but be required to obtain private insurance may prove viable in the US in the future.

Differentiate financing responsibility for health care, housing, and LTC

The reforms in Germany and Japan led to a clearer delineation of which programs cover which costs than is the case in the US, and hence to less confusion among consumers and certainly fewer opportunities for cost-shifting between health and LTC. Germany and (to some extent) Japan have taken the position that room and board costs in both institutional and residential care should not be the responsibility of public LTCI. As a cash benefit, CLASS benefits could have been be used to help pay for LTC and other "non-medical " services in any setting, as well as for some housing related costs. The legislation is ambiguous about what restrictions might have applied to the use of the cash benefits (Wiener 2010).

Family Caregiving

Both Germany and Japan have strong traditions of filial responsibility for the care of older persons, although attitudes are changing. In Germany, if beneficiaries cannot afford the room and board costs in nursing homes, social assistance is available. Their children may be charged for these costs, if they can afford them, or beneficiaries may have to sell their homes, a controversial practice. While a number of court decisions have decreased the financial responsibilities of families, social assistance boards still

have the authority to reclaim funds from children of recipients (Glendinning and Igl 2009).

In Japan, cultural beliefs about filial piety continue to influence family caregiving patterns, but co-residence between children and older parents has declined markedly, from about 80 percent in the 1970s to below 50 percent today (Japanese MHLW 2008). Today, only 20 percent of primary caregivers of the frail elderly are daughters-in-law (Long, Campbell, and Nishimura 2009). In addition, the family system has shifted from the extended family headed by older parents to older parents functioning as an independent family unit (Sugiura et al. 2009).

How System Design Affects Family Caregiving

Given the importance of family caregiver contributions to all aspects of LTC, from financing to workforce to quality, it is surprising that the effect of policies on family caregivers is rarely explicitly discussed as a design goal/dimension in policy development in the US (See also Levine, this volume). Federal and state programs offer only modest assistance to family caregivers through the National Family Caregiver Support Program, along with Medicaid HCBS waivers and some state-funded programs, which provide the majority of public financing to support family caregiving (Feinberg, Newman, and Fox-Grage 2005). In the US, fears among some stakeholders that publicly supported services will supplant family care combine with assumptions that families should bear the sole responsibility for care of adults with disabilities. Such attitudes are consonant with filial responsibility laws in 30 states that legally require adult children to financially support parents unable to provide for themselves, although such laws are rarely enforced (Ross 2008).

In Germany, encouraging family support was a key objective of its public LTC program. In addition, the very nature of social insurance for LTC makes care for older persons a societal as well as private responsibility. However, Japan may be unique among other developed countries in the prominence of the women's movement in the debate about how to structure the program to help relieve family caregivers' burden, with the explicit goal of shifting a portion of responsibility from the family to the state.

Why do the majority of Germans in need of care continue to choose care provided by family members, despite the option to choose publicly-funded services by agencies? Two main reasons for the persistence of family care are: (1) older persons and their families hold traditional care values favoring family care; and (2) older persons and care agencies have quite different definitions of good quality care (Eichler and Pfau-Effinger 2009). Only a small proportion of family caregivers surveyed said that the

need for additional income was decisive in their choice of family care (11 percent), while about 10 percent said it would help secure inheritance of the family's assets. The vast majority cited cultural values and moral responsibility, influenced by lack of trust in formal caregivers, turnover, and the speed with which formal caregivers carried out their tasks.

In 2009, about twice as many Germans were being cared for informally and receiving only the cash allowance (1.03 million) as those receiving any formal home care service (504,000), including respite and short-stay services (Buescher and Kesselheim 2010). However, attitudes seem to be changing. In a 2007 Eurobarometer survey, 68 percent of adults in Germany agreed with the statement "Dependent people have to rely too much on their relatives," higher than the EU average. In a 2008 Eurobarometer survey, 55 percent of German adults said having family care would be the best option if their elderly parent needs LTC and lives alone, while about 45 percent preferred formal care at home or in a nursing home (Huber et al. 2009).

In Japan, caregiving patterns changed after the introduction of LTCI (Campbell, Ikegami, and Gibson 2010). Use of formal caregiving services by older persons increased and financial burdens decreased (Tamiya et al. 2011). In addition, male spousal caregiving, which began before LTCI was introduced, is continuing to increase steadily, i.e., from 11.2 percent in 1984 to 17.9 percent in 1986 to 22.6 percent in 2004. (Suguira et al. 2009, citing the Japanese Ministry of Health, Labour, and Welfare.) As has also been found in some US research, male spouse caregivers are more likely to use LTC services than are female spouses to help alleviate the burden of caregiving (Suguira et al. 2009). Women carers spent significantly less time on elderly care in 2006 than 2001, while men slightly increased their involvement in caring (Tamiya and Shikata 2009). The hours spent by family carers declined significantly only for middle and upper income groups (Tamiya et al. 2011), a finding consistent with some other research on the lower use of formal services by lower income families, Nonetheless, the proportion of family members spending very long hours (more than eight per day) caring for the elderly declined significantly after LTCI was introduced (Shimizutani and Noguchi 2004).

LTCI has helped to remove the stigma in Japan of use of formal services for LTC. Such services are now widely accepted, even in rural areas. Indeed, adult day care as a form of respite is far more widely used in Japan than in Germany, by a factor of at least 100 to 1 (Campbell 2010). Many older Japanese do still live with family members (typically the son and daughter-in-law), but adult day care, home care, and respite in nursing homes provide an opportunity for less friction and more independence. Further, as in Germany, generational attitudes seem to be gradually

changing. Permitting "strangers " to come into the house and provide intimate personal care remains a challenge, but the younger generation in Japan is said to welcome the shift to state responsibility (Izuhara 2003).

Policies to Support Caregivers

In Germany, LTCI pays social security (public pension) and accident insurance contributions for those who do not work more than 30 hours per week and provide at least 14 hours of care per week in the person's own home. Over 90 percent of caregivers who meet this standard are women (European Commission 2008). In 2011, Germany passed a new paid family leave policy to permit workers to care for relatives who need long-term care.[15] Respite care of up to four weeks a year is available to those whose usual caregivers take a vacation or are otherwise unable to provide care. LTCI will cover up to roughly $1,730 per year if the temporary caregiver is a professional or distant relative. If that person is a close relative, the benefit only equals the usual cash allowance, although it can be increased to reflect additional costs the substitute caregiver may incur for travel or loss of earnings. The 2008 reforms reduced the contribution period prior to receiving respite care benefits from one year to six months, and increased funding for respite care centers run by charitable volunteer organizations.

There is a separate benefit for short stays in a German day or night care facility when necessary to supplement home care. The 2008 reform made it easier to combine the day/night care benefit with basic benefits, either cash or in-kind, up to 150 percent of the value of the basic benefit. The use of respite care remains low but has been gradually increasing, i.e., from 0.2 percent in 1998 to 1.4 percent in 2008, as a share of all beneficiaries (German Federal Ministry of Health 2010). Day care and night care services are also rarely used, i.e. by only 0.4 percent of beneficiaries in 1998 and 0.9 percent in 2008. The limited use of these benefits may reflect inadequate supply, bureaucratic obstacles (Lamura et al. 2008), and the lack of information available to family caregivers that such services are available. German caregivers indicated that "information about help available" was the most important of 15 support options they might need (Doehner 2007).

In Japan, respite care is provided through day care and night care (in a nursing home), although the number of short stay beds is inadequate (Tamiya 2011). Adult day care is quite widely used in Japan compared to most other countries. For example, about 1,600,000 older persons, many with dementia, attend day care in Japan, 6 percent of persons 65 or older compared with 0.6 percent in Sweden (Campbell 2010).

Lessons for the US: Family Caregiving

Incorporate the perspectives of family caregivers in all aspects of LTC system design

The Japanese debate over cash versus services provides a critical lesson: family caregivers in the US should be a central part of broader LTC reform --not just with respect to what specific caregiver supports are needed. The potential impacts on family caregivers of varying policy choices are rarely examined closely in US policy discussions of access, quality, training, or financing (Table 5).

Table 5: Family Caregiving and LTC Reform

Germany	Japan	US
Caregiving concerns not prominent when program was started. Program was designed to encourage family caregiving.	Key focus in reform was to remove burdens on family caregivers and to shift some responsibility to the government	No national debate yet about balance between family and government responsibility for LTC
Cash+ formal services, respite and some other caregiver supports	Services only, widespread adult day care; no cash	CLASS: Cash only
Most LTCI beneficiaries in the community continue to rely entirely on family caregivers	Most care recipients in the community now rely on both family care and formal services	In the U.S., more care recipients age 65+ in community rely entirely on family caregivers than a decade ago

The differing goals of encouraging family caregiving versus removing family caregivers' burdens are more frequently discussed in the LTC literature in Europe and Japan than in the US. (Glenndining and Moran 2009; Triantafillou et al. 2010) The US has not yet had a debate about the appropriate balance of responsibilities between the family and the government with respect to LTC, or the limits of family care. In Europe, changing public attitudes on this issue are studied by the EU and through other research (Huber et al. 2009; European Commission 2007).

Many scholars contend that the future will be one of "mixed care arrangements" combining both formal and informal care (Hoffman and Rodrigues 2010). Indeed, there is little evidence that family caregivers will stop providing care if formal services are made available—witness Germany and Japan. However, the type of support families provide may change, as in some Scandinavian nations, where families no longer provide as much physically demanding personal care but can focus instead on giving routine domestic help and psychosocial support. Or, as in Japan, gender patterns in family caregiving may gradually change.

In the US, recognition of the need for stronger partnerships between families and formal care providers, including nurses and social workers, is growing (Kelly, Reinhard, and Brooks-Danso 2008). However, a lower proportion of older community residents in need of LTC were receiving formal services to supplement family care in 2004 than they were in 1994 (Houser, Gibson, and Redfoot 2010).

Adopt policies and programs to support family caregivers, and phase in family caregiver services and supports before other benefits

As with LTC in general, programs to support family caregivers in the US differ widely by state, meet only a small portion of need, and are vulnerable to budget cutbacks. The two most important federal programs, the National Family Caregiver Support Program and Lifespan Respite, receive only miniscule funding (Feinberg et al 2011).

CLASS benefits could have been used to pay family caregivers directly or to purchase home care services, assistive equipment, or other supports. The ability to combine a cash allowance with a formal service benefit, as in Germany, would afford both consumers and family caregivers considerable flexibility. In addition, Japan's widely used network of publicly funded adult day centers is worth examining closely for implications for US practice and policy.

As a general principle, Germany's decision to permit enrollees to obtain respite care services before other benefits makes sense. In addition, the following covered benefits in Germany and/or Japan are all relatively inexpensive, and could be expanded fairly quickly as part of incremental reforms in the US: (1) adult day care; (2) respite care benefits, both short-term and longer term; (3) training programs for family caregivers; (4) information and counseling; and (5) social security tax credits for family caregiving.

Conclusion: Is Universal LTC Reform Feasible in the US?

Germany and Japan adopted many LTC reform goals and policies consonant with their existing structures, funding arrangements, and cultures, and the US is likely to do the same. However, especially in its decision to shift some of the responsibility for care of older person from the family to the state, Japan does show that major changes are possible. It also adopted its reform in the midst of economic recession.

The evolution of both German and Japanese policies demonstrates that, while LTC reform ideally should address coverage, financing, delivery, and quality issues at the same time, mid-course corrections to address major gaps and problems can work. When the program was initially developed in Japan, almost all of the attention was on caregiving, on who would provide care and how it would be delivered, with little attention to spending projections. In contrast, the focus in Germany primarily was on financing issues and sustainability. Hence the Japanese reforms in 2006 were mainly aimed at controlling spending, while Germany's 2008 reforms primarily aimed to increase access to care through adjusting benefits for inflation, introducing care management and local support centers, and expanding access to care by persons with dementia. Germany's recent 2012 reforms also primarily focus on expanding benefits. Today, the German and Japanese LTC social insurance systems are demonstrably superior to the US system in terms of access to services and cost to the public purse.

Current US policies are constrained by tax aversion, anti-government sentiment, and political polarization. Proposals to expand public financing for health care and LTC are countered by arguments that Americans are already over-taxed. However, the reality is that the United States (and Japan) do not have high rates of taxation compared with other OECD countries (OECD 2011).[16]

As in Germany, states may be the prime movers in further structural LTC reform, as burdens on health and LTC Medicaid budgets and the fragmentation and complexity of state LTC programs increase. As in Japan, the women's movement may come to play a prominent role in framing LTC as a women's issue for care recipients as well as caregivers, both unpaid and paid. In the US, open debate about the appropriate balance of responsibilities between the family and the government, as well as the limits of family care, has yet to occur Older women in the US, an often marginalized group, are those most at risk of spending down into poverty and of incurring substantial LTC expenses.[17] Further, the gender gap in family caregiving persists while the gender gap in disabilities among older persons in the US is growing (Redfoot and Houser 2010). As the prevalence of family caregiving increases with the aging of the population, these issues are likely to become increasingly urgent,

especially as more women look to their own potential futures as caregivers and care recipients.

CLASS was a controversial yet important building block that helped to make LTC more prominent on the national agenda. Its suspension suggests that it may not be possible to design a voluntary system that is affordable to most Americans while providing adequate protection against the risks of disability. Germany and Japan, with mandatory social insurance systems, have made and will continue to make significant reforms as their systems mature. These reforms have expanded the contribution base and the services available. They also have made changes in policies to support family caregivers and to improve quality and infrastructure.

Despite the fate of CLASS, LTC reform in the US should be less controversial than the debate over health care reform. (1) Both Germany and Japan, along with many other developed nations, adopted universal LTC systems after they had adopted universal health care systems. The recent health care reform legislation moves the US substantially toward universal coverage; (2) As in Germany and Japan, universal LTC reform would be an improvement for almost everyone compared to the status quo. That was not the case with health care reform in the US, which was threatening to the well-insured; (3) LTC as a percentage of total health care spending is much smaller in the US than in Germany and Japan because the US spends so much on health care—16 percent of its GDP in 2007 compared with 10.4 percent in Germany and 8.1 percent in Japan. Compared to health care reform, further LTC reform in the US should not be as threatening to powerful interests--compare the wealth and influence of hospitals to nursing home chains and home-care agencies, of the health insurance industry to the private long-term care insurance industry, of physicians to nurses and social workers, of the pharmaceutical industry to any providers in the long-term care field. Indeed, many LTC providers have advocated major LTC reform.

Both Germany and Japan enacted their mandatory LTC social insurance programs when about 16 percent of their population was age 65 or older, a line the US will cross sometime around the year 2020. While demography is not destiny, pressures to cover everyone, provide help to family caregivers, and contain both private and public costs for LTC are likely to increase. CLASS may have been a way station on the road to social insurance.

Notes

[1] Comparable cross-national data indicate that the poverty rate among women age 75 or older living alone was 17.7 percent in Germany compared with 48.3 percent in the US. However, older women in this age group are far more likely to live along (61 percent) in Germany than in the US (42 percent) (Choi 2006).

[2] This chapter extends the discussion of policy implications for the US of the LTCI experiences of Germany and Japan in Campbell, Ikegami, and Gibson, 2010.

[3] References to the CLASS legislation are based on a number of sources: (1) primarily, the statute itself [H.R. 3590]; (2) National Health Policy Forum, The Community Living Assistance Services and Supports (CLASS) Act, June 9, 2010; (3) AARP Public Policy Institute, 2010; Understanding the New Community Living Assistance Services and Support (CLASS) Act, by Rhonda Richards and Lina Walker; (4) "Bringing CLASS to Long-Term Care " *Public Policy and Aging Report*, 2010; and (5) Kaiser Family Foundation 2010; "More Than Meets the Eye: Long-Term Care Provisions in the New Reform Law ", transcript from Alliance for Health Care Reform program Oct. 1, 2010. References to CLASS after the program was suspended are cited separately.

[4] Social assistance in Germany refers to tax-financed, means-tested support for persons in need of care who do not receive support from other people, somewhat similar to the US Medicaid program. It is financed by Laender (states) under uniform, national standards for income and assets. The term also includes cash benefits and other income supplementation for low-income persons. In Japan, social assistance (public assistance) refers to cash payments to low-income individuals, similar to the US SSI program, while social welfare refers to means-tested services provided by municipal governments, either directly or contracted out, as in Scandinavia.

[5] See note above.

[6] Converted to $$ using the purchasing power parity rate (PPP) of 0.85 euro to the dollar and 116.32 yen to the dollar in 2008 (Campbell, Ikegami, and Gibson 2010).

[7] Some post-acute services remain under health insurance, e.g., about 20 percent of the total for visiting nurse agencies and over 90 percent of rehabilitation services are provided under health insurance, while maintenance rehabilitation is under LTCI. (Naoki Ikegami 2008).

[8] Germany also required a five year vesting period prior to the beginning of benefits; it recently reduced this period from five to two years.

[9] The specific breakdown is as follows: 19 percent - premiums by persons 65+; 31 percent - premiums by persons 40-64; 25 percent - federal government; 12.5 percent - prefectures; 12.5 percent - municipality.

[10] Pensioners' contributions are based on their public pensions and other income.

[11] Germany reduced the contribution period before benefits begin from five to two years in its 2008 reforms.

[12] Contributions to the LTCI fund for unemployed persons are paid by unemployment insurance fund and social assistance but are lower than would be paid by employed persons.

[13] The formula is set by the national government and allows relatively little autonomous decision making. The main variation comes from how many people are in institutions.

[14] For the range of reform proposals, see Heinicke and Thomsen (2010), Rothgang and Igl (2007), and Rothgang (2010).

[15] Workers can work half time and continue to be paid 75% of their salary. So they do not game the system, they are obliged to return to full-time work again with the 75% salary until the caring time is balanced (WHO 2012).

[16] According to the most recent OECE revenue data available, total tax revenue as a percent of GDP in Japan was 28.1 percent (in 2008), in the U.S. 24% (2009), and in Germany 37 percent (2009). The OECD average in 2008 was 34.8 percent.

[17] Older women in the US "face an exceptionally high risk of income poverty" relative to women in Germany, Sweden, and the UK (Gornick et al. 2009).

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