Long term care policy above the fray? The case of German LTC expansion in the face of austerity

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The impact of budget cuts and/or the financial crisis on access and quality in long-term care services

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1. LTCI in Germany: Institutional arrangements prior to 1994

- Risk of requiring long term care borne by individual and his/her family; and the social assistance program, financed by the municipalities, as a safety net where the family failed.
- Growing problem pressure in the 1970s and 1980s due to demographic change and rising demand in long term care; feminization of the workforce; and the protracted effects of economic turmoil of the 1970s.
- Increasing problem recognition by political actors and policy stakeholders.

2. LTCI in Germany: institutional arrangements post 1994

- **Administration:**
  - Social LTCI is administered by LTCI funds founded as branches of sickness funds. LTCI is independent but under the umbrella of health insurance
  - No competition between funds as all contributions go into one fund which covers all expenditure
    → difference to health insurance

- **Mandatory coverage of the whole population:**
  - 88% Social long-term care insurance (LTCI) and special systems for police, military, firemen
  - 12% private mandatory LTCI

2. LTCI in Germany: institutional arrangements post 1994

- **Financing:**
  - PAYGO system in Social LTCI, contributions levied on income from wages and salaries up to a certain income cap. Parity between employers and employees, extra contribution for childless since 2004.
  - Funding in private mandatory LTCI, but with strong elements of PAYGO as benefits were also for those already in need of care and premiums are capped (for the elderly).

- **Expansion:**
  - With the introduction of the LTCI system, public financing for care has increased by a factor of 2.5.
  - From 1997 to 2012, social insurance expenditure has increased by an additional 60% mainly due to rising numbers of beneficiaries (30%), adjustments (7%), additional benefits for people with dementia (6%), and different utilization patterns

2. LTCI in Germany: institutional arrangements post 1994

- **Entitlement:**
  - According to ADL scheme, differentiated according to three levels of care, no age limit, assessment by the Medical Review Board for social insurance members; and a private company, Medicproof, for the privately insured.

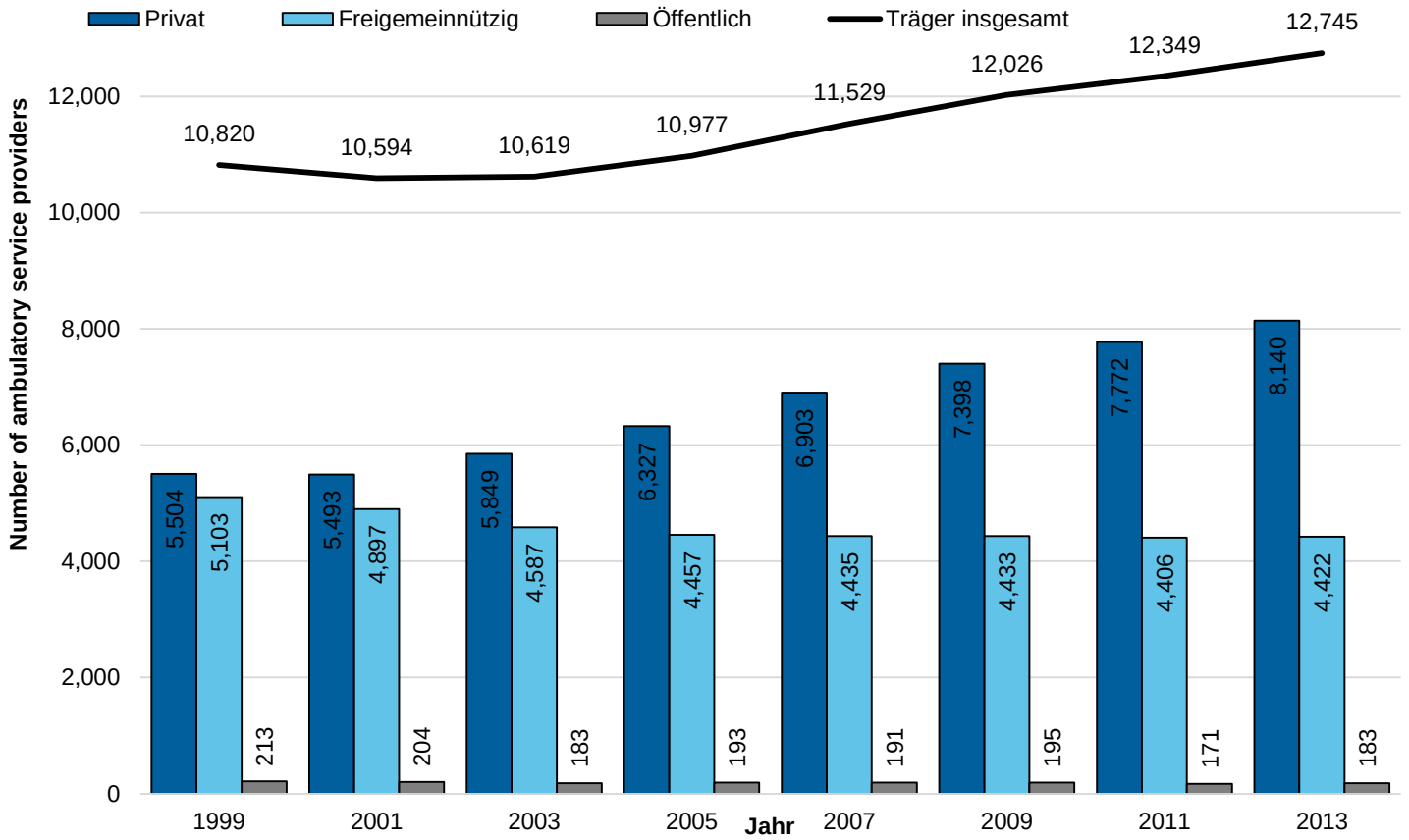
2. LTCI in Germany: institutional arrangements post 1994

- **Benefits:**
  - Cash benefits, in kind benefits (for home care) and benefits for nursing home care with choice for the beneficiary.
  - Capped benefits with caps below need, no provision for automatic adjustment of nominally fixed benefits. Adjustments in 2008 (for 2008-12) and 2015 (for 2012-15).
  - In nursing home care: only capped benefits for care costs, nothing for board and lodging or for investment costs.

  - **Expansion** in years 2001, 2008, 2013 for those affected by mental disabilities, mainly dementia. Another round of expansion planned for 2017. A small round of expansion for others in 2015.

Provider market for formal care, ambulatory services

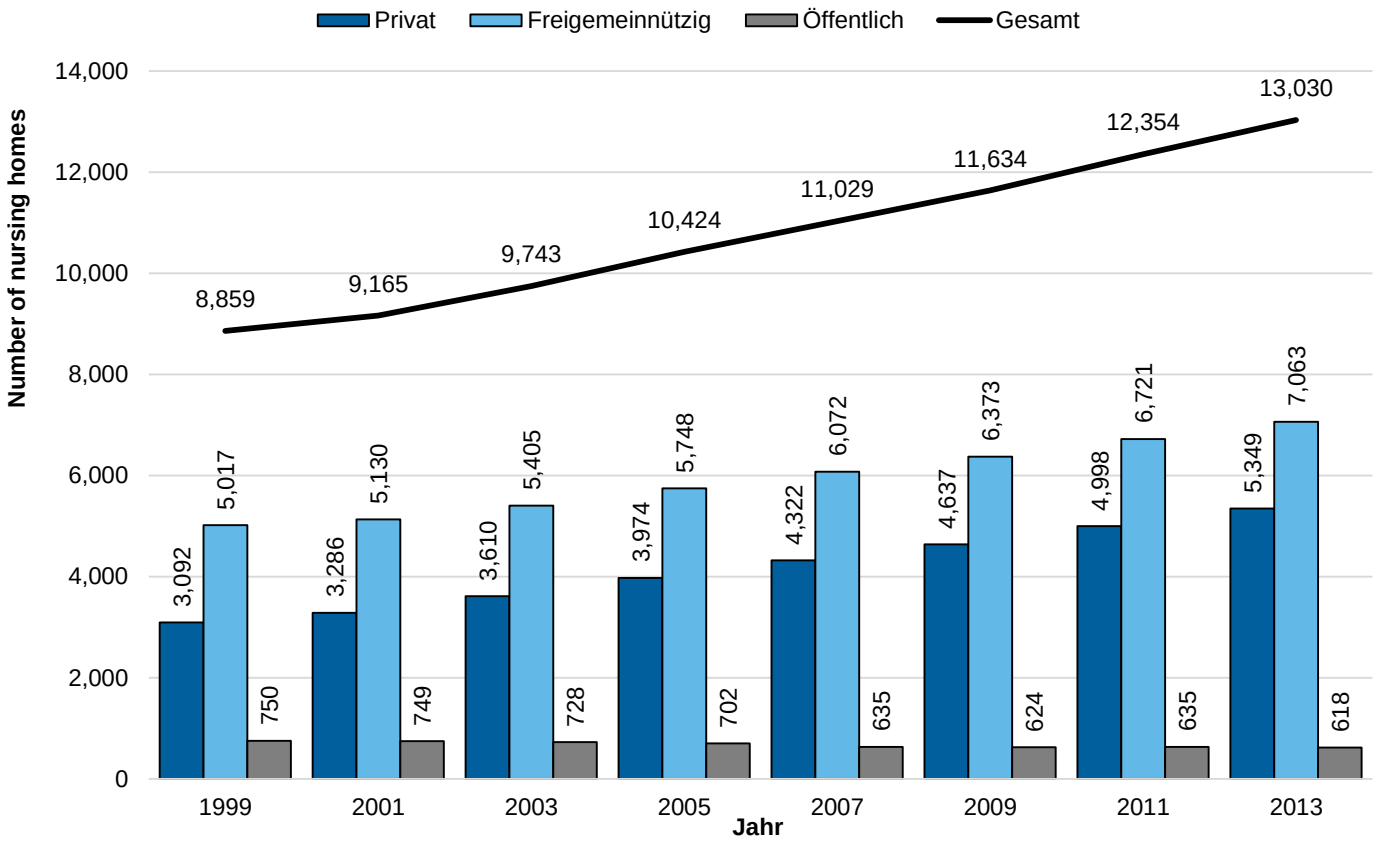
Figure 1: Development in the number of ambulatory service providers (1999 – 2013)



Quelle: Statistisches Bundesamt 2015, 2013, 2011, 2009, 2007, 2005, 2003, 2001, eigene Darstellung.

Provider market for formal care, stationary services

Figure 2: Development in the number of stationary nursing homes (1999 – 2013)



Quelle: Statistisches Bundesamt 2015, 2013, 2011, 2009, 2007, 2005, 2003, 2001, eigene Darstellung.

Capacities of the formal sector

Table 1: Development of care capacities in home services and nursing home services						
	Home care			Nursing home care		For information:
	No. of providers	Staff	W.t.e	No. of Nursing homes	No. of beds	No. of beneficiaries of LTCI
1999	10.820	183.782	108.799	8.859	645.456	2.016.091
2001	10.594	189.567	113.951	9.165	647.292	2.039.780
2003	10.619	200.897	119.793	9.743	713.195	2.076.935
2005	10.977	214.307	125.811	10.424	757.186	2.128.550
2007	11.529	236.162	140.504	11.029	799.059	2.246.829
2009	12.026	268.891	160.921	11.634	845.007	2.338.252
2011	12.349	290.714	178.096	12.354	875.549	2.591.441
2013	12.745	320.077	200.112	13.030	902.882	2.626.206
Change rate in %						
1999–2001	-2,1	3,1	4,7	3,5	0,3	1,2
2001–2003	0,2	6	5,1	6,3	10,2	1,8
2003–2005	3,4	6,7	5	7	6,2	2,5
2005–2007	5	10,2	11,7	5,8	5,5	5,6
2007–2009	4,3	13,9	14,5	5,5	5,8	4,1
2009–2011	2,7	8,1	10,7	6,2	3,6	10,8
2011–2013	3,2	10,1	12,4	5,5	3,1	1,3
1999–2013	17,8	74,2	83,9	47,1	39,9	30,3

Source: Rothgang et al. 2015 based on Statistisches Bundesamt 2015, 2013, 2011, 2009, 2007, 2005, 2003, 2001.

3. Measuring success: a closer look at *access* and *quality*

Table 1: Recipients of social assistance for care

Year	Total	Ambulatory	Stationary
1994	453.613	189.254	268.382
1995	372.828	85.092	288.199
1996	285.340	66.387	219.136
1997	250.911	64.396	186.672
1998	222.231	62.202	160.238
1999	247.333	56.616	190.868
2000	261.404	58.797	202.734
2001	255.883	60.514	195.531
2002	246.212	59.801	186.591
2003	242.066	55.405	186.867
2004	246.372	55.233	191.324
2005	261.316	59.771	202.361
2006	273.063	60.492	213.348
2007	266.701	64.067	203.584
2008	284.899	67.544	218.406
2009	299.321	76.801	223.600
2010	317.670	83.509	235.245
2011	330.400	90.213	241.420
2012	339.392	94.872	245.868

Quelle: Statistisches Bundesamt (2014c)

Increasing numbers

3. Measuring success: a closer look at *access* and *quality*

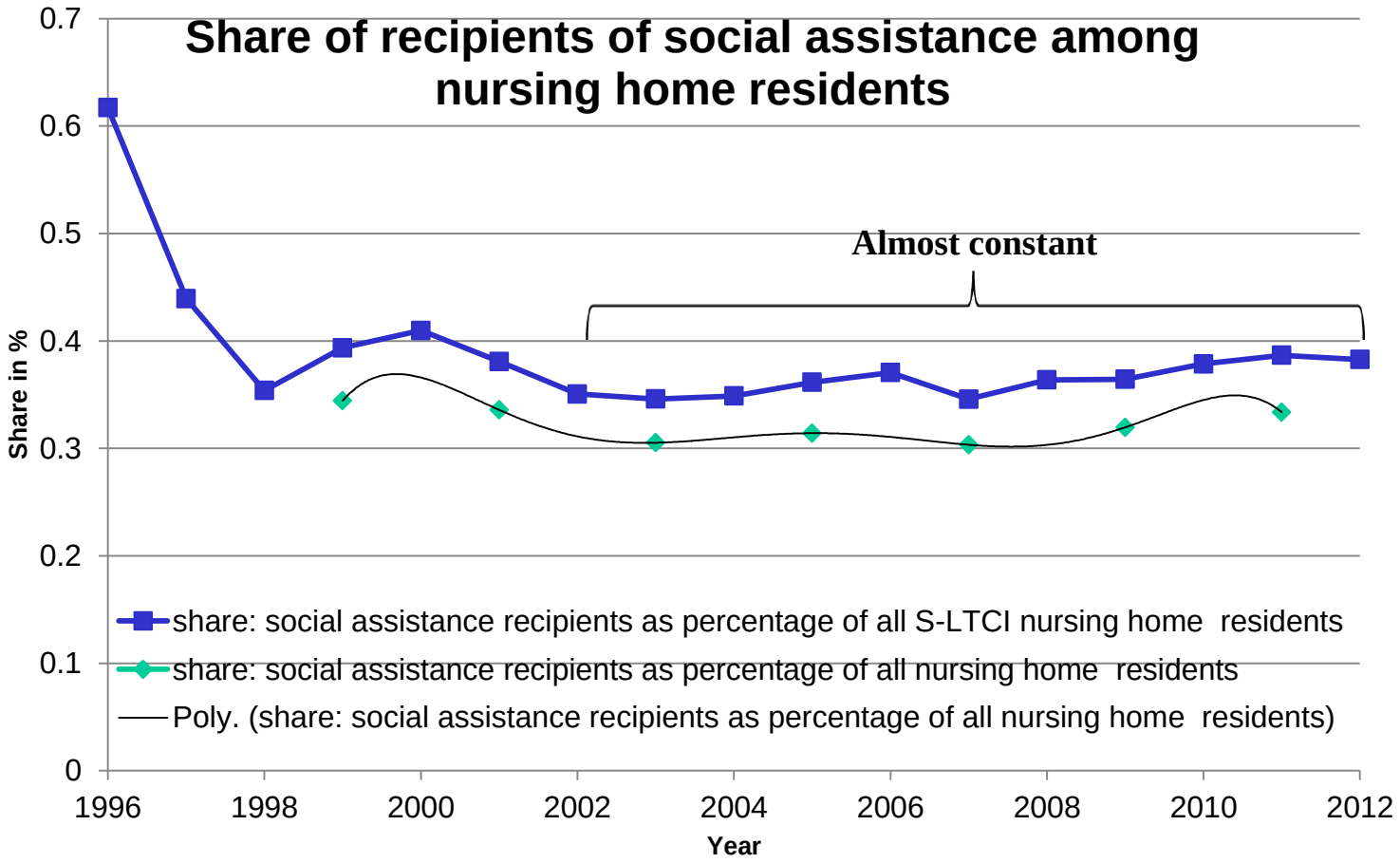
Table 2: Net-expenditure for social assistance for care (in Tsd. €)

Year	Total	Ambulatory	Stationary
1994	6.599.240	803.366	5.795.873
1995	6.263.896	509.492	5.754.404
1996	4.823.045	370.420	4.452.625
1997	2.508.574	375.471	2.133.103
1998	2.284.230	390.280	1.893.949
1999	2.319.851	396.850	1.923.000
2000	2.307.817	421.231	1.895.586
2001	2.349.025	439.419	1.909.605
2002	2.421.293	473.638	1.947.654
2003	2.420.352	514.889	1.905.463
2004	2.513.250	525.181	1.988.069
2005	2.610.673	546.963	2.063.709
2006	2.529.942	600.989	1.928.953
2007	2.666.213	623.611	2.042.602
2008	2.751.300	666.684	2.084.615
2009	2.878.313	714.033	2.164.280
2010	2.966.927	763.163	2.203.763
2011	3.104.107	801.913	2.302.194
2012	3.245.100	850.000	2.394.500

Quelle: Statistisches Bundesamt (2014c)

Increasing numbers

3. Measuring success: a closer look at *access* and *quality*



3. Measuring success: a closer look at *access* and *quality*

Table 4: Nursing home remuneration

	(1)	(2)	(3)	(4)=(1)+(2)	(5)	(6)=(1)-(5)	(7)=(4)-(5)
Level of depend-ency	**Care**	**Room & Board**	**investment**	**Daily rate (total)**	**LTCI benefits**	**Out of pocket care costs only**	**Out of pocket total**
Level I	**1.475**	**651**	**415**	**2.541**	**1.023**	**452**	**1.518**
Level II	**1.875**	**651**	**415**	**2.942**	**1.279**	**596**	**1.663**
Level III	**2.365**	**651**	**415**	**3.432**	**1.550**	**815**	**1.882**

Data from December 2013

- Today LTCI benefits do not even cover care costs
- Out of pocket payment is higher than LTCI benefits – in all levels of dependency.

3. Measuring success: a closer look at *access* and *quality*

Greater emphasis on quality and reporting:

- 2002: Pflege-Qualitätssicherungsgesetz (PQsG):
  - Attempt to enforce quality control by contracts between funds and providers: never introduced properly, failed
  - Failure: has never been fully implemented and then been abolished

- 2008: Pflege-Weiterentwicklungsgesetz (PfWG)
  - Mandatory internal quality management
  - Mandatory standards e.g. for treating decubitus
  - Frequency of quality control increased by factor 10
  - Publication of reports of quality control

→Highly contested but huge potential to increase competition for quality

3. Achievements of the German LTCI system

- Acknowledging long-term care as a social risk
- Establishing coverage of the whole population
- Increasing public spending: by a factor 2.5 in 1994
- Reducing the number of people in nursing homes dependent on welfare
- Dramatically reducing expenditure on social assistance for people in nursing homes
- Improving care infrastructure (quantitatively)
- Putting quality high on the policy agenda
- Working with a stable contribution rate for 15 years

4. Long term care: Germany's policy darling. *But why?*

Three levels of explanation:

- Policy rationale: fiscally (versus socially) driven system
- System or typological: social insurance system type is relatively insulated from economic and political instabilities
- Economic: After 2009 crisis has not been felt in Germany

Main theses

1. LTCI was introduced due to fiscal reasons (releasing municipalities from the burden of social assistance for people in nursing homes) rather than social policy reasons. Thus, there will be resistance against cuts in LTCI benefits as it will once again lead to rising burden for municipalities on welfare

2. Generally speaking, social insurance systems are better protected against cuts than tax-financed systems.
   - First, due to the contributions paid insures are entitled to benefits that cannot be withdrawn easily.
   - Second, in insurance systems the entitlement is set and financing is the variable – in taxed-financed NHS systems it is the other way round.

Main theses

3. The crisis hit Germany only in 2008/9 and has been overcome since then. So, there is no crisis left that could lead to cuts.

4. We rather envisage a considerable *expansion* of LTCI over the last years and expect a new round of expansion in 2017, where one of the shortcomings of the original institutional setting, i.e. the strict definition of “need of long-term care”, which ignored the specific needs of people with dementia, will be healed.

The end

Thank you for your attention!

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3. Measuring performance: a closer look at *access*

Beneficiaries of Social LTCI				
	Total	Level I	Level II	Level III
1995	1.061.418	-	-	-
1996	1.546.746	620.318	670.147	256.281
1997	1.659.948	727.864	675.965	256.119
1998	1.738.118	804.356	682.431	251.331
1999	1.826.362	872.264	698.846	255.252
2000	1.822.169	892.583	683.266	246.320
2001	1.839.602	916.623	679.472	243.507
2002	1.888.969	956.376	685.524	247.069
2003	1.895.417	971.209	679.159	245.049
2004	1.925.703	991.467	685.558	248.678
2005	1.951.953	1.010.844	688.371	252.738
2006	1.968.505	1.033.272	683.109	252.124
2007	2.029.285	1.077.718	693.077	258.490
2008	2.113.485	1.136.500	712.621	264.364
2009	2.235.221	1.214.670	743.970	276.581
2010	2.287.799	1.258.732	750.664	278.403
2011	2.317.374	1.298.951	742.429	275.994
2012	2.396.654	1.356.345	756.892	283.417
2013	2.479.590	1.410.646	779.903	289.041
Quelle: (BMG 2014b)				

In total: 2.6 mio beneficiaries in 2013

- 30% in nursing home care
- 20% in home care using formal services
- 50% just family care

3. Measuring performance: overall financing

Estimated Sources of Funding for Long-term Care in 2012			
Source of Expenditure	in billion. €	As % of all public/private Expenditures	As % of total expenditure
Public Expenditure		100	64.8
Social LTCI	22.94	84.5	54.7
Private LTCI	0.78	2.9	1.9
Social Assistance	3.50	12.0	7.7
Welfare for War Victims	0.20	0.7	0.5
Private Expenditure	14.79	100	35.2
Nursing home care	10.48	70.9	25.0
Community Care	4.31	29.1	10.3
Total	41.96	---	100
Source Rothgang et al. 2014: 133			

3. Basic facts: Capacities in formal care-giving

Capacities in home care and nursing home care since 1999

	Home Care			Nursing Home Care		For
	Providers	**Employcees**	**Full-time equivalents**	**Nursing homese**	**Beds**	**LTC beneficiaries**
1999	10.820	183.782	108.799	8.859	645.456	2.016.091
2001	10.594	189.567	113.951	9.165	647.292	2.039.780
2003	10.619	200.897	119.793	9.743	713.195	2.076.935
2005	10.977	214.307	125.811	10.424	757.186	2.128.550
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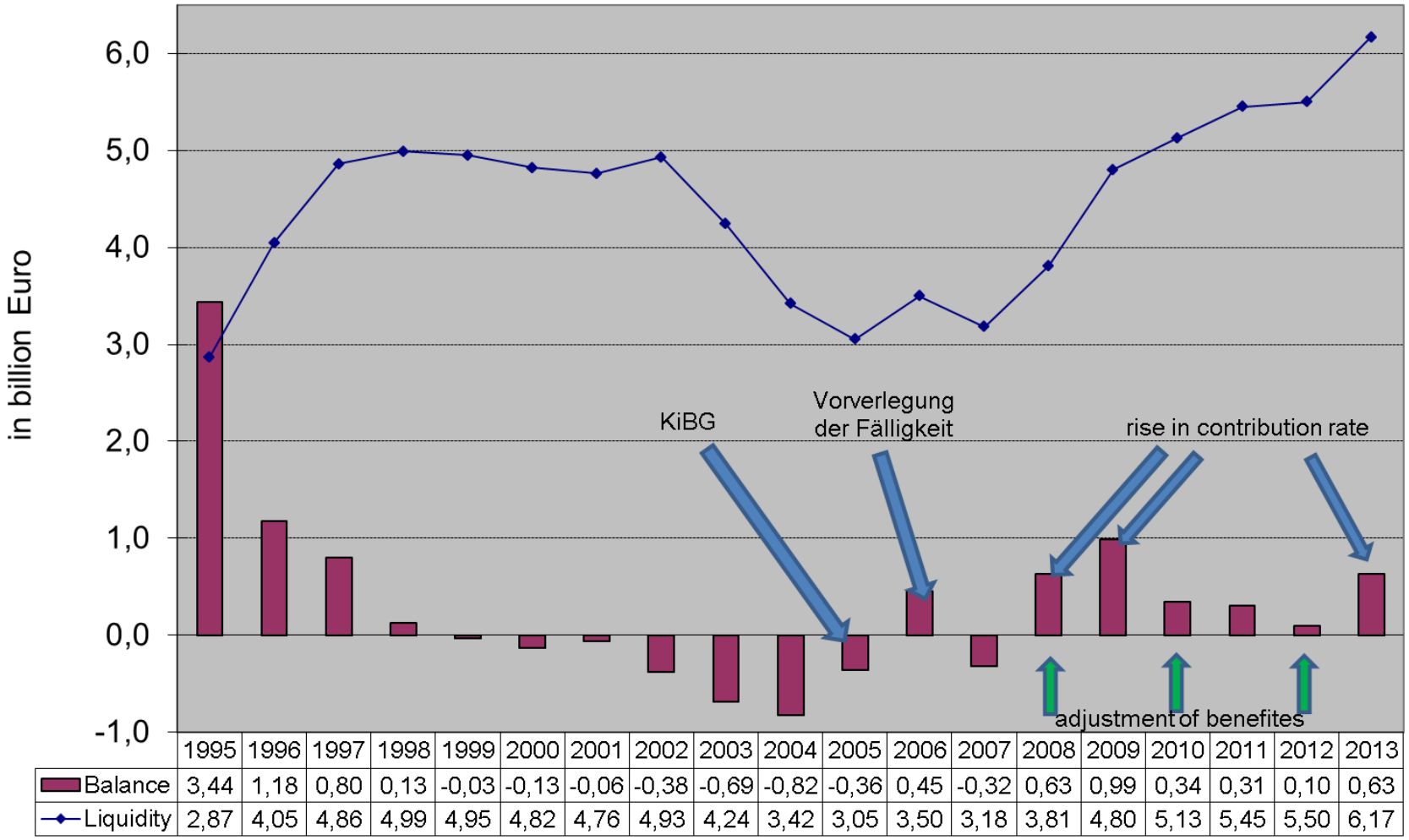
2013	12.745	320.077	200.112	13.030	902.882	2.626.206
			Growith in %			
1999–2001	-2,1	3,1	4,7	3,5	0,3	1,2
2001–2003	0,2	6	5,1	6,3	10,2	1,8
2003–2005	3,4	6,7	5	7	6,2	2,5
2005–2007	5	10,2	11,7	5,8	5,5	5,6
2007–2009	4,3	13,9	14,5	5,5	5,8	4,1
2009–2011	2,7	8,1	10,7	6,2	3,6	10,8
2011–2013	3,2	10,1	12,4	5,5	3,1	1,3
1999–2013	**17,8**	**74,2**	**83,9**	**47,1**	**39,9**	**30,3**

Sources: Statistisches Bundesamt 2015, 2013, 2011, 2009, 2007, 2005, 2003, 2001, eigene Berechnung

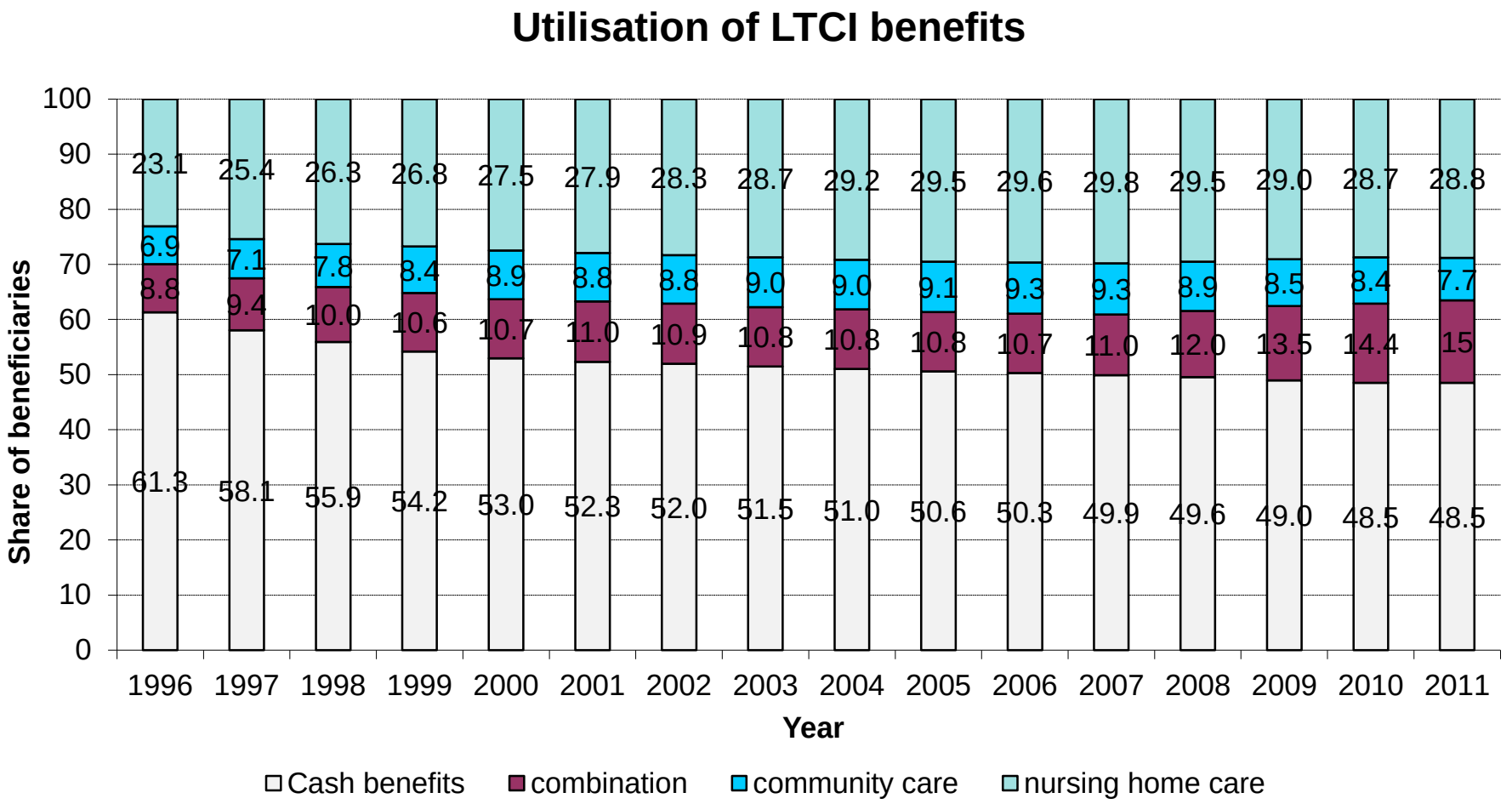
3. Basic facts: Balance Sheet of Social LTCI



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Balance	3,44	1,18	0,80	0,13	-0,03	-0,13	-0,06	-0,38	-0,69	-0,82	-0,36	0,45	-0,32	0,63	0,99	0,34	0,31	0,10	0,63
Liquidity	2,87	4,05	4,86	4,99	4,95	4,82	4,76	4,93	4,24	3,42	3,05	3,50	3,18	3,81	4,80	5,13	5,45	5,50	6,17

Source: own depiction based on data published by the Federal Ministry of Health

3. Basic facts: Shift towards intramural care



Source: own calculations based on data published by the Federal Ministry of Health

3. Basic facts: Nursing home remuneration

Monthly rates, LTCI benefits and out of pocket payments in € / Month

	(1)	(2)	(3)	(4)=(1)+(2)	(5)	(6)=(1)-(5)	(7)=(4)-(5)
Level of depend-ency	**Care**	**Board & lodging**	**investment**	**Daily rate (total)**	**LTCI benefits**	**Out of pocket care costs only**	**Out of pocket total**
Level I	**1.369**	**629**	**395**	**2.393**	**1.023**	**346**	**1.370**
Level II	**1.811**	**629**	**395**	**2.836**	**1.279**	**532**	**1.556**
Level III	**2.278**	**629**	**395**	**3.302**	**1.510**	**768**	**1.792**

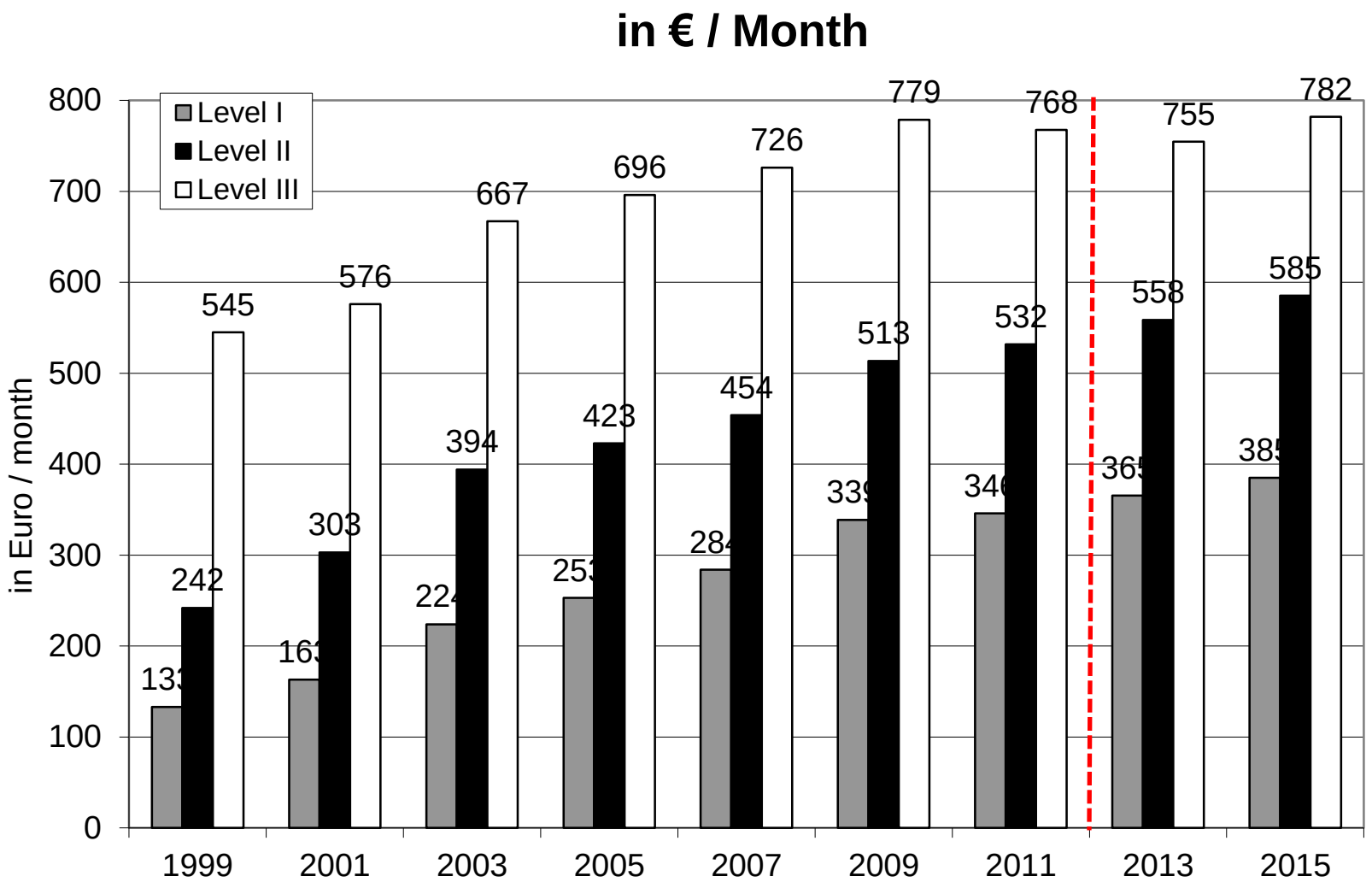
Data from December 2011

- Today LTCI benefits do not even cover care costs
- Out of pocket payment is higher than LTCI benefits – in all levels of dependency

3. Basic facts: Benefits and co-payments (1/2)

- From 1994 to 2008 LTCI benefits have been kept constant in nominal terms.
- Real purchasing power has been decreasing considerably and out of pocket payments increased.
- Only 2008 a first adjustment was introduced
  - Increase: 1.4 per cent per year for 2007-2012, about inflation rate
  - Financed by an increase in contribution rate from 1.7 to 1.95 percent
  - For some benefits there is no increase at all
- 2015: next adjustment: 4 % for all benefits in order to adjust for the inflation 2012-15

3. Basic facts: Benefits and co-payments (2/2)



4. Achievements of the system and future challenges (1/2)

- Achievements
  - Acknowledging long-term care as a social risk
  - Coverage of the whole population
  - Increasing public spending: factor 2.5 in 1994
  - Reducing the number of people in nursing homes depending on welfare
  - Huge reducing of expenditure on social assistant for people in nursing homes
  - Improving care infrastructure (quantitatively)
  - Putting the quality issue on the agenda
  - Work with a stable contribution rate for 15 years

3. Achievements of the system and future challenges (2/2)

- Future Challenges
  - Proper adjustment of benefits
  - Future lack of formal and informal care-givers
  - Quality of Care
  - Definition of entitlement: better provision for people with dementia
    - Most recent reform 2015 / 2017 → massive expansion of benefits (about 5 billion € per year)
  - Sustainable Financing of LTCI
    - Recent reforms: supplementary funding schemes

4. Funding as a supplement in a PAYGO System

- Two new mechanisms for introducing funding in LTC
  1. 2013: Supplementary subsidised voluntary LTC insurance (“Pflege-Bahr”)
  2. 2015: Collective provident fund within Social LTCI (“Pflegevorsorgefonds”)

What is the “Pflege-Bahr”?

- Tax-financed subsidy of 5 Euro per month on contracts
  - with a premium of at least 10 Euro / month
  - benefits of at least 600 Euro in care level III
  - obligation to except every applicant not yet in need of LTC
  - no medical underwriting, but age specific premiums
  - Waiting time no longer than 5 years

Effects and problems of the new subsidy (“Pflege-Bahr”)

- Number of insurees will be limited
  - For 2013: Government put 90 million Euro aside → 1.5 million contracts
  - By the end of 2013: < 400,000 contracts (about 1% of working population)
  - In the long run: < 10% of working population
- Due to social welfare: insurance is unattractive for households with low income
- Redistribution from the bottom to the top as those with lower income will finance tax-subsidy for better off households that buy insurance

Effects and problems of the new subsidy (“Pflege-Bahr”)

- Benefits are insufficient

Monthly „financing gap“ in nursing homes with and without „Pflege-Bahr

	Financing gap		„Pflege-Bahr“	Remaining gap	
	Care costs	total		Care costs	total
Care level I	346	1.380	120	226	1.260
Care level II	532	1.566	180	352	1.386
Care level III	768	1.802	600	168	1.202

Source: own calculation using the „Musterkalkluation“ of private insurance companies

Effects and problems of the new subsidy (“Pflege-Bahr”)

- adverse selection
  - New insurance is particularly attractive for those who could not buy “normal” insurance
  - Due to this risk selection premiums must be higher
  - In the US a respective programme (CLASS Act) was stopped as “unworkable” and then withdrawn
  - Insurance companies are safe as waiting time works as a safety net for the first five years and premiums may be raised thereafter
- Biggest danger: “Pflege-Bahr” might legitimize insufficient adjustments in Social LTCI

What is the “Pflegevorsorgefonds”?

- Starting in January 2013 contribution rate is increased by 0.1 percentage point → revenue of about 1.2 billion Euro
- This additional contribution rate is collected until 2033 and managed by the Deutsche Bundesbank
- From 2035 onwards a maximum of 1/20 of the capital reached then is given to Social LTCI to prevent increasing contribution rates
- Once all is spent the fund will be closed

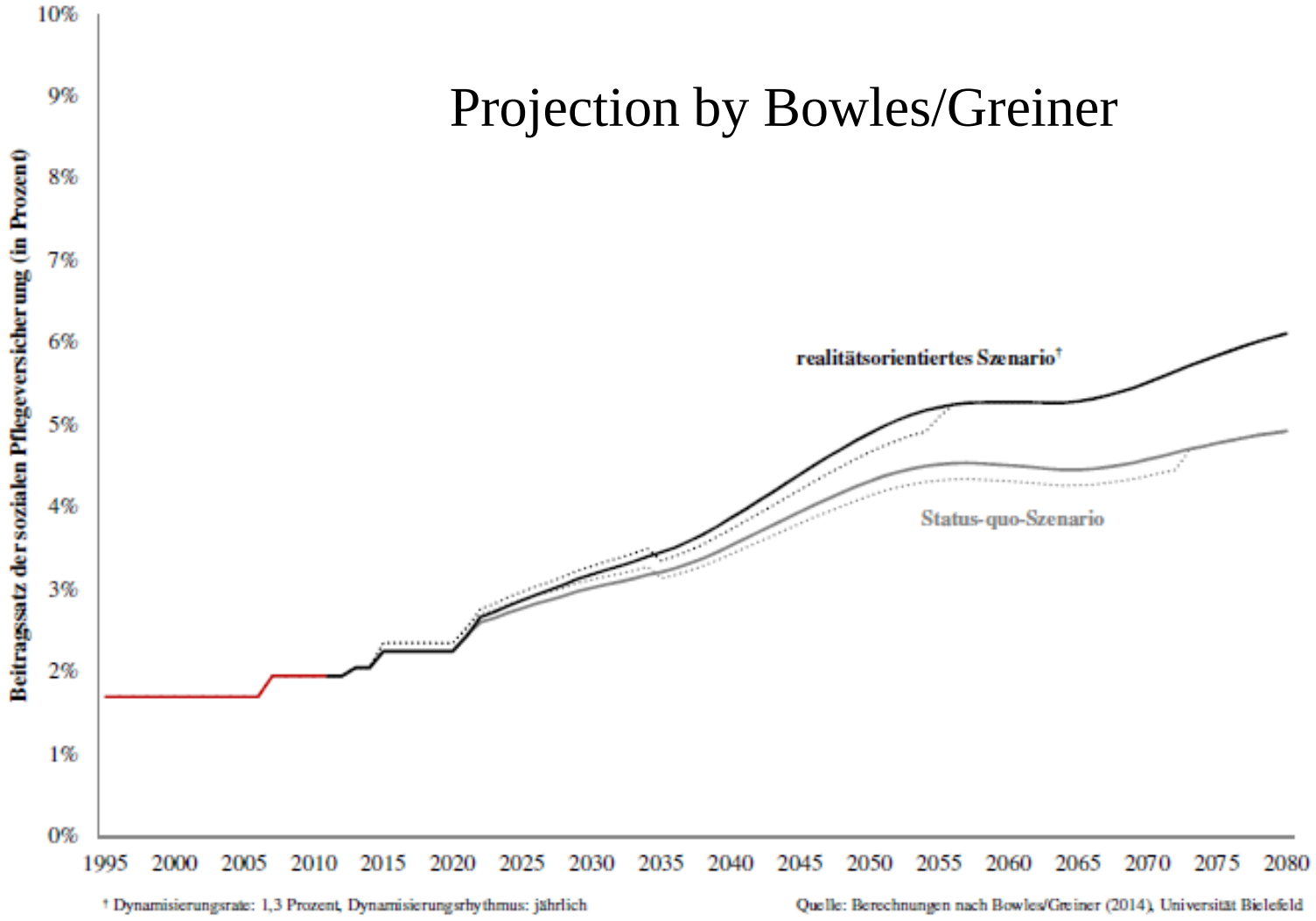
Effects and problems of the “Pflegevorsorgefonds”?

1. The effect is very small
   - For 20 years the contribution rate is increased for 0.1 percentage point
   - For another 20-25 years the contribution rate is then reduced by 0.1 percentage points

2. It is difficult to protect such a fund against politicians once there is a fiscal crisis

3. The fund will be empty when we have the highest number of LTCI beneficiaries. While number of beneficiaries will decrease then, contribution rate will not.

4.2 Long-term projection of contribution rate



5. Some lessons from the German Experience

- (Mandatory) social insurance is a proper solution for the social risk LTC - but should be constructed properly
  - A social insurance should include the total population.
  - Contributions should be levied on all kinds of income, not just on income from gainful employment.
  - The definition of entitlement should be broad enough to include e.g. people suffering from dementia properly.
  - Considerably co-payments are possible, but proper adjustment of benefits is vital.
- Due to demographic and socio-economic change the contribution rate necessarily goes up over time
- Supplementing a PAYGO system with elements of funding is difficult.

5. Some lessons from the German Experience

- Free market access stimulates formal care capacity expansion
- Cash benefits may stabilize family care-giving. More sustainable is the combination of cash benefits and formal services
- Case and care management is necessary, particularly if beneficiaries may choose between different kinds of benefits. The potential of the civic society must be exploited
- Nursing home care is expensive and leaves the potential of dependent people and family caregivers unused. It needs more professional care-givers than we have and should therefore be limited by offering alternatives in home care.

4. Recent reforms and remaining challenges (1/3)

- 2002: Pflegeleistungs-Ergänzungsgesetz (PflEG)
  - Extra benefits for those suffering from dementia (460 € per year)
  - Failure: potential beneficiaries did not take it
    - Expenditure: 30 Mio. € per year in 2007 – expected: 230 Mio. Euro
    - after enlargement of benefits to 1,200 or 2,400 (more severe cases) Euro per year and entitlement also for those who are below the threshold for LTCI benefits, expenditures have risen to 190 Mio. Euro in 2009

- 2002: Pflege-Qualitätssicherungsgesetz (PQsG)
  - Attempt to enforce quality control by contracts between funds and providers: never introduced properly, failed
  - Failure: has never been fully implemented and then been abolished

4. Recent reforms and remaining challenges (2/3)

- 2008: Pflege-Weiterentwicklungsgesetz (PfWG)
  - Quality
    - Mandatory internal quality management
    - Mandatory standards e.g. for treating decubitus
    - Frequency of quality control increased by factor 10
    - Publication of reports of quality control

      → Highly contested but huge potential to increase competition for quality
  - Rehabilitation
    - For providers: if due to rehabilitation level of dependency decreases a bonus is given to cover loss in remuneration
    - For sickness funds: penalty for not granting rehabilitation to LTCI fund

      → Due to close link between LTCI and sickness fund unlikely to work
  - Case and care management

    → High potential for improvements but difficulties in implementation
  - Adjustment of benefits

    → Very important, but still insufficient
  - Increasing contribution rate from 1.7/1.95 to 1.95/2.2

4. Recent reforms and remaining challenges (3/3)

- The 2008 reform
  - did not touch *entitlement*: next reform is underway
  - was weak on *financing*: reform only buys time, next reform is underway
  - Introduced *adjustment*, but
    - Adjustment rate is low (2007-2012: 1.4 percent per year)
    - Adjustment formula for 2015 is insufficient (minimum of inflation and rises of average wages)
    - Adjustment is insecure as it should only be checked every three years whether it is affordable
    - No changes are to be expected
  - is doomed to fail with respect to *rehabilitation*:
    - Possible solution: introducing competition also among LTCI funds

→ The next reform is just around the corner

Appendix: Need for future reform

Vergütung in der vollstationären Pflege (in € pro Monat)

	Pflegesatz der Pflegeklasse			Durchschnitt-licher Pflegesatz	Unterkunft und Verpflegung und Pflegesatz der Pflegeklasse		
	I	II	III		I	II	III
1999	1.155	1.520	1.976	2.056	1.702	2.067	2.523
2001	1.186	1.581	2.006	2.120	1.763	2.158	2.584
2003	1.246	1.672	2.098	2.194	1.824	2.250	2.675
2005	1.277	1.702	2.128	2.223	1.855	2.280	2.706
Wachstum 1999-2005	10,5	12,0	7,7	8,1	9,0	10,3	7,2
Durchschnittliches jährliches Wachstum	1,68	1,90	1,24	1,30	1,44	1,65	1,17

Anmerkung: Für die Jahre 1999 bis 2001 liegen die Angaben in Euro / Tag, gerundet auf ganze Euro-Beträge vor. Wegen dieser Rundungsungenauigkeit sind die Daten für Unterkunft und Verpflegung für sich genommen nicht aussagekräftig.

Quelle: eigene Berechnungen nach Daten der Bundespflegestatistik, publiziert in Statistisches Bundesamt 2002, 2003b, 2005, 2007

1. The introduction of LTC insurance: Goals and rationale (1/2)

- Underlying problem perception
  - Demographic change: number of dependent elderly was expected to grow
  - Socio-structural change: care capacities of families were expected to decrease
  - Increasing numbers of dependent elderly in nursing homes were relying on (means-tested) social assistance

- LTCI was fostered by two distinct discourses
  - Welfare state discourse:
    - German welfare state aims at status maintenance.
    - It is “unworthy” if citizens with after a normal working life depend on welfare just because of needing long-term care
    - High share of welfare recipients was perceived as social scandal
  - Fiscal policy discourse
    - Municipalities were increasingly suffering from high expenditures for people in nursing homes. Federal states acted as advocates.

1. The introduction of LTC insurance: Goals and rationale (2/2)

- Reshaping of the welfare state rather than expansion:
  - Introduction of LTCI was accompanied by cuts in other welfare state areas
  - LTCI marks break with German tradition of service provision according to needs (as in health insurance)
  - LTCI Act was shaped in order to prevent any “cost explosion” thereafter
    - Tight definition of dependency
    - Capped benefits (nominally fixed)
    - Discretionary adjustment of benefits

- Compromise between Christian Democrats and Liberals: two-pillar system with
  - Social LTCI as PAYGO system, but
  - Private mandatory System as funded system

3. Measuring success: a closer look at *access* and *quality*

Table 3: Developments in expenditure for care services, 2003 and 2013					
	2003		2013		Change
Expenditure recipients	Mio. €	in %	Mio. €	in %	in %
Facilities in total	43.499	100,0	58.802	100,0	35,2
Ambulatory facilities	6.735	15,7	12.475	21,2	85,2
Ambulatory care	6.647	15,5	12.344	21,0	85,7
Other ambulatory facilities	88	0,2	131	0,2	48,9
Stationary/Partly-stationary facilities	31.016	72,4	38.916	66,2	25,5
Hospitals	18.385	42,9	21.579	36,7	17,4
Prevention/Rehabilitation facilities	785	1,8	886	1,5	12,9
Stationary/Partly-stationary facilities	11.846	27,6	16.451	28,0	38,9
Other facilities, private households	5.653	13,2	7.237	12,3	28,0
Abroad	95	0,2	174	0,3	83,2
Source: Gesundheitsberichterstattung des Bundes 2015a, own calculation and presentation.					