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Title	Comprehensive Health Care for the Aged and Problems for Care and Nursing in Germany
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Citation	北海道大学医療技術短期大学部紀要, 10, 59-68
Issue Date	1997-12
Doc URL	https://hdl.handle.net/2115/37629
Type	departmental bulletin paper
File Information	10_59-68.pdf

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Comprehensive Health Care for the Aged and Problems for Care and Nursing in Germany

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Abstract

The traditional German health insurance system covers a range variety of needs for health care provision. However, aging of population in Germany progress than Japan and other advanced countries. For this reason, parts of the German population are at a disadvantage. No adequate coverage is accessible to those individuals, who need more than medical care: to long-term patients, to people with handicaps and functional impairments, and to those, whose condition requires rehabilitation, nursing and promotion due to a functional disability. One of the groups mostly affected by the short-comings of the health insurance system is the growing aged population, especially the very old and in particular chronically disabled among them. This paper is a review of the attempts to introduce a new insurance for care. The range of these insurance plans is analyzed in consideration of the increasing need for comprehensive health care in Germany.

Key Words: aged population, domiciliary care, need for care, insurance, hierarchy of services.

1. Introduction

Social security system and medical and health insurance system in Germany are developed mostly in Europe since the Bismark period in the later half of 1800's, the German government founds the insurance system since 1994.

The Japanese government plan to institute the care insurance system currently as for the present situation of Germany and an introduction of the present problems is a important significance.

2. Demographic background

In the unified Germany about 13 million people are 65 years old and older-that are 15.4 percent of the whole German population. (Fig.1) Of this age group 95 per cent live at home and up to 5 percent in institutions, such as nursing homes, homes for the aged and other institutions

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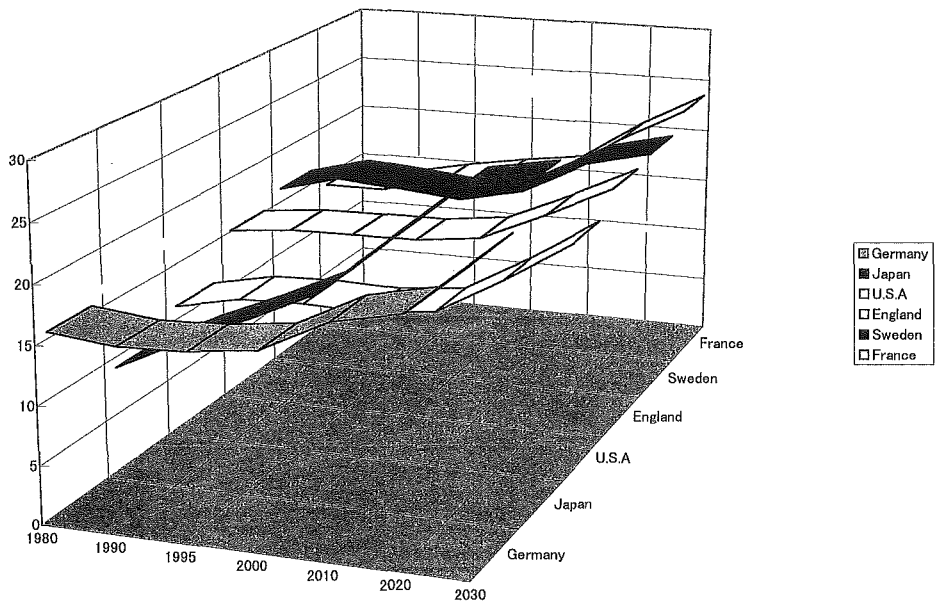

Fig. 1 Comparison of the ratio of agvanced aged. (65 over)

for senior citizens.

Although the average percentage of those aged people, who occupy these special housing facilities is rather low, the portion is four to five times higher among the very old and oldest[1].

During the time span since 1950 the aging of the German population has advanced rapidly. Especially the group of the oldest members of the society has increased. The 85 to 89 years old population has grown by 400 percents, the group of those 90 to 95 years old by 720 percent, and the group of the 95 years old and older has grown by 2,140 percent[1]. It is clear that the elderly-even if the majority is neither ill nor handicapped play an important role among all consumers of the health care provision. Still the German system is not adjusted sufficiently to the requirements of the aged population.

2. Main pillars of the organization of health care for the elderly and coverage of the costs.

The large majority (79.4 million)-of the 81.57 million German population are members of a health insurance. In most cases they belong to an insurance required by law, only 8.8 percent are privately insured[2]. The "direct members", persons who are insured themselves, constitute the main group of the insured population (38.4 percent). Their insurance covers medical and health care also for their dependents(children, wives), who do not draw an income of their own. These last mentioned "indirect members" constitute about one third of the insured population. Old people who draw a retirement income within the statutory pension system are also members of the insurance required by law (which covers also their family members) and are therefore eligible for all available benefits. This group of retired members of the statutory health insurance institutions counts about 14.3 million persons[2].

When an aged person is ill and needs medical treatment at home or in a hospital, he and she faces no problems to get available service. Until today the "need for medical treatment" is the first and the most important factor determining the status of "illness" and as a result of that also the "claim entitlement". According to this regulation which is also reflected by the existing scale of charges for medical treatment, a hierarchy of services and health measures is formed. In spite of the fact, that the strict limitation of the "claim entitlement" (the status of illness defined in terms of medical treatment) had been weakened several times until today, this hierarchy still dominates the insurance regulations and the provision of services. The more specialized the health measure, the easier the reimbursement of the costs by the health insurance institutions. The more sophisticated a treatment, the more specialized medical knowledge and high technology is needed, the higher the resources provided for them by the insurance. This situation clearly mirrors the power of the medical profession, which managed to get control over a great part of the system of social policy and social security[3].

Thus, as far as the service provision for the aged is concerned, priority is given to the medical treatment. The situation starts to be complicated when other services-like rehabilitation, nursing and home care for patients at home-are required. The purpose of providing nursing is to prevent or shorten a stay in hospital, to guarantee the necessary medical care provision, and to ensure continued stay in the private home. The provision of nursing and care can also be granted if hospitalization is necessary but impracticable, or when out-patients' medical treatment presupposes such service. These criteria clearly show that the "need" for nursing and care services has little to do with the "personal need" of the patients, e.g. with their diseases, their symptoms, and their functional impairments in coping with day-to-day living. Instead it is the requirement of the medical part of the care which is of primary importance. It speaks for this interpretation that only the provision of specialized nursing allows for provision of basic nursing, since specialized nursing is defined as an adjunct to medical treatment, and basic nursing (as well as home care) is defined as adjunct to specialized nursing.

Here again the just mentioned hierarchy of services is traceable. Most difficult of all is the reimbursement of the costs for home care (=basic personal care and home making) and home help (=home making), since the traditional coupling of the home care/help to specialized nursing has by no means been divorced by the "reformative" legislation enforced in 1988, which for the first time has recognized "pure nursing" as a statutory payment of the health insurance.

This change has improved only the situation of the people "heavily dependent on care"- of those, who are helpless and continuously needing intense help for all regularly recurring activities. Starting in January 1991 these individuals-Schwer pflege bedurftige-get nursing and help for management of the household lasting up to I hour per visit and up to 25 visits per month. Yet the costs which the health insurance reimburses must not exceed DM 750 per case and month. This reason is a cause that ratios of the person whom a person of advanced aged in Germany compares with other european countries, and is rich are a little. (Fig.2)

Since January 1989 also so called "Urlaubspflege" has been introduced-nursing and care

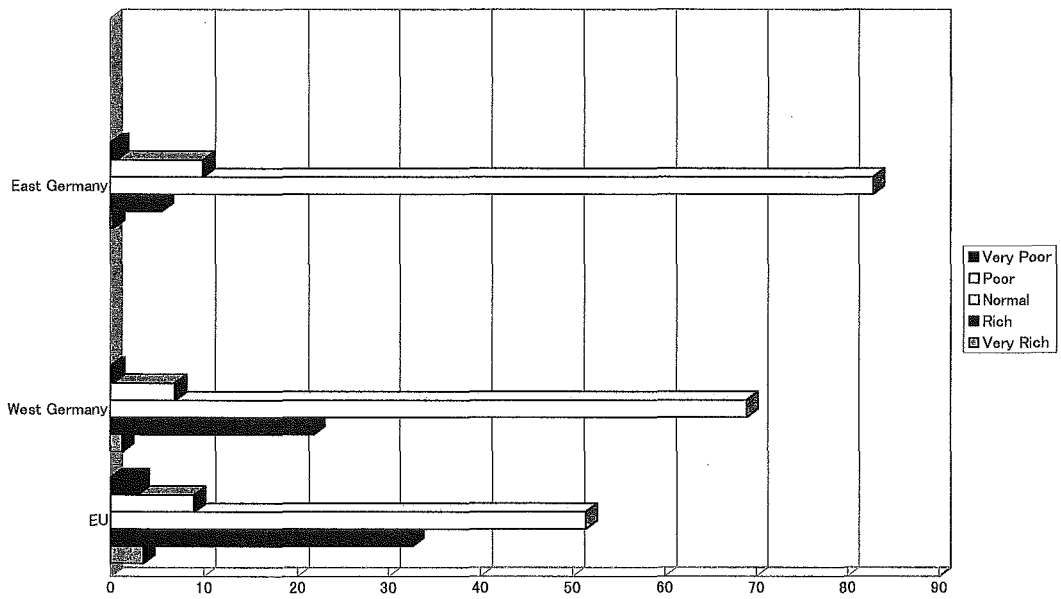

Fig.2 Economy of advanced aged.

during the holiday of the informal care-givers. This provision covers up to four weeks and 1,800 DM.

Like the previous law, the Reich Insurance Code, the "reformative" law emphasizes also the fact that illness is the decisive criterion for the granting of home care and home help as a statutory payment by the health insurance institutions. Whereas the young patients suffering from chronic diseases and injured young persons suffering from long-term effects are usually labeled as ill and as "requiring medical treatment" for a long period of time, and can therefore claim reimbursement of the costs for nursing and care by the health insurance institutions, even when their status does not show any improvement by medical therapy for months, the very old patients and the injured aged are automatically suspected of not being ill but "only" dependent on care, and consequently the costs reimbursement for treatment, rehabilitation and above all for nursing can be stopped at any time.

In such cases, funding of the home care/help may be forth coming from the Federal Social Assistance Act (Bundessozialhilfegesetz-BSHG). This type of funding, however, which is frequently felt as a marginalization, could only be granted after a means test and can therefore also have financial implications for close relatives. In the new federal states particularly many old people fear that their relatives would have to refund the social security benefit[4]. For this reason the community care providers (Sozialstationen) in eastern federal states make little use of the possibilities offered by the Federal Social Assistance Act.

Only 6.5 percent of their total remuneration comes from this source[5]. A similarly difficult situation arises, when care in nursing homes, in homes for the old aged or in any of a number

of geriatric and long term institutions for in-patients and out-patients becomes necessary. It also must frequently be funded on the basis of the Federal Social Assistance Act. The institutions just mentioned are not a part of the health system but of the "social service system". The term "social service system" usually means that the costs must be covered by the individual person or-when he or she is not able to pay (generally the costs go beyond 3,500 DM per month and therefore exceed the retirement incomes of the majority of the population)-by his/her adult children. If the children cannot come up with the resources, the person in need has to apply for social welfare. At present a population of 4.2 million persons are dependent on social welfare, a large portion of them are the old and very old. While in the public statistics only 12.7 million DM were indicated as the expenditure for nursing in 1991[2], the greater part of the real costs appeared as "help in the running of the household" or as "support in a special life situation", and as other social security benefits.

3. Inconsistencies in the utilization of services

The most characteristic consequence of this idiosyncrasy of the German social security system is a disequilibrium in the use of medical care and of other health and social services. On the one hand an enormous portion of the aged population makes frequent use of medical treatment, in particular of doctors and of hospitals. On the other hand only a minority of the aged makes claims for all remaining health and social services.

Number one on the utilization scale are contacts with doctors in free practice. As an illustration I would like to mention some data compiled by my own research team on urban population age 70 to 90 years in 1987, and as a follow-up survey in 1988). Of these age groups more than 80 per cent belonged to the regular users of doctors in free practices. 78 percent of them visited their doctors during the two months prior to the survey.

Another highly relevant health facility is the general hospital. In terms of admission frequency, duration of stay, and the age structure of the patient population, hospitals (not their geriatric wards, but the wards for acute treatment) hold a predominant place among all intramural institutions involved in providing care for chronically ill old people[7,8]. About 20 percent of a surveyed urban population between 70 and 90 years were hospitalized at least one time in the course of 12 months. Within this time period the average length of the hospital stay amounted to 38 days for men and to 42 days for women. The probability of admissions increased with ascending age. More specifically, the oldest women accounted for the greatest number of admissions and days spent in hospitals in the course of one year[6].

Another analysis showed, that from those who were disabled or in need of care 36 per cent were hospitalized during 12 months[9].

Indeed the high and frequent utilization is not the only reason for the fact, that the hospital is such an important institution in the field of care for the elderly. General hospitals (particularly their wards for the acute treatment) substitute increasingly for services which other-underdeveloped or entirely absent-health institutions fail to provide. Moreover, the hospital

fills gaps at the interface between health care and social services and also discharges functions which could be conducted by institutions and networks outside the health care system. In addition, the hospital functions as a major allocates of ambulatory and in-patient services[10]. For example more than 80 per cent of the clients of the home nursing/care are sent to these services by the hospital[11]. The opportunity to get a free place in a nursing home or long-stay institution is actually only available when being transferred from the general hospital. Even the transfers within the nursing homes and long stay institutions (e.g. between levels of different intensity of care) are carried out using frequently the hospitals as shunting points[12].

In comparison to the use made of the doctors in free practice and of hospitals all other health and also social services play a relatively unimportant role.

For example the rehabilitation services for out-patients, like hydrotherapy, physiotherapy, were found to be used extremely seldom, with the utilization rates declining rapidly as one moves from the so called younger to the oldest groups of male and female of 70 to 90 years of age.[6]. Hardly anything was done to stop the progress of functional disabilities and to maintain functional health within the oldest population living in private households[13]. From those aged who were already disabled only a minority gets physiotherapy (20 per cent of those 65 to 79 and 11 percent of those 80 + years old) and occupational therapy (1 percent of each of the age groups mentioned[9].

The rehabilitation services for the aged in-patients are equally under-developed. Despite the fact that the number of institutions providing special rehabilitation for geriatric and psycho-geriatric patients increased between 1979 and 1990 from 65 or 73 to 110 to 109 respectively, the number of beds in these facilities remained unchanged under twenty thousand[14].

Only about 4 percent of the 70 to 89 years old population in an urban and 5 percent in a rural area belonged to the users of home nursing and/or home care. But at the same time at least 3 per cent of these age groups were heavily dependent on care; at least 15 percent of the women and 3 percent of the men needed daily care and support in more than one area of daily living without having back-up for this matter by family members[11].

4. Outlook

1) Domiciliary services have precedence over institutional care.

For this reason an infrastructure of efficient services should be created.

The costs of the investments (approximately 3.6 billion) would be reimbursed on the basis of the insurance via a federal contribution covered by the social security benefits not paid out. From the point of view of the individuals in need the priority of the domiciliary care must not mean blocking the entry to the institutional care for all those patients, who would not reach the highest degree of disability but could not stay at home because of isolation, desperate housing condition, neglect or abuse by relatives.

2) Care by family members and by other informal care-givers has precedence over professional care/nursing.

One of the acknowledged aims of the new law is to support informal care provided by relatives and neighbors. The authors emphasis that the insurance benefits are not thought to be full coverage but a contribution to cover only a part of the costs arising when care/nursing is needed.

Instead other support would be made available to families who care for their disabled members: education and supervision by professional nurses. However this notion does not pay much attention to the prognosis regarding the development of the population[1]. and to the fact that the one person households already are a wide spread living arrangement[6].

3) Care provision to individuals heavily dependent on care has precedence over the support and promotion of less disabled persons.

Only those members of an insurance institution are eligible who are ill or handicapped and therefore permanently not in a position to carry out the common and recurring activities of daily living. The term "permanently" means at least six months. Additionally the need for help has to be comprehensive and large. The amount of the contribution benefits is dependent on the degree of the disability. Many problems are related to the rather restrictive definition of the receivers of the benefits, according to which many individuals actually in a great need Of care and support would be locked out:

_patients suffering from psychiatric and mental problems (at least every third person of the 85 years old and older) who have often no bodily impairments;

_people whose need would be classified as minor-at present about half a million of those who need care several times during a week but not daily[9].

_all those persons who are still not fully dependent on care but are "at risk" of dependency and who need rehabilitation and promotion to regain their functional capabilities (about 26 per cent of people 80+ years of age.

-patients who need much support "only" during the stages of recovery and normalization between the recurrent crises caused by chronic diseases.

4) Basic nursing and home help have precedence over maintenance and promotion of functional capabilities and health.

According to this principle the value of the provision of basic nursing and home help would increase. They would be treated as equal with acute medical treatment and nursing and would gain the position of a central service. The outline stresses the importance of rehabilitation in several places. However only the medical rehabilitation is mentioned explicitly.

At the same time the outline excludes all slightly impaired persons by restrictive classification, despite of the fact that these people would probably have the greatest potential for recovery when some support in activities of daily living were available to them. Thus the

central function of the home help is devaluated.

Despite the proclaimed intention to create an infrastructure for nursing and care and to increase the value of professional nursing, it is not this profession who will discharge the allocation function. Instead the physicians in the medical service of the health insurance institutions and general practitioners will be authorized to make the decision if a person is eligible or not.

5) Orgarnizational solution has precedence over the recognition of the fact that the distinction between the status of illness and the status causing the need for care is inappropriate.

Both insurance institutions-the statutory health insurance institutions required by law and the private institutions-are responsible for their own members. The reason proclaimed by the authors of the outline is: avoiding of quarrels on the reimbursement of the costs in case of "illness" on the one hand and of "need for care" on the other hand. Such quarrels may occur, when the responsibility for the coverage of both not clearly distinctive conditions would be divided. Yet the question is appropriate why, similarly to the existing system, the new one also lays down this dubious distinction?

For the moment the new insurance law has every prospect of realization. Certainly after the last months of discussion it has been substantially cut back. The main characteristic of the recent outline shows that the originally ambitious plans for the Pflegeversicherung shrank and if at all, the insurance will bring rather a limited improvement of the health care for the aged population.

5. Opinion

Social security system and medical and health insurance system in Germany are developed mostly in Europe, the German government founds the insurance system since 1994.

Therefore I compare with Germany and in other European countries, as for degree of satisfaction to an old aged pension in Germany is higher than in other countries. (Fig.3)

In late years, in Germany , increase of a person who is out of work number becomes a serious problem. As the rate of employment of a person of advanced age compare in other country and is low. (Fig.4) About the care insurance system, 80 % of being at home payment recipient selects cash payment. The insurance finances is the black still, but must turn finances into stability in future not to fall quality of care service.

Finally I would compare with German situation and the same situation in Japan, I insist as follows;

An advanced aged man who needs care have a problem of care and large anxiety about old age life, number of people called dementia and "lied idle"' increase and care period is prolonged, the mind and physical load becomes very heavy. Therefore I would emphasis that right and hope of advanced aged persons is respected, quality of life is improved and its policy is rapidly

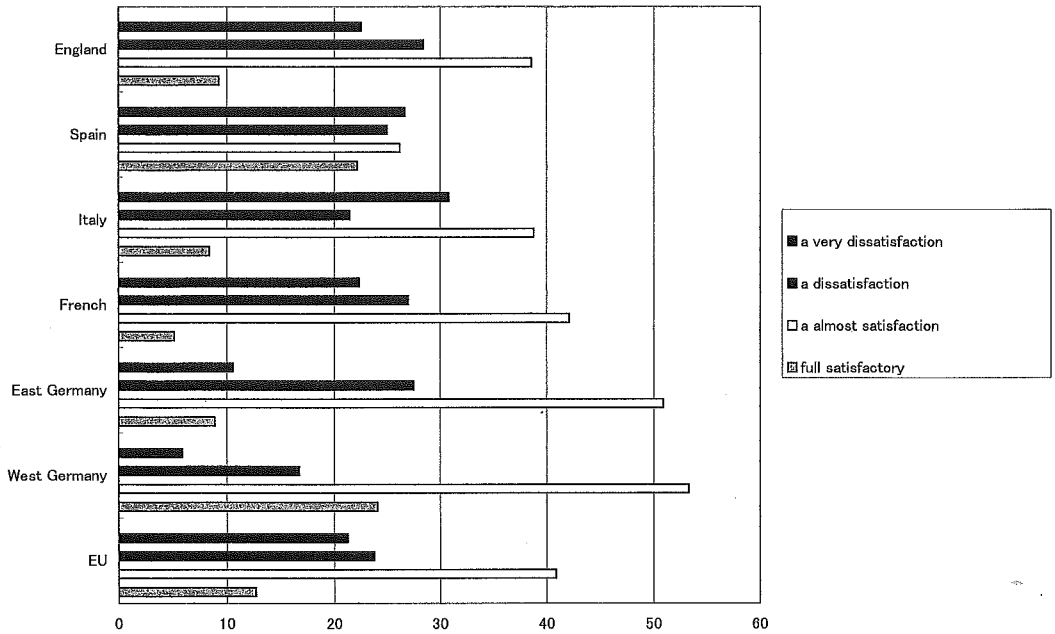

Fig.3 A satisfactory degree to a pension.

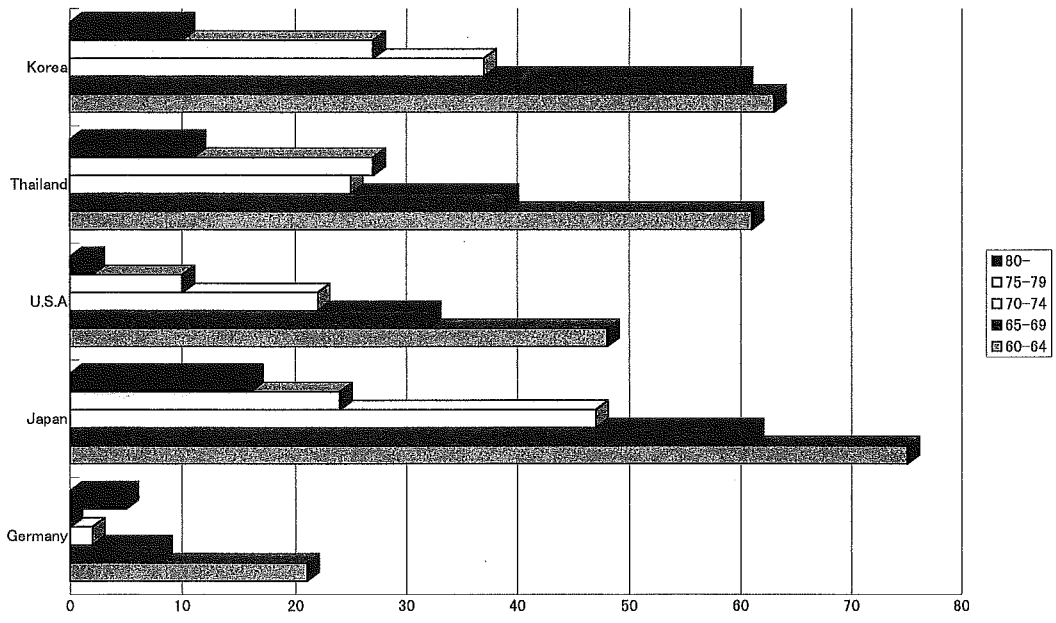

Fig.4 The employment ratio of a person of advanced age.

demanded in Japan.

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