

# Financing Long-Term Care in Germany and Slovakia

**Gerda Schmahl**

[schmahl1@uniba.sk](mailto:schmahl1@uniba.sk)

Comenius University, Faculty of Management, Bratislava, Slovakia

---

**Abstract:** The importance of long-term care (LTC), in terms of costs and demand, continues to grow in Slovakia and Germany. This is a direct consequence of demographic changes. The two countries are under pressure to find solutions to finance LTC. This paper aims to contribute to the acquisition of more knowledge about LTC financial systems within the EU and, in particular, to present how the financial risk of LTC dependency is covered in Slovakia and Germany. The paper organizes existing literature on organization and financing of LTC and uses it to analyze as well as to compare the economic, policy and behavioral forces that underpin the observed equilibrium. The Slovak and German LTC systems share a high degree of family-based and informal service provision. The emphasis is not placed on the actual needs of the care recipient, but rather on minimizing the public expenditures. It seems that a mixed financing system based on private payments with public subsidies is the path they have chosen in covering the financial risk of LTC.

**Keywords:** Long-Term Care, Financing, Social care insurance, Long-term care system

**JEL Classification codes:** G22, I11, J14

---

## INTRODUCTION

Long-term care (LTC) is defined as a range of services and supports for people who, as a result of mental and/or physical fragility and/or disability (Social Protection Committee, 2014), require assistance in the instrumental- and/or activities of daily living for an extended period of time (Costa-Font, Courbage & Zweifel, 2017). The declining relative size of the working-age population, decreasing family-based care supply due to higher female labor force participation, and reducing family size will drive up the demand and cost of LTC in the coming decades (Costa-Font & Courbage, 2012). In recognition of these factors, there is growing concern in Europe that the current mechanisms for financing LTC will not be sufficient to adequately protect people from the risk of needing LTC (Comas-Herrera et al. 2003). Since many European countries are facing this challenge, it is worthwhile to take a look abroad in order to identify different models in the area of care and generate possible starting points for improvements. In this article, the regulatory and financial framework as well as the basic structure for provision of LTC in the German and Slovak care systems is described. The incentives associated with respective regulatory structures are theoretically explained and the findings are discussed. The aim of this article is to compare the German and Slovak LTC systems in terms of their regulatory, financing and benefits structure (Jacobs et al. 2020) and to make a statement about the sustainability of LTC financing.

## 1. COUNTRY PROFILES

For the European comparison two countries were selected which take a different approach to the financing structure of the LTC system and are associated with a different welfare model. The objective of this chapter is to provide a comprehensive overview of the current state of LTC systems in Germany and the Slovak Republic.

## 1.1 Germany

On 1 January 1995, the fifth pillar of the social security system in Germany created a LTC insurance (Heintze, 2015). It is intended to cover the financial risk of the need for care (Kimmel & Breuninger, 2016). Unlike in most European countries this marked the beginning of a process of de-communalisation. LTC insurance is regulated at the national level. This includes above all the determination of the degree of care and the type and amount of care services. Carriers of the social care insurance (SCI) are the LTC insurance funds. They are financed within the federal legal framework at state level by means of contracts between the LTC insurance funds and the providers of social services (Auth, 2012). They negotiate the compensation rates and other contractual provisions. The national regulatory system with a market orientation should ensure greater social justice and consumer choice. The responsibility is transferred to the lower levels of both state and private actors (Nadash, Doty & van Schwanenflügel, 2018). LTC insurance is an addition to the health system. Since 2009, it is compulsory for every citizen to join LTC insurance. The principle is that the LTC insurance follows the health insurance. Accordingly, members of the statutory health insurance scheme must be compulsorily insured within the framework of the SCI and all members of private health insurance are covered by private care insurance (PCI).

### *Care benefits*

All persons in need of care, regardless of their age, are entitled to benefits from the SCI (Gerlinger, 2018). The benefits are flat-rate and do not vary according to income or assets (Nadash, Doty & van Schwanenflügel, 2018). An independent medical service of the German health insurance funds determines whether the need for LTC exists and at what level (Heintze, 2015). The granting of the LTC allowance depends on the level of care assessed and the care measures taken (at home or in a retirement home). Independent of the care level, support services for prevention and rehabilitation can be granted. These are given priority over all other care benefits, just as home care has priority over institutional care (Gerlinger, 2018). As of 2022, strong incentives will be provided for the expansion of short-term care services due to the passage of the Health Care Expansion Act (Gesundheitsversorgungsweiterentwicklungsgesetz, GVWG) (Bundesministerium für Gesundheit, 2021). The benefits from SCI do not differ between regions and are unlimited in time (Gerlinger, 2018). In Germany there are three different arrangements that a person in need of LTC can choose from: Cash benefits or benefits in kind such as home care and institutional care (Schmähl, Augurzky & Mennicken, 2014). There has been no increase in benefits since the introduction of LTC insurance until 2008. Benefits were only adjusted inconsistently and irregularly thereafter (Rothgang & Müller, 2021).

In 2019, a total of 4.1 million people were entitled to receive benefits from SCI. Of these about 818,000 (20%) persons received benefits for inpatient care. At home 3,3 million (80%) people in need of LTC were cared for. A combination of outpatient care benefits and cash allowance was paid to 983,000 (24%) people. The remaining 2.3 million dependent people received only cash benefits which meant that they had to look after their own care provision (Statistisches Bundesamt, 2020). In Germany, the relatives of those in need of care are the main service providers (Rothgang & Müller, 2018). In 2019, 56% of all people in need of care will be cared for without the involvement of external care services. This resulted in about 2.3 million informal main caregivers in 2019. In addition to these, there are often other people who look after those in need of care (Statistisches Bundesamt, 2020). According to a study conducted in 2017, 59% of people in need of care in private households stated that they receive help from two or more people. This means that the number of people involved in home care is at least twice as many as 2.3 million informal main caregivers. Germany's largest care service thus consists of the informal care workers (Rothgang & Müller, 2018). LTC insurance requires that a large proportion of the care work is self-financed and privately provided. Thus, Germany

relies on subsidiarity: the state only provides what the lowest level, in this case the family, cannot afford (Kesselheim et al. 2013).

### *Funding*

The LTC insurance is based on the structure of the statutory health insurance. One major difference, however, is that it is only partially comprehensive insurance. As a rule, persons in need of nursing care have to make additional payments (Auth, 2012). Thus, the SCI already bears only just under half of the actual costs of the need for LTC with a downward trend. The remaining amount is borne privately by those in need of LTC. Those who cannot afford the additional payments are entitled to social assistance under the "Help for Care" scheme (Breyer, 2016). Social assistance is financed through national tax revenues. However, this component plays only a minor role in the funding of publicly financed care services (BMASGK, 2020). In Germany, the most important sources of financing are the SCI, social welfare and private equity (Rothgang & Müller, 2018). In 2019, 89% of the German population is covered mandatory under the SCI. The remaining 11% of citizens are obliged to purchase a mandatory PCI (to supplement their private health insurance) (Bundesministerium für Gesundheit, 2021). Premiums have risen since the SCI was founded. Most recently, on January 1, 2019, the premium rates were increased by 0.5 points to 3.05% of the gross income (Bundesministerium für Gesundheit, 2018) and for childless persons, the premium was increased by 0.1 percentage points in 2022 (Bundesministerium für Gesundheit, 2021). Employers pay one half, while after retirement the insured pays the full premium (Nadash, Doty & von Schwanenflügel, 2018). As of the age of 23, childless persons must pay a surcharge of 0.26 percentage points from their income, to be paid by them solely. PCI charge premiums regardless of the income of the insured. All employees who are privately insured receive a subsidy from their employer in the amount that would be charged if they were members of the SCI (Heintze, 2015). In Germany, LTC is mainly financed by the SCI. The income of the SCI is almost exclusively generated by contributions, which are paid on a pay-as-you-go basis (Rothgang et al. 2014). The PCI operates on the basis of the projected unit cost method. Under this method, age-related provisions are set up for the expected future need for care. In the event of needing nursing care and outpatient services are used, the principle of cost reimbursement applies to the PCI and the principle of benefits in kind to the SCI (Heintze, 2015). In 2019, 86.7% of total public expenditure on LTC was covered by the SCI. A further 8% of this expenditure is covered by social welfare. In contrast, the share of public spending, borne by the PCI with a quota of 2.6%, war victims' benefits with a quota of 0.1% and civil servants' allowances with a quota of 1.3%, is relatively small. Overall, these sources of funding accounted for 76.9% of total LTC expenditure. The SCI is thus the most important funding source and at the same time covers only 66.7% of the costs incurred. Another 23.1% of total LTC expenditure was privately financed in 2019 (Rothgang & Müller, 2021). However, this figure does not take into account the opportunity costs of family care nor the privately funded costs for board, lodging and investment allowance in nursing homes. The partial insurance character of the LTC system is therefore very clear (Rothgang & Müller, 2018).

LTC insurance contains a number of birth defects that still have an impact today and are shaping current reform projects and debates. These include the dual system of SCI and PCI (Rothgang et al. 2014). In 2016, the average per capita expenditure from public sources for a PCI person (plus those entitled to subsidies) was € 168 and € 393 per SCI person. This corresponds to about 42% of the expenditures of the SCI for a PCI person (Rothgang & Müller, 2018). These result in a disadvantage for those insured under the SCI. An integrated LTC insurance system comprising the entire population would be the easiest way to compensate for the unequal distribution of risks (Rothgang, Müller & Unger, 2013). The concept of advance financing through a demographic reserve fund was enabled in 2015 with the establishment of the LTC provision fund (Nadash, Doty & von Schwanenflügel, 2018). Currently, 0.1% of the SCI contributions per year are invested in this fund. The aim is to pay into this fund by 2034.

Thereafter, the paid-in funds plus interest will be added to the contributions to finance expenditure (Nadash, Doty & von Schwanenflügel, 2018). The LTC provision fund has been the subject of considerable criticism. The Deutsche Bundesbank concedes that it is not possible to protect these reserves from future access by the finance minister, so there are doubts that this fund is really secure. On the other hand, the fund is so small that a relief of 0.1 contribution rate points is inevitable in the period from 2035 to 2045, when the contribution rate is likely to be closer to 4 contribution rate points. In addition, the fund is not sustainable. This is because it will be exhausted precisely when the highest number of people in need of LTC will probably be reached at the end of 2050 (Rothgang et al. 2014). In 2022, a fixed annual federal subsidy of €1 million was approved by the German Health Care Expansion Act (Gesundheitsversorgungsweiterentwicklungsgesetz - GVWG). Its purpose is to help finance expenditures in SCI (Bundesministerium für Gesundheit, 2021).

Recent policy reforms aim to address one of the program's core problems: the financial sustainability of SCI in view of an ageing population. However, it remains to be seen what the long-term impact of this will be, given the unpredictability of demographic change and future care needs and the adequacy (or otherwise) of funding reforms (Nadash, Doty & von Schwanenflügel, 2018).

## **1.2 Slovak Republic**

The LTC system in Slovakia can be characterized by family orientation, residualism, welfare orientation, and a comparatively low level of service provision (Costa-Font & Courbage, 2012). LTC is not regulated in a legally separate social insurance (Golinowska & Sowa, 2013) and does not consist of a unified social and health care system (Social Protection Committee, 2014). The responsibility for legislative and oversight of LTC is divided between two bodies - the Ministry of Labor, Social Affairs and Family (MoLSAF) and the Ministry of Health (MoH) (Nádaždyová et al. 2013). Individual benefits are covered by multiple regulations and laws (Radvanský & Páleník, 2010), which address different conditions and/or risks, including old age, invalidity, social security, and health care (Social Protection Committee, 2014). Health care is legally and formally provided by the state, while social care (including care for the elderly, disabled or chronically ill) is partially provided by the state, regions, non-profit and private institutions. The MoLSAF is in charge of determining national strategy and supervising providers of social services. The role of municipalities is to provide LTC. They bear responsibility over social services in terms of developing municipal plans, defining a local policy, contracting with service providers, and even determining contributions. The MoH is responsible for medical services and defines the national strategy in the medical field (Radvanský & Páleník, 2010). Social care is separate from health care. They are insufficiently aligned, as LTC is only partially provided in both systems. Thus, an integrated model of care is not in place (Smatana et al. 2016).

### *Care benefits*

The Slovak legislation does not contain a definition of LTC (Lamura et al. 2014). Eligibility criteria for social benefits is defined differently within each of the various welfare sectors (MISSOC, 2020). As a result, social protection may differ significantly for people with similar health problems (MoF SR & MoH SR, 2019). Access to state LTC benefits is based on an assessment of the applicant's personal situation (Gerbery & Rastislav, 2018). Based on the outcome of the assessment, the amount as well as the type of care required and thereby the benefits granted are determined (Schulz & Geyer, 2014). In Slovakia, both benefits in kind and cash benefits are available. There is a free choice of services and providers. During the receipt of benefits in kind, the person in need of LTC is obliged to contribute to the costs. In an inpatient care facility, the costs incurred must be paid by the recipient according to his income, up to 25% of the subsistence level per month. For home care services, the recipient must at least maintain 165% of the subsistence income (MISSOC, 2020). Eligibility for cash benefits is

means-tested (European Commission, 2019). The granting of cash benefits is limited from two sides. It is limited according to the income of the person in need of care (means testing) and to the earned income of the caregiver (Gerbery & Rastislav, 2018). Moreover, social care services offer different financial compensations for the disabled. These include cash benefits to assist with mobility, communication, and orientation (Smatana et al. 2016).

From a historical perspective, the provision of inpatient care was the main and often the only public response to LTC in Slovakia. Given the lack of alternative care arrangements outside the family, inpatient care remains an important alternative even today when informal care networks are not available (Österle, 2010). This is also confirmed by Eurostat data: In 2014, only 1.3% of the population reported using home care services, compared to a total of 4% for the EU average (Gerbery & Rastislav, 2018). The strategy for deinstitutionalizing social services and strengthening care, adopted by government resolution at the end of 2011, provides for a systematic transition from institutional to community-based care (European Commission, 2019). Services provided by the healthcare sector for LTC are found in the inpatient sector (in special facilities and in departments of general hospitals) as well as in the outpatient sector (Costa-Font & Courbage, 2012). Currently, inpatient follow-up care capacity in Slovakia is insufficient, resulting in redundant readmissions (MoF SR & MoH SR, 2019). It is estimated that more than 20% of inpatient hospitalizations in Slovakia are "ambulatory care-dependent," meaning that they are preventable and could potentially be treated in ambulatory care facilities (Kuenzel & Solanič, 2018). In 2019, the government passed an amendment to the Health Care Act. According to it, inpatient follow-up care capacity is to be increased (MoF SR & MoH SR, 2019), by transforming acute care beds into LTC beds (Kuenzel & Solanič, 2018). The lack of capacity in home care leads to long waiting lists for places in social inpatient care (OECD, 2017). The number of people on waiting lists in nursing homes for the elderly and in specialized facilities exceeds the number of available places by 30% (MoF SR & MoH SR, 2019). Demand for LTC has increased significantly, but the system still relies on informal caregivers (Smatana et al. 2016). Most services (about 60%) are provided through informal home care (OECD, 2017). The shortage of formal care capacities is replaced by informal caregivers. This form of care is not sufficiently supported in Slovakia. In 2018, 54,700 people received financial compensation for providing care to a person in need of LTC, which amounts to an average of €215 per month for one person in need of care. According to the AOPP survey, 71% of respondents reported taking care of their relatives themselves. Of these, only 20% were entitled to care benefits (MoF SR & MoH SR, 2019).

### *Funding*

In the Slovak Republic, a mixed financing system for LTC is in place. It is financed from two public sources, depending on the type of service provided (Österle, 2010). The medical LTC component is financed through the statutory health insurance (Nádaždyová et al. 2013). Thereby the regulations of the social insurance apply (Österle, 2010). Health-related services are fully reimbursed by the health insurance company. No additional co-payments are charged for home nursing. The social LTC component is financed through taxes (Radvanský & Páleník, 2010). Social welfare principles are applied in this scheme (Österle, 2010). Social services, such as formal LTC services and cash benefits, are provided by several tax sources. The in-kind services are financed by the regional municipalities through local taxes and (Nádaždyová et al. 2013) cash benefits are provided through the state's central budget (Giorno & Londáková, 2017). Health and social insurance are mandatory in Slovakia. Contributions to health insurance are shared by the employee and the employer (Radvanský & Páleník, 2010).

The Slovak LTC system suffers from chronic funding problems which have worsened under the influence of the economic crisis which began in 2009 and budget restrictions imposed by regional authorities. These difficulties forced the central government to intervene in the social sector with occasional bailouts to prevent the closure of several care centers (OECD, 2017).

As a result, an amendment to the law came into force on March 1st, 2012, determining a direct state participation in the financing of certain types of social services (mostly LTC) (European Commission, 2019). At present, social services are partially subsidized through the state's central budget (Nádaždyová et al. 2013). Both sectors are under budgetary pressure, which not only increases financial stress within the segments, but also creates incentives for stakeholders to shift responsibilities and costs to other sectors (Österle, 2010). Beneficiaries of social LTC services were asked to contribute directly to its financing, which created social tensions given the low-level of pensions (OECD, 2017). Public funding covers around two-thirds of expenditure. About one-third is supplemented by private co-payments from recipients. This applies to both institutional and home care (Radvanský & Páleník, 2010). On average, private co-payments amount to €320-350 per month (Smatana et al. 2016). All social services, with a few exceptions such as counseling services and social rehabilitation, are subject to cost-sharing (Nádaždyová et al. 2013).

Public spending on LTC in 2016 amounted to 0.9% of the country's GDP, therefore lying considerably below the EU average of 1.6% (European Commission, 2019). The spending level of the health- and social care sector is relatively low compared to the EU average. Therefore, it is not surprising that LTC funding from the modest resources of both sectors is low. In Slovakia, the structure of spending on LTC services is diverse and volatile. A comprehensive evaluation of LTC expenditures requires numerous estimations, as the amount of spending on LTC services is not distinguished (reported separately) in either the health or social sectors. This complicates the breakdown of financial data for LTC and demonstrates that the sector is still in a developing state (Golinowska & Sowa, 2013).

The fragmented organization of the LTC system makes it difficult for beneficiaries to access and use. The multiple channels for assistance administered by different agencies make the system non-transparent and difficult for users to navigate. The bureaucracy involved in assessing the need for care is burdensome, and the various types of assistance are poorly coordinated (Giorno & Londáková, 2017). The social care sector is considered an appropriate context for the provision of LTC, but the relevant infrastructure in this sector is far from sufficiently developed (Costa-Font & Courbage, 2012). There is a lack of home-based care capacity and the few existing nursing homes are considered inadequate due to low personnel resources. This is mainly due to the lack of funding (Smatana et al. 2016). The Slovak Republic presents a family-based LTC system with a social security system in the process of being established (Schulz & Geyer, 2014).

## **2. DISCUSSION**

The countries of Germany and Slovakia have developed their own systems in accordance with social traditions, their cultures and the financial means available. Germany has created a universal social insurance system based on the Bismarck model and introduced a LTC insurance. In Slovakia, as a former socialist country, LTC is not regulated in any uniform system. It is still strongly rooted in the health care system, has a high institutionalization degree and is in the process of establishing a social sector. The design of the two LTC systems is largely determined by the underlying welfare state model and thereby strongly influenced by social norms as well as legal regulations. Consequently, there is great heterogeneity in the design of LTC systems. For the two European countries, they can be assigned to two organizational and financing models of LTC.

Two models can be identified in the area of organizational structure: All responsibilities are located on a central level (Germany) in the LTC system or the responsibilities are distributed among several entities (Slovakia). A centralized LTC system provides uniformity in the service structure by centrally defined specifications (Jacobs et al. 2020). For example, it specifies a

universal entitlement for LTC without hindering the access (Heintze, 2015). The German LTC system has a positive impact on equitable distribution, as it offers little or no incentive to shift benefits. In Slovakia, LTC services which are not linked to the health care system are designed differently as a municipal task in each region. This has a negative impact on equitable distribution. In terms of allocative efficiency, such designed LTC systems require very well-thought-out regulations to counteract negative effects due to the inherent incentives to shift from one service sector to another. Unfortunately, this is not the case in the Slovak LTC system. However, a decentralized LTC system offers the advantage of being sensitive to local preferences or taking local circumstances into account, which is harder to do in centrally controlled systems.

In terms of financing the LTC systems, two main models can be derived: First, financing is primarily provided by social security contributions (=social security model) and second, financing is provided by a mix of tax and social security funds (=mixed financing model). The German social insurance model has the following advantages compared to the mixed-financed Slovak model: There is an assigned care budget, it does not compete for funding with other public benefits, it has high transparency due to clear responsibilities, it provides security of entitlement for insured persons, it prevents variation in the provision of benefits, and it is possible to dynamize contributions. However, the German financing model also has disadvantages: the financing risk and the entitlement to benefits are limited to certain groups of people, the link to earned income restricts revenues, and the increased indirect labor costs resulting in contributions create negative incentives on the labor market (Jacobs et al. 2020). Slovakia provides LTC services under its health insurance and other social security programs through a tax-funded LTC system (Costa-Font, Courbage & Swartz, 2014). In these provision mechanisms, financing originates from the public budget (through central, regional or local government). The tax revenue collected by the state constitutes the revenue (Rodrigues, 2015). The strengths of tax-based public systems are: Broad tax diversity for revenue generation, fair resource allocation for horizontal equity, and flexible expansion in times of high need. The disadvantages of tax-funded LTC systems are: Poor eligibility transparency of benefits, tax revenues are in direct competition with other uses, and the stability of tax revenues may vary over the business cycle (BMSGK, 2020).

An LTC model that offers primarily fixed cash benefits creates few, if any, disincentives for informal caregivers. This would help moderate the increase in public spending on LTC (Courbage, Montoliu-Montes & Wagner, 2020). Expanding coverage can be done by developing a partnership. This involves extending the availability of proportional in-kind benefits (Costa-Font & Zigante, 2020). This type of public benefit provides disincentives for informal caregivers and could be socially beneficial because it reduces the burden of caregiving in terms of health and their low labor force participation (Courbage, Montoliu-Montes & Wagner, 2020). In Germany and Slovakia, social care benefits are currently provided in the form of cash benefits and benefits in kind. Eligibility for social benefits is subject to a one- to twofold means test in Slovakia. Entitlements to cash benefits and/or benefits in kind are linked in both countries to strict bureaucratic regulations for assessing the need of care. In this context, a narrowed definition of care has the function of keeping the proportion of those in need of care to a minimum according to the law. In addition, the fragmented organization of the Slovak LTC system makes access difficult for users (Heintze, 2015). As a result, Slovakia favors the incentive for informal care and a slowdown in public spending. Germany's latest reform addresses potential care needs for sustainable financing. With the expansion of benefits in the area of respite care, the focus is on supporting informal caregivers, and by strengthening preventive services, the growth in formal care needs should be moderated in the longer term (Jacobs et al. 2020).

The concept of value for money or cost-effectiveness does not come easy in the social service sector. Services for LTC present complexities which make it difficult to evaluate efficiency and

especially in a system comparison. The most obvious way to reduce cost would be to lower potential dependency and support independent living in an LTC-system (Colombo et al. 2011). Implementing a value-based service approach would promote coverage of care options that provide the greatest benefits to dependent people and their informal caregivers at the lowest cost to the system. It would ensure that resources are not wasted on low-impact services, and therefore could be an economically dominant strategy in the long run. This suggests a re-evaluation on which services should be covered in the LTC-System. New technologies (Rapp & Swartz 2021) and comprehensive information platforms to improve information sharing (Colombo et al. 2011) as well strengthening preventive services could favor an optimization of resources (Rapp & Swartz 2021).

## CONCLUSION

The importance of LTC, measured in terms of costs and utilization, is growing in both countries. It is a direct consequence of the ageing population and, in particular, the increasing number of very old people in the population (Costa-Font & Courbage, 2012), whereby Slovakia is expected to be slightly more affected than Germany. Despite drastic reforms, the financing of the German LTC-System is not yet sustainable in the long run. If attempts are made to maintain the current levels of benefits in the nursing care insurance system, the contribution rates will have to be increased considerably. In addition to this, there is the fact that the LTC insurance already covers only just under half of the actual costs of care. Those in need of LTC who are unable to pay privately for the costs of care have claims on their social welfare institutions. This amount is likely to increase dramatically in the next few years, as the level of benefits will probably fall and the many costs will rise disproportionately (Beyer, 2016). It is expected that there will be an even larger "care deficit" in Slovakia in the next few years. The nature of the "Slovak care deficit" results from the fact that many elderly people in need of LTC do not receive any social assistance. However, this is not due to a shortage of local (national) workforce, but to inadequate funding and efforts to meet LTC needs primarily through family members (Nádaždyová et al. 2013). The declining relative size of the working-age population, decreasing family-based care supply due to higher female labor force participation, and reducing family size will drive up the demand and cost of LTC in the coming decades. The evidence shows that institutional models do not have much impact when needs assessments are conducted and countries rely heavily on private cost-sharing to build the demand for services (Costa-Font & Courbage, 2012). Germany and the Slovak Republic share a high degree of familiarization and informal service provision. In the case of informal care provided by relatives, only a small recognition payment known as care allowance is paid. This assigns care-giving relatives the role of cheap care providers. The main focus is not on the specific needs of dependent persons, but on keeping public expenditures to a minimum (Heintze, 2015). It can be summarized that both countries with their family-based care systems are unable to show sustainable financing for the future challenges. However, the German LTC system has already started to build up sustainable financing, with concrete measures such as a possible dynamization of social security contributions and the introduction of a LTC provision fund (Jacobs et al. 2020).



## REFERENCES

- Auth, D. (2012). Ökonomisierung von Pflege in Großbritannien, Schweden und Deutschland. *Zeitschrift Für Gerontologie Und Geriatrie*, 45 (7), 618-623. <https://doi.org/10.1007/s00391-012-0389-0>
- BMASGK - Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz. (2019). *Zukünftige Finanzierung der Langzeitpflege Ansatzpunkte für Reformen* (pp. 28 - 43). Wien: Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz.
- Breyer, F. (2016). Die Zukunft der Pflegeversicherung in Deutschland: Umlage und Kapitaldeckung. *Zeitschrift Für Die Gesamte Versicherungswissenschaft*, 105 (5), 445-461. <https://doi.org/10.1007/s12297-016-0357-7>
- Bundesministerium für Gesundheit. 2021. *Gesundheitsversorgungsweiterentwicklungsgesetz (GVWG)*. [online] Available at: <<https://www.bundesgesundheitsministerium.de/gesundheitsversorgungsweiterentwicklungsgesetz.html>> [Accessed 13 February 2022].
- Bundesministerium für Gesundheit. (2021). *Siebter Bericht der Bundesregierung über die Entwicklung der Pflegeversicherung und den Stand der pflegerischen Versorgung in der Bundesrepublik Deutschland Berichtszeitraum: 2016-2019* (p. 11). Berlin: Bundesministerium für Gesundheit.
- Bundesministerium für Gesundheit. (2018). *Warum höhere Pflegebeiträge notwendig sind*. Bundesgesundheitsministerium. Retrieved 15 August 2020, from <https://www.bundesgesundheitsministerium.de/themen/pflege/pflegeversicherung-zahlen-und-fakten/warum-hoehere-beitraege-zur-pflegeversicherung-notwendig-sind.html>.
- Colombo, F., Llena-Nozal, A., Mercier, J., & Tjadens, F. (2011). Help wanted? Providing and Paying for Long-Term Care (pp. 296-315). OECD Publishing.
- Comas-Herrera, A., Gori, C., Maio, A., Patxot, C., Pickard, L., & Pozzi, A. et al. (2003). *European study of long-term care expenditure: Investigating the sensitivity of projections of future long-term care expenditure in Germany, Spain, Italy and the United Kingdom to changes in assumptions about demography, dependency, informal care, formal care and unit costs* (p. 4). European Commission, Employment and Social Affairs DG.
- Costa-Font, J., & Courbage, C. (2012). *Financing Long-Term Care in Europe - Institutions, Markets and Models* (pp. 17 & 240). Palgrave Macmillan.
- Costa-Font, J., & Zigante, V. (2020). Building 'implicit partnerships'? Financial long-term care entitlements in Europe. *Policy Sciences*, 53(4), 697-712. <https://doi.org/10.1007/s11077-020-09403-1>
- Costa-Font, J., Courbage, C., & Swartz, K. (2015). Financing Long-Term Care: Ex Ante, Ex Postor Both?. *Health Economics*, 24, 45-57. <https://doi.org/10.1002/hec.3152>
- Costa-Font, J., Courbage, C., & Zweifel, P. (2017). Policy dilemmas in financing long-term care in Europe. *LSE Research Online Documents On Economics*, (61032), 38.
- Courbage, C., Montoliu-Montes, G., & Wagner, J. (2020). The effect of long-term care public benefits and insurance on informal care from outside the household: empirical evidence from Italy and Spain. *The European Journal Of Health Economics*, 21(8), 1131-1147. <https://doi.org/10.1007/s10198-020-01215-7>
- European Commission. (2019). *Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability* (pp. 460 - 461). Directorate-General for Economic and Financial Affairs.

- European Commission. (2019). *Country Report Slovakia 2019 - Assessment of progress on structural reforms, prevention and correction of macroeconomic imbalances, and results of in-depth reviews under Regulation (EU) No 1176/2011* (p. 31). European Commission.
- Gerbery, D., & Rastislav, B. (2018). *ESPN Thematic Report on Challenges in long-term care - Slovakia* (pp. 4 -10). Brussel: European Union.
- Gerlinger, T. (2018). *ESPN Thematic Report on Challenges in long-term care - Germany* (pp. 6 - 7). Brussel: European Union.
- Giorno, C., & Londáková, K. (2017). Improving the efficiency and outcomes of the Slovak health-care system. *OECD Economics Department Working Papers, 1404*, 36 - 37. <https://doi.org/10.1787/f2b496cd-en>
- Heintze, C. (2015). *Auf der Highroad - der skandinavische Weg zu einem zeitgemäßen Pflegesystem* (pp. 15 - 18). Bonner Universitäts-Buchdruckerei.
- Jacobs, K., Kuhlmeier, A., Greß, S., Klauber, J., & Schwinger, A. (2020). *Pflege-Report 2020 - Neuausrichtung von Versorgung und Finanzierung* (pp. 27 - 36). Springer Nature.
- Kesselheim, H., Schildmann, C., Schmidt, S., Steffen, M., Stiegler, B., & Wallrafen-Dreisow, H. (2013). *Pflege zwischen Familie, Markt und Staat - Wie Pflegearbeit in Zukunft organisiert werden kann* (p. 5). Bonner Universitäts-Buchdruckerei.
- Kimmel, A., & Breuninger, K. (2016). Pflegereform 2017 - Grundlagen des neuen Pflegebedürftigkeitsbegriffs und des neuen Begutachtungsinstruments zur Feststellung der Pflegebedürftigkeit nach dem SGB XI. *Das Gesundheitswesen, 78* (07), 477 - 488. <https://doi.org/10.1055/s-0042-101411>
- Kochskämper, S. (2017). *Alternde Bevölkerung: Herausforderung für die Gesetzliche Kranken- und für die soziale Pflegeversicherung* (p. 10). Cologne: IW - Institut der deutschen Wirtschaft.
- Kuenzel, R., & Solanic, V. (2018). *Improving the cost-effectiveness of Slovakia's healthcare system* (p. 7). Publications Office of the European Union.
- Lamura, G., Chiatti, C., Barbabella, F., & Di Rosa, M. (2014). *Zweckorientierte Migrationspolitik gegen Fachkräftemangel in der Langzeitpflege* (p. 19). Publications Office.
- MISSOC. (2020). *MISSOC Vergleichstabellen Datenbank Ergebnisse anzeigen*. MISSOC Gegenseitiges Informationssystem für soziale Sicherheit. Retrieved 24 November 2020, from <https://www.missoc.org/missoc-information/missoc-vergleichende-tabellen-datenbank/?lang=de>.
- MoF SR & MoH SR - Ministry of Finance of the Slovak Republic & the Ministry of Health of the Slovak Republic. (2019). *Healthcare spending review II Final report* (pp. 109 - 113). Bratislava.
- Nadash, P., Doty, P., & von Schwanenflügel, M. (2018). The German Long-Term Care Insurance Program: Evolution and Recent Developments. *The Gerontologist, 58*(3), 588 - 597. <https://doi.org/10.1093/geront/gnx018>
- Nádaždyová, M., Brichtová, L., Mesároš, S., Laktišová, M., & Repková, K. (2013). *Filling the gap in long-term professional care through systematic migration policies - In search for win-win solutions in the LTC sector making use of managed migration* (pp. 3 - 6).
- OECD. (2017). *OECD Economic Surveys: Slovak Republic 2017* (pp. 132 - 134). Paris: OECD.
- Österle, A. (2010). Long-term Care in Central and South-Eastern Europe: Challenges and Perspectives in Addressing a 'New' Social Risk. *Social Policy & Administration, 44* (4), 461 - 480. <https://doi.org/10.1111/j.1467-9515.2010.00723.x>

- Rapp, T., & Swartz, K. (2021). Implementing Value-Based Aging in Our Long-Term Care Systems. ISPOR | International Society For Pharmacoeconomics and Outcomes Research. Retrieved 13 April 2022, from <https://www.ispor.org/publications/journals/value-outcomes-spotlight/vos-archives/issue/view/the-benefits-and-challenges-of-aging-in-place/implementing-value-based-aging-in-our-long-term-care-systems>.
- Rodrigues, R. (2015). *Langzeitpflege - das Problem nachhaltiger Finanzierung* (p. 8). European Union.
- Rothgang, H., & Müller, R. (2021). *BARMER Pflegereport 2021 - Wirkungen der Pflegereformen und Zukunftstrends* (pp. 116 - 133). Berlin: BARMER.
- Rothgang, H., & Müller, R. (2018). *BARMER Pflegereport 2018* (pp. 20 - 101). BARMER.
- Rothgang, H., Müller, R., & Unger, R. (2013). *BARMER GEK Pflegereport 2013* (p. 2). Asgard-Verl.-Service.
- Rothgang, H., Müller, R., Mundhenk, R., & Unger, R. (2014). *BARMER GEK Pflegereport 2014* (pp. 17 - 116). Asgard-Verl.-Service.
- Schmähl, W., Augurzky, B., & Mennicken, R. (2014). *Pensions, health and long-term care - Germany* (p. 22). European Commission.
- Schulz, E., & Geyer, J. (2014). Pflegebedarfe und Pflegesettings – Ein Vergleich formeller und informeller Pflege in ausgewählten europäischen Ländern. *Vierteljahrshefte Zur Wirtschaftsforschung*, 83(4), 137 - 157. <https://doi.org/10.3790/vjh.83.4.137>
- Smatana, M., Pažitný, P., Kandilaki, D., Laktišová, M., Sedláková, D., & Palušková, M. et al. (2016). Slovakia: Health system review. *Health Systems In Transition*, 18(6), 122 - 146.
- Social Protection Committee. (2014). *Adequate social protection for long-term care needs in an ageing society* (pp. 12 & 230). Publications Office of the European Union.
- Statistisches Bundesamt (Destatis). (2020). *Pflegestatistik 2019 - Pflege im Rahmen der Pflegeversicherung Deutschlandergebnisse* (p. 19). Berlin: Statistisches Bundesamt. Retrieved from [https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Pflege/Publikationen/Downloads-Pflege/pflege-deutschlandergebnisse-5224001199004.pdf;jsessionid=604212E08388739B2E4B5DF8858494DF.live712?\\_blob=publicationFile](https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Pflege/Publikationen/Downloads-Pflege/pflege-deutschlandergebnisse-5224001199004.pdf;jsessionid=604212E08388739B2E4B5DF8858494DF.live712?_blob=publicationFile)