Social Security and Long-Term Care Dependency in Switzerland

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Contents

For more details, in particular on jurisprudence see: Bischberger/Landolt, Absicherung der Pflegebedürftigkeit in der Schweiz, Zeitschrift für ausländisches und internationals Sozialrecht (ZIAS) 2013, 105–168 (in German language).

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1 Introduction

Since the founding of the Swiss Federal State in 1848, a very complex coexistence of laws has been developed with refined legal foundations, procedures and allowances, providing social protection against the risks of old age, illness and accident. As a result, there is an increased need for coordination between legislations and the consistent use of terms and concepts.

Societal changes (such as heterogeneous familial structures, professional and social mobility or new employment patterns), the rise in chronic diseases, increasing life expectancy with considerably longer disability-free years including, however, also increasing frailty and, consequently, the need for help in old age,[1] as well as longevity *with* adverse health effects due to pharmaceutical, technical and surgical progress require support, including professional guidance and advice, and the coordination of services particularly in private households.

Swiss social security legislation makes a difference between *need of support* (of a person who requires assistance with regard to the activities of daily living such as personal hygiene or household maintenance), *need for attendance* (in case of a health condition which requires professional nursing care, particularly regarding

[1] Cf. Lieberherr et al. (2010).

guidance and advice with respect to the provision of nursing care[2]) and *long-term care dependency* as part of the entire system of dependence on support.[3]

In Switzerland, the number of persons requiring long-term care is estimated at 115,000–135,000.[4] By 2030 this number will have risen to 170,000 or 230,000, depending on the scenario.[5] Especially the need for help with household chores and the activities of daily living is growing exponentially in old age.[6]

In 2004 family caregivers provided about 34 million hours of support and long-term care to adults in private households. This does not include informal assistance from private persons to other households: 12% of women and 11% of men engage in this kind of assistance with about 100 million hours per year, unpaid.[7]

The relatively rare *special risk* of "long-term care dependency" involves high costs for the cantons, communities and the individual, including the opportunity costs incurred by family members.[8] According to the Swiss care provision principles, support and long-term care in the case of long-lasting functional restrictions are mainly provided by the private household of the person concerned and his/her relatives.[9]

It is not guaranteed that the staff offering the services for the care providers are qualified professionals. In 2009 only two thirds of the required professional care staff were trained so that there was a lack of 2400 qualified carers,[10] and, according to forecasts, approximately 25,000 additional qualified carers will be needed by 2020.[11]

Need of support, need for attendance and long-term care dependency and their costs and financing will therefore become *central social tasks* in the future.[12]

[2]See Art. 7 Para. 2 lit. a KLV.

[3]Cf. Wingenfeld et al. (2011) and Landolt (2001b, 2002a, b, 2003, 2009).

[4]Cf. Höpflinger and Hugentobler (2005), p. 48.

[5]Cf. Höpflinger et al. (2011), p. 10.

[6]Cf. Lieberherr et al. (2010), p. 23 ff.

[7]Cf. Schön-Bühlmann (2005). These numbers are based on the Swiss Labour Force Survey [*Schweizerische Arbeitskräfteerhebung, SAKE*] or, where applicable, taken from the "Unpaid Work" module. This report distinguishes between long-term care and assistance on the one hand, and informal care provision and services provision on the other.

[8]Cf. Perrig-Chiello and Höpflinger (2012), Bischofberger (2011).

[9]Cf. Höpflinger et al. (2011).

[10]Cf. Swiss Conference of the Cantonal Healthcare Directors [*Schweizerische Konferenz der kantonalen Gesundheitsdirektoren, GDK*] (2009).

[11]Cf. Swiss Observatory on Healthcare [*Schweizerisches Gesundheitsobservatorium, Obsan*] (2009).

[12]See on this also the 2020 health policy priorities (Prioritäten Gesundheit 2020) of the Swiss Federal Council (http://www.bag.admin.ch/gesundheit2020/ – last viewed on 23/07/2013).

2 Foundations of the Swiss Long-Term Care Insurance System

2.1 Constitutional Foundations

In Art. 41 (1) (b), the Federal Constitution (BV) obliges the federal authorities and the cantons to ensure, in addition to the individual's personal responsibility and private initiative, that *every person is provided the necessary care required for his/her health.*[13] This refers neither to a competence provision[14] nor to a fundamental social right, but is merely a social objective.[15] Also from Art. 12 BV (right to seeking help in situations of need) no right arises regarding domiciliary care.[16]

Federal mandates regarding social security matters[17] exist with respect to the social risks of old age and disability,[18] as well as illness and accident.[19] On the basis of Art. 3 BV, of a specific constitutional provision[20] or a responsibility delegated by the federal government,[21] the cantons may also adopt new social security standards.

The social security competence provisions do not refer to long-term care dependency as a separate issue. The term has, however, many features in common with other constitutionally recognised facts related to dependency.[22] As long-term care dependency is always a consequence of old age, illness or accident, the federal government primarily has to determine whether and in what way the costs for long-term care are to be covered by social security. In contrast, the cantons and communities are first of all held responsible for the provision of sufficient long-term care.

[13]Cf. Art. 41 Para. 1 lit. b BV.

[14]Cf. Art. 41 Para. 3 BV.

[15]Cf. Art. 41 Para. 4 BV.

[16]Cf. judgment BGer of 17.06.2005 (2P.73/2005) E. 5.

[17]See e.g. Art. 59 Para. 5 BV and Art. 112 ff. BV.

[18]Cf. Art. 112 f. BV.

[19]Cf. Art. 117 BV.

[20]Cf. Art. 114 Para. 4 BV and Art. 115 BV.

[21]Cf. e.g. Art. 111 Para. 3 BV.

[22]E.g. old age (Art. 8 Para. 2, 41 Para. 2 and 111 BV), disability or, respectively, disabled persons (Art. 8 Para. 2 and 108 Para. 4 BV), very old persons (Art. 108 Para. 4 and 112 Para. 4 BV), persons in need (Art. 108 Para. 4 and 115 BV), invalidity or, respectively, invalids (Art. 41 Para. 2, 111 and 112 Para. 6 BV), illness or, respectively, mental illness (Art. 41 Para. 2, 117, 118 Para. 2 lit. b, 119 Para. 2 lit. c and Art. 136 Para. 1 BV), accident (Art. 41 Para. 2, and 117 BV) as well as the need for subsistence support (Art. 112 Para. 2 lit. b BV and 10th transitory provision [*Übergangsbestimmung*] BV).

2.2 *Dual Financing System*

In the overcomplicated dual financing system relating to the costs of attendance and longterm care, the federal government and the cantons grant various allowances for care services to persons dependent on long-term care in terms of *subject financing* [*Subjektfinanzierung*], in particular helplessness allowances (including a supplement for intensive care and compensation for support in life skills), long-term care allowance, care support devices and reimbursement for services provided by third parties, as well as care vouchers.

In addition, the federal government and the cantons provide *object financing* [*Objektfinanzierung*] to facilities for people with disabilities, long-term care facilities[23] and aid groups.[24] Depending on whether the subsidies are associated with the individual level of attendance required by a person in need of long-term care or not, we speak of subject-oriented object financing (sometimes also called indirect or pseudo-subject-related financing [*indirekte oder unechte Subjektfinanzierung*], or of pure object financing [*reine Objektfinanzierung*]. In cases in which the nursing home[25] or long-term care expenses[26] are not covered by social insurance, the cantons may choose between object financing and (pseudo-)subject-related financing.

3 Subsidies Granted to Long-Term Care Facilities

3.1 *General*

State subsidies for both inpatient care facilities (*hospitals [Spitäler]*[27] pursuant to Art. 39 (1) KVG, *nursing homes [Pflegeheime]*[28] pursuant to Art. 39 (3) KVG and *other homes*, particularly *facilities for persons with disabilities*[29,30]) and outpatient

[23]Cf. Art. 25a KVG and infra margin No. 21 ff; Landolt (2010a).

[24]Cf. Art. 74 IVG and Art. 17 Para. 1 ELG.

[25]Cf. Art. 13 Para. 2 ELG.

[26]Cf. Art. 25a Para. 5 KVG.

[27]Art. 39 Para. 1 KVG.

[28]Art. 39 Para. 2 KVG.

[29]According to Art. 3 IFEG, the following are considered as institutions supporting the inclusion of persons with disability:

- facilities which employ on-site or at decentrally located workplaces invalids who could, under normal circumstances, not exercise any gainful activity,
- residential homes and other assisted forms of collective living for persons with disability,
- daycare centres where persons with disabilities spend their time in a community and can participate in leisure and gainful activity programmes.

[30]Art. 25a ELV does not distinguish between the terms 'long-term care home' and 'facility for persons with disabilities'. A care home is considered to be any facility which is recognised by a

care services (Spitex organisations[31] or freelance professional nursing staff[32]) are regulated in various cantonal decrees.[33]

3.2 *Facilities for Persons with Disabilities*

The IFEG and subsidiary cantonal law have obliged the cantons since 1 January 2011 to implement a subsidy and supply system for the nursing homes and the facilities for persons with disabilities located in their own territory.[34]

Art. 7 IFEG[35] requires *cost sharing by the canton of residence* of a disabled person who is accommodated in a recognised care institution either within or outside of the canton of domicile.[36] Co-payments must cover the costs in a way so that "no disabled person will become dependent on social assistance because of such accommodation".[37]

The IFEG does not stipulate *insurance payments or subsidies* to be granted by the cantons; there must be a *legal entitlement to subsidies,* however, if cantonal law provides for co-payments to be made in terms of subsidies to recognised institutions

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canton as a home or which has obtained cantonal approval for operation. If—in connection with the granting of helplessness allowance—the IV authority grades an insured person as a care home resident within the meaning of Art. 42ter Para 2 IVG, this grading is also valid for claims to supplementary services as are deliverable to care home residents.

[31]Cf. Art. 51 KVV.

[32]Cf. Art. 49 KVV.

[33]E.g. in the canton of Zurich: Long-Term Care Act [*Pflegegesetz*] of 27/09/2010 (855.1) and the Regulation on Long-Term Care Provision [*Verordnung über die Pflegeversorgung*] of 22/11/2010 (855.11), as well as the Act regarding Facilities for Adult Invalids [*Gesetz über Invalideneinrichtungen für erwachsene Personen (IEG)*] of 01/10/2007 (855.2) and the Regulation on Facilities for Adult Invalids [*Verordnung über Invalideneinrichtungen für erwachsene Personen (IEV)*] of 12/12/2007 (855.21).

[34]Cf. Art. 10 Federal Act of 6 October regarding Institutions Supporting the Inclusion of Invalids [*Bundesgesetz vom 6. Oktober 2006 über die Institutionen zur Förderung der Eingliederung von invaliden Personen (IFEG)*].

[35]Art. 7 I.E. reads (translated):

1. The cantons bear part of the expenses incurred for a stay in an approved facility to the extent that no invalid needs to claim social assistance due to such a stay.
2. If an invalid cannot find placement in a facility approved by the canton of residence that adequately meets the needs of the invalid, the latter is—in line with Para. 1—entitled to claim contributions from the canton to costs incurred for placement in a different institution which meets the conditions according to Art. 5 Para. 1.

[36]The Intercantonal Agreement on Social Institutions [*Interkantonale Vereinbarung für soziale Einrichtungen (IVSE)*] of 13 December 2002 http://www.sodk.ch/ueber-die-sodk/ivse.html has the purpose of facilitating without impediments the intercantonal placement of persons with special requirements regarding assistance and support in appropriate institutions outside their canton of residence.

[37]Cf. Art. 7 Para. 1 IFEG.

or disabled persons.[38] To guarantee that the persons concerned are accommodated in appropriate institutions, federal legislation obliges the cantons to establish a requirement and disability concept, and it obliges the canton of domicile to make co-payments within and outside the canton.[39]

If persons in need of long-term care are *accommodated in an institution for disabled persons outside their canton of residence*, there is an obligation on their part, according to Art. 28 (2) IVSE and the provisions of the canton of residence, to participate in the costs: partially or entirely, by using their income and part of their assets.[40]

3.3 Nursing Homes

According to Art. 39 (3) KVG, "nursing homes" are considered to be homes and facilities and their departments serving *long-term and medical care*[41] *as well as the rehabilitation of long-term patients.*[42] Homes which primarily focus on non-medical care, such as homes for the elderly that have no long-term care unit or residential homes for needy persons are excluded, as are hospices serving medical and palliative care of the seriously ill and dying persons who are covered by social insurance.[43]

Nursing homes must be recognised under health insurance law (Art. 39 (1) KVG), dispose of sufficient medical care capacities,[44] the necessary qualified personnel[45] and adequate medical facilities.[46] They must comply with the cantonal and intercantonal assessment of needs, have received a service mandate or be cited on the cantonal nursing homes list.[47]

According to the Swiss Sickness Insurance Act/Swiss Health Care Benefits Ordinance (KVG/KLV) and subsidiary cantonal law, the pension costs are borne by the person in need of care and the local canton. As to the long-term care costs, the health insurance funds solely contribute to the nursing and Spitex care costs,[48]

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[38]Cf. Art. 8 IFEG.

[39]Cf. Art. 2 and 7 IFEG.

[40]Cf. Art. 28 Para. 3 IVSE.

[41]Nursing and medical care not only include care treatment but also the general and socio-psychiatric basic nursing care (cf. Art. 7 Para. 2 KLV).

[42]Cf. Art. 39 Para. 3 KVG.

[43]Cf. judgment EVG of 19/12/2001 (K 77/00) E. 3b.

[44]Cf. RSKV (1979), p. 277.

[45]Cf. 107 V 54 E. 2a and RSKV (1979), p. 277.

[46]See on this BGE 115 V 38 E. 9b/aa and 107 V 54 E. 1 and 2.

[47]Cf. Art. 39 Para. 3 KVG.

[48]Cf. Art. 25a Para. 1 KVG. The care home tariff, valid as of 1 January 2011, provides for 12 needs levels or, respectively, a monthly allowance of CHF 270.– (tariff level 1: daily long-term care needs of up to 20 min) through to CHF 3240.– (tariff level 12: daily long-term care needs of more than 220 min) (cf. Art. 7a Para. 3 KLV).

while the person in need of care pays up to 20% of the maximum long-term care contribution and the remaining amount of the costs is borne by the canton.[49] It is up to the cantons to decide whether the maximum co-payment is required from the person in need of care. In the light of the principle that "outpatient care has precedence over inpatient care", some cantons, such as Zurich, take over half of a patient's co-payment in the case of long-term care being rendered in the private household.[50]

The costs of hospital care, as well as of intensive and transitional care if necessary after a hospital stay and if medically ordered by the hospital, will, however, be reimbursed by mandatory health insurance and by the canton of residence of the insured person for a maximum period of 2 weeks according to the rules governing hospital financing.[51] Care costs are co-financed on a 55:45 basis, with 55% borne by the canton of residence and 45% by the insurance company.[52]

4 Care Benefits

4.1 Historical Development

The governmental duty of care for helpless persons ["*Hülflose*"] was first recognised under the "Pension Law" of 7 August 1852. The Federal Act on Health and Accident Insurance with the inclusion of military insurance of 5 October 1899[53] stipulated that sickness benefits were to be increased by 100% in the case of complete helplessness.[54] Later the "supplementary pension for helpless people" was transferred into the Federal Health and Accident Insurance Act of 13 June 1911,[55] Art. 77 of which stipulated that pensions be increased from 70 to 100% of the annual insured income if the insured person was „helpless in such a way that he or she is in need of special maintenance and care". Art. 26 of the Federal Military Insurance Act of 23 December 1914[56] provided for a similar regulation with regard to sickness benefits. Art. 42 of the Federal Military Insurance Act of 20 September 1949[57] provided for an increase in daily sickness allowances and invalidity

[49]Cf. Art. 25a Para. 5 KVG.

[50]Cf. e.g. § 9 Para. 2 Long-Term Care Act [*Pflegegesetz*] of 27/09/2010 (Canton of Zurich).

[51]Cf. Art. 25a Para. 2 KVG.

[52]Cf. Art. 49a Para. 2 KVG.

[53]See BBl 1899 IV 61.

[54]Similarly, Art. 24 Para. 9 and Art. 29 Para. 2 Federal Act regarding the Insurance of Military Persons against Illness and Accidents [*Bundesgesetz betreffend Versicherung der Militärpersonen gegen Krankheit und Unfall*] of 28 June 1901 = BBl 1901 III 65.

[55]Cf. BBl 1911 III 523.

[56]See BBl 1915 I 45.

[57]Cf. BBl 1949 II 509.

pensions and stipulated, in addition, an "appropriate allowance" if "helplessness requires extraordinary expenditures".

With the entering into force of the IVG, Swiss Parliament decided to create a legal entitlement to helplessness allowances: "Helpless persons are those who, because of their disability, permanently require help from a third person or personal surveillance to carry out activities of daily living."[58] In 1968 an entitlement to helplessness allowance was also introduced in the AHV.[59] The restrictive criterion for severe helplessness were eased in the years following 1968. However, it is only since the entering into force of the new care-financing arrangement on 1 January 2011 that also moderate helplessness is considered with a view to an entitlement to helplessness allowance, however only for those old-age pensioners who are not accommodated in nursing homes.[60] In accident insurance, the terms on helplessness allowance were only laid down in 1981.

4.2 Helplessness Allowance

4.2.1 General

The helplessness allowance granted by AHV/IV is exclusively financed by the federal government[61] and is only granted to insured persons[62] who have their residence[63] and habitual abode[64] in Switzerland. Contrary to the premium-financed helplessness allowance granted by accident insurance, this allowance is a special non-contributory benefit that is not subject to the principle of the exportation of benefits.[65]

Helplessness allowance is granted, at the earliest, from the day of birth.[66] Insured persons who have not yet completed the first year of age are entitled to helplessness benefits as soon as it has been ascertained that they are likely to suffer from helplessness for more that 12 months.[67]

[58]Art. 42 Para. 2 aIVG (1967).

[59]Amendment to the Federal Act regarding Pension and Survivors' Insurance [*Änderung des Bundesgesetzes über die Alters- und Hinterlassenenversicherung*] of 4 October 1968.

[60]Cf. Art. 43bis Para. 2 AHVG.

[61]Cf. Art. 77 Para. 2 IVG.

[62]Cf. Art. 43bis Para. 1 AHVG and Art. 42 Para. 1 IVG.

[63]Cf. Art. 13 Para. 1 ATSG.

[64]Cf. Art. 13 Para. 2 ATSG.

[65]Cf. on this BGE 132 V 423.

[66]Cf. Art. 42 Para. 4 IVG.

[67]Cf. Art. 42bis Para. 3 IVG.

4.2.2 Helplessness

4.2.2.1 General

Helpless persons are those who—due to impaired health—permanently require assistance from third persons or personal surveillance to carry out activities of daily living.[68]

4.2.2.2 Assistance with Carrying Out Activities of Daily Living

The activities of daily living cover six areas[69]:

- dressing/undressing
- getting up, sitting/lying down
- eating
- personal hygiene
- using the toilet
- mobility.

The requirements are fulfilled if a person in need of help regularly depends to a considerable degree on assistance through another person with respect to one of the above activities.[70] In the legal practice, a distinction is made between *direct and indirect*[71] *third party help.*

4.2.2.3 Need for Surveillance

Severe helplessness[72,73] means that the insured person regularly depends to a considerable degree on the help of a third party with respect to all activities of daily living and, furthermore, that he or she is permanently in need of long-term care or personal surveillance.[74] Moderate helplessness, in contrast, requires permanent personal surveillance or particularly intensive long-term care.[75]

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[68]Cf. Art. 9 ATSG and e.g. Art. 37 IVV and Art. 38 UVV.

[69]With further references BGE 121 V 88 E. 3a.

[70]Cf. BGE 117 V 146 E. 2. The need for assistance is regarded as considerable, for instance, if the insured person cannot cut his/her meals into small pieces or if he/she cannot hold the eating utensils him−/herself, cf. BGE 106 V 158 E. 2b; Landolt (1995).

[71]Cf. e.g. BGE 133 V 472 E. 5.1, 121 V 88 E. 3c as well as 107 V 145 E. 1c and 136 E. 1b; Landolt (2004).

[72]Cf. Art. 37 Para. 1 IVV and Art. 38 Para. 2 UVV.

[73]Cf. Art. 37 Para. 3 lit. b IVV and Art. 38 Para. 4 lit. b UVV.

[74]Cf. Art. 37 Para. 1 IVV.

[75]Cf. Art. 37 Para. 3 IVV and Art. 38 Para. 4 UVV.

A permanent personal need for surveillance corresponds to a need for support with respect to two of the six activities of daily living and is deemed to be moderate helplessness.[76] Moderately severe helplessness is assumed if there is a need for support with respect to two of the four above-mentioned activities of daily living, and, in addition, permanent personal surveillance.[77]

A permanent personal need for surveillance[78] involves a *need for qualified surveillance*[79] and goes beyond the mere *need for minor surveillance*.[80] Permanent personal surveillance is hence a kind of medical or nursing care service which is needed due to the insured person's physical, mental or psychological state of health.[81] This service is required if a third person must be present to help the dependent person get up during the night.

As a rule, permanent need for long-term care is a criterion met by tetraplegics,[82] who will require help with taking *medicines*[83] and the daily opening of drug packages.[84]

4.2.2.4 Long-Term Care Dependency

4.2.2.4.1 Permanent or Particularly Intensive Long-Term Care

Severe helplessness only applies if an insured person regularly depends to a considerable degree on the help of a third party with respect to all activities of daily living and is permanently in need of long-term care or personal surveillance.[85] Moderate helplessness, in contrast, requires permanent personal surveillance or particularly intensive long-term care.[86]

"Permanent surveillance" means that a certain medical or nursing care service is required due to the insured person's physical, mental or psychological state of

[76]Cf. Art. 37 Para. 3 IVV and Para. 38 Para. 4 UVV.

[77]Cf. Art. 38 Para. 3 UVV.

[78]Art. 37 Para. 2 lit. b IVV bzw. Art. 38 Para. 3 lit. b UVV.

[79]Cf. BGE 107 V 145 E. 1d.

[80]Art. 37 Para. 1 IVV and Art. 38 Para. 2 UVV.

[81]Cf. judgment BGer of 05/03/2009 (8C_912/2008) E. 3.2.3 and furthermore BGE 107 V 136 E. 1b and ZAK 1990, 44 E. 2c. The need for permanent care services does not mean that the cargiver is tied exclusively to the person dependent on help, and it neither means 24-hour-care, but is rather to be understood in terms of care services that are not of a temporary nature.

[82]Cf. judgment BGer of 19/06/2007 (U 595/06) E. 3.2.2.

[83]Cf. judgment EVG of 03/09/2003 (I 214/03) E. 4., also qualifies in terms of the need for supervision, cf. judgment BGer of 23/09/2003 (I 360/03) E. 4.1.

[84]Cf. judgment EVG of 03/09/2003 (I 214/03) E. 4, not, however, in the case of a roughly 15-minute long supervision of the taking of daily medication, cf. judgment EVG of 21/11/2006 (H 4/06) E. 4.2.

[85]Cf. Art. 37 Para. 1 IVV.

[86]Cf. Art. 37 Para. 3 IVV and Art. 38 Para. 4 UVV.

health. The term "nursing care" implies, for example, that there is a need to administer medication or apply bandages on a daily basis. "Permanent" in this context does not mean "around the clock" but stands in opposition to "temporary".[87]

Long-term care is "particularly intensive" if it is very time-consuming, causes high expenses or has to be provided under aggravated circumstances, e.g. in cases where it proves to be especially strenuous or has to be delivered at an unusual time.[88] A daily need for care of 2–2.5 h must certainly be classified as especially intensive when aggravating qualitative factors come into play.[89]

4.2.2.4.2 Intensive Long-Term Care Dependency

Invalidity insurance grants insured persons under age 18 a supplement for intensive long-term care.[90] The text of the law acknowledges "intensive long-term care" as a service covered by this insurance.[91] Also the "increased demand for treatment and basic care compared to that required by non-disabled minors of the same age" is allowable,[92] but not the amount of time required for medically prescribed treatment or pedagogical therapeutic care.[93]

Intensive care refers to an allowable increase in long-term care of a daily average of at least 4 h. Additionally required permanent surveillance is allowable in terms of 2 h of care, and particularly intensive surveillance due to a disability in terms of 4 h.[94]

The monthly supplement for intensive long-term care due to disability amounts to the following percentage of the maximum pension level[95]:

- 60% (CHF 46.80) in the event of at least 8 h of attendance a day
- 40% (CHF 31.20) in the event of at least 6 h of attendance a day
- 20% (CHF 15.60) in the event of at least 4 h of attendance a day

des Höchstbetrages der Altersrente.

[87]Cf. BGE 116 V 48 E. 6b.

[88]Cf. margin No. 8057 KSIH.

[89]Cf. judgments BGer of 31.05.2005 (I 565/04) E. 4.2.1 and of 07/11/2001 (I 633/00) E. 1.

[90]Cf. Art. 42ter Para. 3 IVG and Art. 39 IVV.

[91]Cf. Art. 42ter Para. 3 IVG.

[92]Cf. Art. 39 Para. 2 IVV.

[93]Cf. Art. 39 Para. 2 IVV.

[94]Cf. Art. 39 Para. 3 IVV.

[95]Cf. Art. 42ter Para. 3 IVG.

4.2.2.5 Life Skills Assistance

A person who lives in his/her home environment and is permanently dependent on life skills assistance due to impaired health is also referred to as a helpless person. An allowance for life skills assistance represents an "additional and autonomous provision of support"[96] for psychologically, physically and mentally disabled persons.[97] If only the psychological health is impaired, the person involved must at least be entitled to a quarter pension for helplessness to be assumed. The mere requirement of permanent life skills assistance always refers to moderate helplessness.[98]

There is need for life skills assistance if an adult insured person does not live in a nursing home,[99] is covered by invalidity insurance (IVG)[100] and is no longer able to *live independently* without the help of another person because of an impairment of his/her health, if he or she depends on other persons with regard to the *activities of daily living or contacts outside the house* or if there is a high risk of this person *permanently isolating him–/herself from the outside world.*[101] Only such life skills assistance is to be taken into account which is required on a regular basis and within the context of the abovementioned situations.

It is of no importance whether the "assistance" is provided directly or indirectly. The aide can therefore also carry out the required activities him/herself if the insured person is not able to do so in spite of detailed instructions or surveillance/control in consequence of health problems.[102] Furthermore, it is also of no relevance whether the assistance services are free of charge or not.[103]

Life skills assistance does, however, not cover direct or indirect help from another person with respect to the six activities of daily living, nor does it cover the provision of long-term care or surveillance to the person insured. It is rather a complementary, autonomous provision of support.[104] If the focus is on active attendance with regard to the three aforementioned spheres of life, primarily with a view to facilitating independent living, a need for surveillance is not to be assumed.

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[96]BGE 133 V 450 E. 9.

[97]Cf. judgments BGer of 23/10/2007 (I 317/06) E. 4.3.2, of 23/07/2007 (I 211/05) E. 2.2.3 and of 17/10/2005 (I 528/05) E. 1.

[98]Cf. Art. 42 Para. 3 IVG.

[99]Cf. Art. 42bis Para. 5 IVG and Art. 38 Para. 1 IVV.

[100]In accident insurance and for *old-age pensioners* (cf. BGE 133 V 569 E. 5.3 and 5.5) no allowance is paid for life skills assistance. If the helplessness status is only partly due to an accident, the insuree may claim from AHV or from invalidity insurance (IV) the amount incurred for helplessness allowance which these insurances would pay out to the insuree if he had not had an accident (cf. Art. 38 Para. 5 UVV).

[101]Cf. Art. 38 Para. 1 IVV.

[102]Cf. BGE 133 V 450 E. 10.2.

[103]Cf. BGE 133 V 472 E. 5.3.2.

[104]Cf. BGE 133 V 450 E. 9.

4.3 Degrees of Helplessness

In the old-age and dependants' insurance (AHV), invalidity and accident insurance, the assessment of helplessness allowance follows the same criteria,[105] but differs in the amount.

In the case of severe helplessness, the insured person is completely helpless, i.e. he or she regularly depends to a considerable degree on the help of another persons with respect *to all activities of daily living* and is furthermore *permanently in need of long-term care* or *personal surveillance*.[106]

In the case of moderately severe helplessness, the insured person regularly depends to a considerable extent on other persons' assistance despite the provision of therapeutic appliances; this kind of assistance refers to

- *most activities of daily living*
- at least *two activities of daily living* and, in addition, *permanent personal surveillance*
- at least *two activities of daily living* and, in addition, permanent *life skills assistance*.[107]

Moderate helplessness means that an insured person, despite being provided therapeutic appliance,

- regularly depends to a considerable extent on the assistance of other persons with respect to at least *two activities of daily living*
- requires permanent personal surveillance
- requires permanent and *especially intensive long-term care* due to infirmity
- is only able to *have social contacts due to substantial services regularly provided by other persons* as a result of severe sensory impairments or severe physical infirmity, or
- permanently depends on life skills assistance.[108]

Regarding the assessment, a medical professional will specify the extent to which the insured person has limited physical or mental abilities as a result of impairments. If the physical, psychological or cognitive impairments and/or their impacts on the activities of daily living cannot be clearly determined, the medical professional can, and even must, be contacted again for further clarification. Indications provided by the persons offering support, normally the parents, must also be taken into account, and diverging opinions of the persons involved must be mentioned in the report. The final text of the report must contain plausible, detailed and substantiated information regarding the individual activities of daily living and

[105]Cf. BGE 127 V 115 E. 1d.
[106]Cf. Art. 37 Para. 1 IVV.
[107]Cf. Art. 37 Para. 2 IVV.
[108]Cf. Art. 37 Para. 3 IVV.

Table 1 Amount of helplessness allowance

Degree of helplessness	Percentage of the maximum old-age pension level[a]	Invalidity insurance	AHV
Severe	80	CHF 1'872.–	CHF 936.–
Moderately severe	50	CHF 1'170.–	CHF 585.–
Moderate	20	CHF 468.–	CHF 234.–

[a]Cf. Art. 42ter Para. 1 IVG; Art. 43bis Para. 3 AHVG

must meet the requirements of permanent personal surveillance and long-term care.[109]

A careful diagnosis of helplessness is of particular significance with respect to progressive diseases such as dementia.

The monthly amount of helplessness allowance paid to insured persons who live in their home environment is shown in Table 1 as follows:

4.3.1 Long-Term Care Allowance

4.3.1.1 General

Regarding the entitlement to curative treatment, the different social insurance branches assume *different obligations to compensate for care services* in terms of both the acknowleged forms of long-term care (hospital, institutional and Spitex care, as well as care provided by family carers) and the scope of acknowledged care (medical and non-medical care).

Curative treatment is exclusively taken over[110] by one single social insurance within the statutory limits, and financed,[111] in the following order, by military insurance,[112] accident insurance, invalidity insurance, health insurance.

[109]See, inter alia, judgment SozVersGer of the Canton of Zurich of 29/06/2009 (AB.2009.00020) E. 3.1 (regarding an insuree born in 1942 who has been suffering from advanced Parkinson's disease in combination with dementia and hallucinations for over 20 years, and who has been living in an elderly home since July 2007).

[110]Cf. Art. 64 Para. 1 ATSG.

[111]Cf. Art. 64 Para. 2 ATSG.

[112]Long-term care compensation under military law is not referred to in the following.

4.3.1.2 Accident Insurance

4.3.1.2.1 General

Accident insurance only applies in the case of *accident-related long-term care dependency* (occupational and non-occupational accidents and occupational diseases[113]).

Upon retirement, a long-term care allowance can only be granted if the insured person[114]

- suffers from an occupational disease,
- suffers from a recurrence of the disease or from long-term effects thereof and if his/her capacity to work can be considerably improved through precautionary medical measures or if a major impairment of health can be prevented,
- requires long-term treatment and care to maintain his/her remaining capacity to work, or
- is incapacitated for work and if his/her state of health can be considerably improved through medical precautions or if a major impairment of health can be prevented.

4.3.1.2.2 Acknowledged Forms of Long-Term Care

Accident insurance pays for accident-related hospital, nursing home[115] and Spitex service costs.[116] *Family caregivers* are also recognised as service providers.[117] With a nursing diploma they can charge the insurance for their work in the same way as freelance professional carers can according to the relevant collective agreement.[118]

If they do not have a diploma, they can be granted an allowance, although no legal entitlement exists.[119] The relevant recommendations[120] make an allowance conditional on the fact that material damage can be proved (e.g. loss of income of the otherwise also economically active spouse, travel expenses for children who live outside the area) or on support going clearly beyond what a family member can

[113]Cf. Art. 7 ff. UVG; Landolt (2010b, c).

[114]Cf. Art. 21 Para. 1 UVG and further Subpara. 3 of the recommendation of the ad hoc Damages Commission UVG on the application of UVG and UVV, No. 7/90 in-home care [*Empfehlungen der AD-HOC-Kommission Schaden UVG zur Anwendung von UVG und UVV, Nr. 7/90 Hauspflege*], dated 27/11/1990, revised on 29/03/2005.

[115]Cf. Art. 10 UVG in connection with Art. 15 ff. UVV.

[116]Cf. Art. 18 Para. 1 UVV.

[117]Cf. Art. 18 Para. 1 and 2 UVV.

[118]The UVG wage agreement can be downloaded from http://www.sbk-asi.ch/webseiten/deutsch/8dokumente/freiberufliche/Tarifvertrag-Sozialw.pdf (last viewed on 16.10.2017).

[119]Cf. Art. 18 Para. 2 UVV.

[120]See http://www.koordination.ch/fileadmin/files/ad-hoc/archiv/07-90-alt-08.pdf (last viewed on 16.10.2017).

justifiably be entitled to expect (such as providing daily care for hours and hours over a longer period of time).

4.3.1.2.3 Acknowledged Long-Term Care Services

In the context of long-term care theories, "health and nursing care" means that care is provided autonomously, either by one person alone or jointly with other qualified professionals, to people of all ages, to families or other life partnerships, as well as to groups and social communities, healthy or ill, in all life situations.

Professional long-term care implies the promotion of health, the prevention of diseases and the provision of care to sick, disabled and dying people. Further key tasks of long-term care are the satisfaction of interests and needs, the promotion of a secure environment, investigation and research, participation in the formulation of health policy as well as in the management of health care and in education.[121]

The legal definition of long-term care is more restrictive. In the context of health insurance, "long-term care" relates to treatment and basic nursing care[122] and in the context of accident insurance it relates to medical care. In the case of "treatment care", care services fulfil the very purpose of treatment.[123] Health insurance law provides an exhaustive list of insured activities regarding treatment care,[124] while there is no legal definition for medical care in accident insurance law.

The nursing care concept as it is contained in accident insurance not only comprises care treatment as related to health insurance but, in addition, all basic nursing care measures. In this respect, notably those nursing care services are insured which are either required to maintain a person's remaining capacity to work or which, in the case of incapacitated insured persons, serve to considerably improve their state of health or prevent any major impairment of the latter.[125]

Measures taken in the context of the activities of daily living, household maintenance or the handling of everyday matters are not part of medical care. They may, however, substantiate the criterion of helplessness to the extent to which the above-mentioned requirements have been fulfilled.[126]

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[121]The International Council of Nurses (ICN) defines the task of professional caregivers as follows: "Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles" (see http://www.icn.ch/about-icn/icn-definition-of-nursing/ – last viewed on 16.10.2017).

[122]On this see infra margin No. 97 ff.

[123]Cf. Art. 7 Para. 2 lit. b Subpara. 1 ff. KLV.

[124]Cf. BGE 136 V 172 = Pra 2010 No. 135 E. 4.3 and judgment BGer of 21/12/2010 (9C_702/2010) E. 4.2.2.

[125]Cf. Art. 21 Para. 1 lit. c and d UVG.

[126]On this see supra margin No. 32 ff. and infra margin no. 102 ff.

4.3.1.3 Invalidity Insurance

4.3.1.3.1 General

Invalidity insurance as a final public insurance only provides for medical rehabilitation measures[127] for insured persons up to the age of 20.[128]

4.3.1.3.2 Acknowledged Forms of Long-Term Care

Medical measures comprise the treatment which is provided by the physician him- or herself or by qualified nursing care staff at the physician's request either in nursing homes or in the patient's home environment (an exception being logopaedic and psychomotoric therapies), as well as the administration of medically prescribed medications.[129] When deciding on medical treatment to be provided in a nursing home or in the patient's home environment, the recommendation of the treating physician and the personal circumstances of the insured have to be taken adequately into account.[130]

4.3.1.3.3 Acknowledged Long-Term Care Services

Medical Rehabilitation Measures

Domiciliary, outpatient or inpatient medical care (treatment including accessory basic care[131]) is only provided if it does not aim at the treatment of the illness per se,[132] but directly at the integration into gainful employment or into the person's field of activity and if it is suited to permanently and significantly improve the functional, pension-relevant performance capability or to prevent from major impairment.[133]

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[127]Cf. Art. 12 ff. IVG.

[128]Cf. Art. 12 and 13 IVG.

[129]Cf. Art. 14 Para. 1 IVG.

[130]Cf. Art. 14 Para. 3 IVG.

[131]Accessory basic care means basic care measures which are required or become necessary in connection with the performance of long-term care services. Accessory care involves, for instance, basic care services related to body hygiene or, respectively, body cleansing (cf. Art. 7 Para. 2 lit. c Subpara. 1 KLV) after bowel evacuation as may be necessary in line with long-term care treatment (cf. Art. 7 Para. 2 lit. b Subpara. 11 KLV), cf. also BGE 120 V 280 E. 3b.

[132]Treatment of the disease includes, in particular, the treatment of injuries, infections, as well as of internal and parasitic diseases (cf. Art. 2 Para. 4 IVV).

[133]Cf. Art. 12 Para. 1 IVG.

Insurance to Cover Congenital Defects

Up to the age of 20, insured persons suffering from an acknowledged congenital defect[134] are entitled to the necessary medical treatment regarding their defect.[135]

Intensive Long-Term Care Supplements for Minors

What is also attributable to care is the supplement for intensive long-term care for persons under age 18.[136] This supplement is particularly granted for increased need for treatment, basic care and permanent surveillance as compared to the needs of non-disabled minors of the same age.[137]

4.3.1.4 Health Insurance

4.3.1.4.1 General

Health insurance applies in the event of sickness-related and accident-related long-term care dependency, in the latter case, however, only subsidiarily to accident insurance.[138] To the extent that the insurance covering congenital defects does not have to pay for long-term care services granted in the context of health insurance, these services have to be compensated for by the health insurance in a subsidiary way.[139]

4.3.1.4.2 Acknowledged Forms of Long-Term Care

Hospital Care

The costs of a hospital stay are fully covered and include board and lodging.[140] Hospital care implies that there must be a *medical or social necessity of hospitalisation*[141] on the part of the insured person. If the insured person is no

[134]See on this Annex of the Regulation of 9 December 1985 regarding birth defects [*Verordnung vom 9. Dezember 1985 über Geburtsgebrechen (GgV)*].

[135]Cf. Art. 13 IVG; BGE 136 V 209 ff.

[136]Cf. on this supra margin No. 46 ff.

[137]Cf. Art. 39 Para. 2 and 3 IVV.

[138]Cf. Art. 1a Para. 2 lit. b KVG.

[139]Cf. judgments BGer of 10/06/2011 (9C_886/2010) E. 4.5.

[140]Cf. Art. 25 Para. 2 lit. a KVG.

[141]Necessity of hospitalisation is the case if the necessary diagnostic and therapeutic measures can be performed in a purposeful way only in a hospital, or if all possibilities of outpatient care have been exhausted, or if it is only by means of a hospital stay that there is still any prospect of success with regard to treatment. The health insurance may also be obliged to cover the costs of a hospital stay in cases where the state of health of an insuree does not necessarily require such a stay, but where—due to particular personal circumstances—the patient can receive medical treatment nowhere else but in a hospital (cf. BGE 126 V 323 E. 2b and 120 V 206 E. 6a).

longer in need of hospital care but requires nursing home or Spitex services,[142] he or she is entitled to *a two-week period of intensive and transitionary care.*[143]

Intensive and transitionary care services comprise all measures specified in Art.7 (2) KLV (diagnosis, advice, coordination and examination as well as treatment and basic care) which prove necessary after a hospital stay and which have been medically ordered by the hospital[144] and are carried out by freelance professional carers, a Spitex organisation or a nursing home.[145]

Nursing Home Care

Care services provided in a nursing home[146] are compensated for according to the principles of outpatient care[147] on the basis of a time tariff.[148]

The Swiss Federal Council regulates the insured care services, the needs assessment, the tariff and the quality controls[149]; in addition to the general criteria of effectiveness, appropriateness and cost-effectiveness, the legislator insists on ensuring the "necessary quality"[150] when the insured care services are determined.

Spitex Care

Spitex care comprises daytime or night-time care[151] provided by freelance professional carers pursuant to Art. 49 KVV,[152] and by cantonally recognised Spitex organisations in terms of Art. 51 KVV.

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[142]For patients with chronic psychiatric problems—even if their state of health is subject to changes—the rules applicable to care home patients are generally valid, unless temporary deterioration of the illness requires acute hospital treatment (cf. BGE 120 V 200 E. 6a and judgment EVG of 20/10/2006 [K 20/06] E. 3.1).

[143]Cf. Art. 26a Para. 2 KVG.

[144]Cf. Art. 25a Para. 2 KVG.

[145]Cf. Art. 7 Para. 3 KLV. Acute care and temporary long-term care are remunerated pursuant to the *hospital financing* regulations (*Regeln der Spitalfinanzierung* (see Art. 49a KVG)) and not according to the otherwise applicable long-term care tariffs (cf. Art. 25a Para. 2 KVG).

[146]Art. 39 Para. 3 KVG.

[147]Cf. Art. 50 KVG.

[148]Cf. Art. 25a Para. 1 KVG and Art. 7 Para. 1 lit. c KLV.

[149]Cf. Art. 25a Para. 3 and 4 KVG.

[150]Cf. Art. 25a Para. 4 KVG.

[151]Cf. Art. 25a Para. 1 KVG and Art. 7 Para. 2bis KLV.

[152]Professional carers are approved if they hold a diploma from a school for health care and nursing care (since the education reform in the healthcare system of 2004 referred to as "higher vocational school / Höhere Fachschule" or "senior technical college / Fachhochschule"), as well as an approval for exercising the profession in the respective canton, and practical experience in the field of long-term care of a minimum of 2 years. A certificate issued by the Swish Red Cross confirming the attendance of an "assistant caregiver (Pflegehelfer/in)" training does not count as a professional nursing care diploma (120 h of theory, 12 days of practical training) (cf. judgment EVG of 05/09/2000 [K 62/00] E. 2).

In contrast to the tariff of the Spitex organisations, the nursing home tariff does not take account of the type of care measure provided but only of the time needed daily for care measures, which must also be shown on the invoice.[153]

Caregivers Caring for Relatives

According to the KV, family carers who are not approved by the Swiss Common Institution under the Federal Sickness Insurance Act (KVG) are not considered as recognised service providers.[154] Therefore, no obligation exists to remunerate caregiving relatives,[155] except for family carers who have been attributed a creditor code (ZSR number).[156]

The employment of family caregivers by an approved Spitex organisation is not considered in terms of care provided by relatives but in terms of a provision of Spitex care that must be paid for.[157] Employed family caregivers are only entitled to provide relatively simple basic care and/or care in ordinary everyday situations,[158] but no nursing care.[159]

4.3.1.4.3 Acknowledged Long-Term Care Services

General

Outpatient and nursing home health-care services comprise the following measures[160]:

- diagnosis, advice and coordination (lit. a)
- examination and treatment (lit. b)
- basic care (lit. c)

Diagnosis, Advice and Coordination

The service category "coordination" of 1 January 2012 is based on an adjustment in the course of the implementation of the national palliative care strategy of the Swiss federal government. To ensure that persons dependent on long-term care can stay in their home environment until the end of their lives even in the case of an unstable state of health, it has been recognised that the often numerous providers of long-

[153]Cf. Art. 9 Para. 2 KLV.

[154]Cf. BGE 111 V 324.

[155]Cf. BGE 126 V 330 = RKUV 2000, p. 288 E. 1b.

[156]Cf. BGE 133 V 218 E. 6, judgment BGer of 10/05/2007 (K 141/06 and K 145/06) E. 5.2.

[157]Cf. judgment EVG of 21/06/2006 (K 156/04) = RKUV 2006, p. 303 E. 4.

[158]Cf. Art. 9a Para. 1 lit. a and b KLV, as well as judgments EVG of 25/08/2003 (K 60/03) E. 3.3 and VersGer Kanton St. Gallen of 18/08/2006 i. S. L. = SGGVP 2006 No. 18.

[159]Cf. judgment BGer of 19/12/2007 (9C_597/2007) E. 5.1.

[160]Art. 7 Para. 2 KLV.

term care active in one private household should be well coordinated and that this coordination service must be remunerated accordingly.[161] The conditions for remuneration set out in the regulation are not confined to palliative situations.

Care Treatment

In the case of "care treatment"[162] only those services are insured[163] which are explicitly included in a 'positive' list. Care treatment and basic care services[164] differ in terms of tariffs.[165] Helplessness allowance is only attributable to basic care and not to care treatment.[166]

Basic Care

In the case of basic care, a distinction is made between general basic care and the measures aiming at the surveillance and assistance of persons with psychological impairments which help the latter cope with the basic activities of daily living[167]:

- *General basic care* includes, for example: Bandaging of legs, applying compression bandages, patient bedding and positioning, moderate exercises, physical activation, decubitus prophylaxis, measures to prevent or remedy treatment-related skin damage, assistance with dental and personal hygiene, dressing/undressing, eating and drinking.[168]
- The *measures aiming at the surveillance and assistance of persons with psychological illnesses* include, among other things, the elaboration and practical training of an appropriate daily routine, targeted training regarding the structuring and encouraging of social contacts, assistance in respect of guidance and safety measures.[169]

[161]Cf. Rex et al. (2013).

[162]The recognised treatment and nursing care services are listed in Art. 7 Para. 2 lit. b KLV.

[163]Cf. BGE 136 V 172 = Pra 2010 No. 135.

[164]The conceptual term "basic and treatment care (Grund- und Behandlungspflege)" was introduced to the German-speaking area in 1967 by hospital economist Siegfried Eichhorn. The terms "basic care" and "treatment care" in this context were the results of translations from an essay in English written in 1954, cf. Friesacher (2008), p. 192 f. The dualism in long-term care practise arising from this distinction between relatively undemanding (basic) care measures and activities requiring a higher qualification and medical expertise was abandoned for the benefit of a more holistic approach in the course of the change in professional attitude and the emergence of the nursing science, cf. Müller (1998), Mittelstaedt (1998).

[165]Cf. Art. 7a Para. 1 KLV.

[166]Cf. judgment BGer of 12/07/2012 (9C_43/2012) E. 4.1.1.

[167]Cf. Art. 7 Para. 2 lit. c Ziff. 2 KLV.

[168]Cf. Art. 7 Para. 2 lit. c Subpara. 1 KLV.

[169]Cf. Art. 7 Para. 2 lit. c Subpara. 2 KLV.

It must be examined whether the service provided constitutes an insured long-term care service or an uninsured attendance or household service.[170] While measures aiming at the surveillance and assistance of persons with psychological illnesses may also cause obstacles with regard to the basic activities of daily living, an allowance for such measures is only paid if the measures are necessitated due to illness. Furthermore the measures must concern assistance provided to the person and not material support (especially domestic help). The particular basic care shall enable psychologically ill persons to cope with the activities of daily living again themselves ('help towards self-help').[171]

Domestic help services are activities that relate to household maintenance (from both the actual and the economic perspective) and comprise activities such as food shopping, preparing meals, including help with eating and drinking,[172] doing the washing and so on, activities which are not part of the list of the basic care services refunded by mandatory long-term care insurance.[173] Depending on the context, help with eating and drinking may be regarded as a basic care service.[174]

4.4 Assistance Allowance

4.4.1 General

It is only with the 6th revision of the IVG (Part I, 6a) that assistance allowance, which had been discussed since the 1990s, was finally introduced as of 1 January 2012.[175] This was to fulfill the purpose of the IV to make a *self-determined, independent life* possible for the insured.[176] A further purpose was to delay the *moving into a nursing home* for as long as possible or to make it possible for a patient to move back home from an old-age and nursing home.[177]

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[170]Cf. BGE 131 V 178 E. 2.2.3.

[171]BGE 131 V 178 E. 2.2.3.

[172]Cf. decision of the Swiss Federal Council of 09/03/1998 = RKUV 1998 KV No. 28 p. 180 E. II.

[173]Cf. BGE 136 V 172 E. 5.3.2. Accompaniment of a care-dependent person from the bedroom to the dining room does not count as a care measure according to KVG/KLV either.

[174]Cf. Art. 7 Para. 2 lit. c Subpara. 1 KLV and infra Rz 182 f.

[175]Cf. Art. 42quater ff. IVG, Art. 39a ff. IVV and Circular on the Assistance Contribution [*Kreisschreiben über den Assistenzbeitrag (KSAB)*], valid as of 1 January 2013, as well as explanatory notes on the regulation regarding invalidity insurance [*Erläuterungen zur Verordnung über die Invalidenversicherung*] of 16/11/2011 (hereinafter referred to as Explanatory Notes Assistance Contribution/Erläuterungen Assistenzbeitrag); available online at http://www.bsv.admin.ch/themen/iv/00025/index.html?lang=de – last viewed on 16. Oktober 2017).

[176]Cf. Art. 1a lit. c IVG.

[177]The Swiss Federal Council Bundesrat expects 400 withdrawals from care homes and 700 avoidable care home admissions in the next 15 years, cf. Botschaft 6. IV-Revision, 2010, p. 1922.

4.4.2 Eligibility Requirements

The persons eligible are insured adult persons who live in their home environment and are granted helplessness allowance according to the IV,[178] not, however, recipients of helplessness allowance from accident[179] or military insurance[180] or from the AHV,[181] or persons who suffer from only partially accident-related helplessness.[182]

4.4.3 Acknowledged Forms of Assistance

Recognised as care assistants are persons who are employed by the insured under a contract of employment,[183] who are neither married to the former, nor live in an officially registered or de facto partnership with him/her, and who are not related in a direct line.[184] The reason for *excluding close family members*[185] is based on support[186] and maintenance obligations.[187]

4.4.4 Acknowleged Assistance Services

Eligibility to assistance allowance only exists if the need for care leads to one or more assistants being employed for more than 3 months.[188] The following activities are reimbursable:

- activities of daily living,[189]
- household maintenance,[190]
- participation in society and organisation of leisure activities,[191]

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[178]Cf. Art. 42 quater Para. 1 IVG.

[179]Cf. Art. 26 f. UVG.

[180]Cf. Art. 20 MVG.

[181]Cf. Art. 43bis AHVG.

[182]Cf. Art. 42 Para. 6 IVG; Botschaft 6. IV-Revision, 2010, p. 1900.

[183]Accordingly, dependent persons are not entitled to assistance services that are provided by inpatient (care homes, hospitals, psychiatric clinics) or semi-inpatient institutions (sheltered workshops, daycare centres and integration centres); or by organisations and other legal entities (exception: advisory and support services).

[184]Cf. Art. 42 quinquies lit. a and b IVG.

[185]Cf. Botschaft 6. IV-Revision, 2010, pp. 1867 and 1902 f.

[186]Cf. Art. 328 ZGB.

[187]Cf. Art. 163, 276 f. ZGB.

[188]Cf. Art. 39d IVV.

[189]Cf. Art. 39c lit. a IVV and Botschaft 6. IV-Revision, pp. 1904 f.

[190]Cf. Art. 39c liA t. b IVV and Botschaft 6. IV-Revision, pp. 1904 f.

[191]Cf. Art. 39c lit. c IVV and Botschaft 6. IV-Revision, pp. 1904 f.

- childcare and education,[192]
- non-profit or voluntary activities,[193]
- vocational education and training,[194]
- economic activities in the regular labour market, except activities in the protected environment of workshops or day centres and the attendance of vocational training courses in disability organisations,[195]
- surveillance during the day,[196] and
- night-time services.[197]

Aids compensating for the loss of hearing or vision are recognised as direct support, while guidance, control and surveillance in the context of pursuing activities are recognised as indirect support.[198]

The need for support required in order to be granted assistance allowance is determined by way of a standardised assessment tool (FAKT) for direct and indirect support services.[199] The time spent on support services covered by helplessness allowance,[200] the contributions paid for third party services instead of devices[201] and the contributions paid by the mandatory health care insurance for basic care[202] in terms of care services[203],[204] have to be deducted from the monthly need for assistance[205] as shown in Table 2.

The contribution paid for assistance amounts to CHF 32.80 per hour,[206] in the case of necessary special qualifications pursuant to Art. 29 (c) lit. e-g it amounts to CHF 49.15 per hour,[207] and for night-time services, depending on the intensity, to a maximum of CHF 87.40 per night.[208]

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[192]Cf. Art. 39c lit. d IVV.

[193]Cf. Art. 39c lit. e IVV.

[194]Cf. Art. 39c lit. f IVV and Botschaft 6. IV-Revision, pp. 1904 f.

[195]Cf. Art. 39c lit. g IVV.

[196]Cf. Art. 39c lit. h IVV.

[197]Cf. Art. 39c lit. i IVV.

[198]See Rz 4005 ff. KSAB.

[199]See on this Latzel and Andermatt (2007).

[200]Cf. Art. 42 ff. IVG.

[201]Cf. Art. 21ter Para. 2 IVG.

[202]Cf. Art. 25a KVG i.V.m. Art. 7 Para. 2 lit. c KLV.

[203]There is no need for coordination with regard to treatment care services, as these are not taken into the equation for assistance contribution (cf. Art. 42sexies Para. 3 IVG) and are exclusively covered by the health and accident insurance (cf. Art. 25a KVG and Art. 7 Para. 2 lit. b KLV and Art. 18 UVV). Margin no. 4110 KSAB, on the other hand, provides for a deduction of medical care measures pursuant to Art. 13 IVG.

[204]Cf. Art. 42sexies Para. 1 and 3 IVG.

[205]Cf. margin No. 4105 ff. KSAB.

[206]Cf. Art. 39f Para. 1 IVV.

[207]Cf. Art. 39f Para. 2 IVV.

[208]Cf. Art. 39f Para. 3 IVV.

Table 2 Maximum amounts per month for support services

Support Services	Helplessness	Hours
Activities of daily living, household maintenance, participation in society and organisation of leisure time	Moderate Moderately severe Severe	20 30 40[a]
Education and childcare, pursuit of non-profit or voluntary activities, vocational training or education, pursuit of an activity in the regular labour market		60[b]
Surveillance during daytime		120[c]

[a]Cf. Art. 39e Para. 2 lit. a IVV
[b]Cf. Art. 39e Para. 2 lit. b IVV
[c]Cf. Art. 39e Para. 2 lit. c IVV

5 Medical Aids

5.1 Provision of Medical Aids

Medical or nursing aids (nursing beds, wheelchairs, aids for incontinence, ointments etc.) are either covered by health insurance (KV) within the framework of the list of materials and objects (the so-called "MiGel" list)[209] or by invalidity insurance (IV) even if the insured person has already acquired the aid in question[210] or a similar aid.[211]

The lists of medical aids exhaustively specify the potential categories of aids. In the case of each category of aids it must be investigated whether the list of the individual aids (within this category) is exhaustive or whether it is only exemplary.[212] The respective aids can be provided in kind[213] or in terms of a monetary benefit.[214]

In item 14 of the list of aids, the invalidity insurance (IV) has specified all medical aids available (aids for self-provision). Neither the AHV nor the accident insurance have a catalogue of aids available in addition to this list.

Since 1 January 2011 the cantons have been obliged to pay for the necessary, appropriate, economic medical—and especially nursing—aids, with the scope to be determined by the cantons.[215]

[209]Annex 2 on KLV (available at http://www.bag.admin.ch/themen/krankenversicherung/00263/00264/04184/index.html – last viewed on 16.10.2017).

[210]Cf. Art. 21 f. IVG and HVI, Art. 11 UVG and HVUV, Art. 21 MVG.

[211]Cf. Art. 2 Para. 5 HVI.

[212]Cf. BGE 121 V 260 E. 2b and Art. 2 Para. 5 HVI.

[213]Cf. Art. 21 Para. 3 IVG.

[214]Cf. Art. 21bis Para. 1 and 2 IVG, as well as Art. 21 Para. 2–4 MVG.

[215]Cf. Art. 14 Para. 1 lit. f ELG. Most cantons have kept up the previous list of nursing aids issued by ELKV.

5.2 *Allowances for Third Party Services*

Invalidity[216] and military insurance[217] provide for an entitlement to third party services if the insured person fulfills the prerequisites for being provided a certain medical aid, especially in the context of a permanent living wage job,[218] but cannot make use of the aid for reasons related to his/her personal circumstances.[219]

Instead of the aid, the insured person will be granted a monetary benefit. The monthly allowance for third party services must not exceed the insured person's gross monthly income from employment nor one and a half times the amount of the minimum regular simple retirement pension, i.e. CHF 1755.00 (as of 1 January 2013).[220] If the insured person is entitled to an aid which he or she cannot handle independently, e.g. drive a motor vehicle, he or she must be refunded the substitution costs up to the abovementioned maximum amount.

If the insured person has already been adequately provided with aids such as a hearing aid, for example, services from other persons, in particular the costs for a sign language interpreter, cannot be granted due to their substitutive nature.[221] Services provided by other persons may only compensate for the loss of certain parts or functions of the human body in order to enable the insured to get to work or cope with professional tasks.[222]

The list of aids of the invalidity insurance (IV) especially specifies the following third party services[223]

- *transport and accompanying services for persons with disabilities to get from home to work and back* instead of using a motor vehicle or a guide dog, and especially also taxi transportation,
- *the reading out of texts indispensable for work* in the case of blindness and low vision,[224]
- *interpreting services for especially demanding teaching points or topics of conversation* in the case of deafness or severe hearing loss.

In the case of *agricultural or commercial activities, a self-amortising loan* can be paid out for *costly aids*.[225]

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[216]Cf. Art. 21bis Para. 2 IVG. The rules of IV also apply accordingly for AHV (cf. Art. 4 HVU).

[217]Cf. Art. 21 Para. 4 MVG.

[218]Cf. 118 V 200 E. 3c.

[219]Cf. BGE 112 V 11 E. 1a and EVGE 1968, p. 272.

[220]Cf. margin No. 1042 KHMI and Annex 1 Subpara. 6.4.

[221]Cf. judgment EVG of 17/03/2005 (I 354/03) E. 3.4.

[222]Cf. BGE 112 V 11 E. 1b and 96 V 84.

[223]Cf. margin No. 1037 KHMI.

[224]See on this judgment BGer of 18/09/2009 (9C_493/2009) E. 5.2.2.3.

[225]Cf. Art. 21bis Para. 2bis IVG; Cf. judgment BGer of 25/01/2008 (9C_592/2007) E. 3.2 and Communication of 21/02/2001 on the 4th Revision of the Federal Act on Invalidity Insurance [*Botschaft vom 21.02.2001 über die 4. Revision des Bundesgesetzes über die Invalidenversicherung*] = BBl 2001, pp. 3205 ff., 3264.

6 Additional Allowances

6.1 General

Persons whose *place of residence and habitual residence* is in Switzerland are entitled to additional allowances if they receive a pension or helplessness allowance from the invalidity insurance[226] or if they were entitled to an invalidity pension from the IV in the case of completion of the minimum contribution period pursuant to Art. 36 IVG.[227] The insured additional allowances consist of an *annual supplementary benefit*[228] as well as of an *allowance for costs incurred due to illness and disability*.[229] Both benefits include co-insurance of the risk of nursing care needs which is, however, not fully covered.

The additional allowances aim at *guranteeing the minimum subsistence level with respect to social security*[230] beyond the absolute minimum level granted by social assistance[231] and are subsidiary to other social security benefits (especially from health care and accident insurance[232]).

6.2 Annual Supplementary Benefits

6.2.1 Expenditures Eligible for Coverage

The difference between eligible expenditures and revenues is paid out on a monthly basis.

6.2.1.1 Home Care

Expenditures eligible for coverage comprise, inter alia, the *amount needed for general living expenses, housing costs* and the *health insurance premium.* In the case of unmarried partner or family households, an overall assessment is made

[226]Persons entitled to helplessness allowance are granted supplementary benefits only once they have reached 18 years of age (cf. Art. 6 ELG); Landolt (2011).

[227]Cf. Art. 4 Para. 1 lit. c and d ELG.

[228]Cf. Art. 3 Para. 1 lit. a ELG.

[229]Cf. Art. 3 Para. 1 lit. b ELG.

[230]Cf. Art. 2 Para. 1 ELG.

[231]The allowable expenses of CHF 31340.– for a single person plus expenses as mentioned in Art. 10 Para. 3 ELG are higher than the subsistence minimum under social assistance as referred to in the SKOS guidelines.

[232]Cf., among others, e.g. judgment EVG of 23/01/2002 (P 72/01) E. 2.

which takes account of the acknowledged expenditures and revenues of all its members.[233]

Expenditures due to disability can be eligible for coverage up to a maximum of CHF 3600.00 for *renting a wheelchair-accessible home* in addition to the annual maximum amount[234]; in the case of a privately owned home this refers to non-value-maintaining investments made on grounds of disability (e.g. the installation and use of a stairlift).[235]

6.2.1.2 Nursing Home Care

In the case of a patient *living in a nursing home*, an *amount for personal expenses* is taken into account with a view to the general living requirements and a *daily allowance* to accommodate the housing costs.[236] Because of the principle of equal treatment of nursing home and home care, the resident of a nursing home may receive, as an additional allowance, the equivalent of the maximum amount of the minimum subsistence level calculated for a person living in the home environment.[237] If the costs for a nursing home exceed the minimum subsistence level of supplementary benefit recipients who are provided care in their home environment, the cantons must cover the balance.[238]

With effect from 1 January 2011, pursuant to federal law, the daily allowances eligible for coverage in the case of accommodation in a recognised nursing home must be high enough to prevent the insured from having to draw on social assistance.[239]

When implementing the prohibition of making a person dependent on social assistance, the cantons have a margin of discretion so that it is not self-evident that a pensioner is granted enough supplementary benefits in order to be able to pay for the nursing home stay.[240] The prohibition of making a person dependent on social assistance only applies in the case of "recognised nursing home" stays.[241]

The canton must ensure that every person has the chance of actually being accepted. On principle, the insured cannot be deprived of the possibility to choose

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[233]Cf. Art. 9 Para. 2 ELG.

[234]Cf. Art. 10 lit. b Subpara. 3 ELG.

[235]See Art. 16 ELV and Subpara. 4.3.9 of Circular No. 11 of 31/08/2005 on the deduction of expenses incurred for healthcare and accidents, as well as for costs incurred due to disability ["Abzug von Krankheits- und Unfallkosten sowie von behinderungsbedingten Kosten vom 31.08.2005"] of the Swiss Federal Tax Administration.

[236]Cf. Art. 10 Para. 2 lit. a ELG.

[237]Cf. Art. 13 Para. 2 ELG.

[238]Cf. Art. 13 Para. 2 last Sent. ELG.

[239]Cf. Art. 10 Para. 2 ELG.

[240]Cf. BGE 138 V 481 = Pra 2013 No. 31 E. 4.

[241]Cf. Art. 10 Para. 2 lit. ELG.

between the homes specified on the cantonal list. In the case of high accommodation costs, the home may accept the person at the rate covered by the canton.[242]

The maximum amount granted by the canton of residence is also valid for a specialised nursing home in another canton, even if the latter provides for a higher maximum amount eligible for coverage.[243]

When calculating the supplementary benefit for the spouse who does not live in a home or hospital, only the rent allowable for single persons of currently CHF 13,200.–is taken into consideration.[244] The result of this regulation is that the spouse who does not live in the nursing home is at risk of having to leave the marital home in spite of the higher exemption limit for assets of CHF 300,000.–[245] if the annual costs for the home exceed CHF 13,200.–

6.2.1.3 Allowable Revenues

Allowable revenues (income from gainful employment and pensions, interest revenues, etc.) are deducted. In the case of old-age pensioners, one fifteenth (for single persons) or one tenth (for the combined assets of spouses) of the amount exceeding the exemption limit for assets (CHF 37,000.–for single persons and CHF 60,000.–for the combined assets of spouses) can be attributed to these revenues.[246] In the case of a nursing home stay, the cantons may increase the proportion of attributable assets to 20%.[247]

With the entering into force of the new law on the financing of long-term care of 1 January 2011, an increase in the exemption limit for assets for *capital invested in an owner-occupied residential property* to CHF 300,000.–is to be granted in the event that one spouse lives in a nursing home and the other spouse in a self-owned property or that both spouses live in a self-owned property and one of them is provided helplessness allowances by the AHV, IV, accident or military insurance.[248]

If the daily tariffs of a nursing home or a hospital also comprise *the costs for long-term care* of a helpless person, the helplessness allowance granted by the AHV, IV, military or accident insurance will be attributed to the deductible revenue.[249]

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[242]Ibid.

[243]Cf. BGE 138 V 481 = Pra 2013 No. 31.

[244]Cf. Art. 1c Para. 2 ELV.

[245]On this see infra Rz 142.

[246]Cf. Art. 11 Para. 1 lit. c ELG.

[247]Cf. Art. 11 Para. 2 ELG.

[248]Cf. Art. 11 Para. 1bis ELG.

[249]Cf. Art. 15b ELV.

6.3 *Reimbursement of Costs Incurred Due to Illness and Disability*

6.3.1 General

The recipients of an annual supplementary benefit can claim a *compensatory payment for the costs incurred due to illness and disability.*[250] Persons living in nursing homes are, however, only entitled to receive a maximum of CHF 6000.–per year.[251] Insured persons who are not entitled to an annual supplementary benefit because of a revenue surplus and who otherwise meet all the eligibility requirements regarding the payment of an annual supplementary benefit, are entitled to be reimbursed the costs incurred due to illness and disability exceeding the revenue surplus.[252]

6.3.2 Recognised Costs Incurred Due to Illness and Disability

The costs incurred due to illness and disability to be reimbursed are specified by the cantons[253] in conjunction with the federal law.[254] According to federal law, the cantons are obliged to reimburse as follows[255]:

- dental treatment,
- assistance, long-term care and attendance in the home environment and in daycare centres,
- medically prescribed spa therapies,
- diets,
- transport to the nearest place of treatment,
- aids and
- co-payments according to Art. 64 KVG.

As of 1 January 2011, the cantons have been obliged to issue their own regulations regarding the compensation for *the loss of income of family caregivers.*[256]

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[250]Cf. Art. 14 Para. 1 ELG.

[251]Cf. Art. 14 Para. 3 lit. b ELG.

[252]Cf. Art. 14 Para. 6 ELG.

[253]Cf. Art. 14 Para. 2 ELG.

[254]Cf. Art. 14 Para. 1 and 3 ELG.

[255]Cf. Art. 14 Para. 1 ELG.

[256]In the Canton of Aargau, for instance, currently a loss of income of 10% over a period of 4 weeks entitles caregivers to claim compensation, § 14 Para. 3 of the Regulation of 17 November 2010 on the reimbursement of costs of supplementary benefits (ELKV-AG) incurred for health care or due to disability [Verordnung über die Vergütung von Krankheits- und Behinderungskosten bei den Ergänzungsleistungen (ELKV-AG) vom 17. November 2010].

The cantonal implementation provisions regularly refer to the former federal principles,[257] but occasionally also provide for allowances for family caregivers irrespective of a proof of loss of income.[258]

The question as to whether and to which extent family caregivers might have taken up gainful employment is to be assessed in the light of the personal, family, economic and social circumstances under consideration of the extent of long-term care to be provided.[259] Given the difficulties of proof, the administration has to ascertain "with particular care" the facts of a possible gainful employment conferring entitlement to an allowance.[260]

6.3.3 Maximum Amounts

Within the framework of the federal law, the cantons are free to determine the costs which are to be reimbursed as well as the maximum amounts which are to be paid.[261] In particular, they are authorised to confine the cost reimbursement to the expenses necessary to ensure an economic and appropriate service provision.

The recognised costs incurred due to illness and disability will be reimbursed within the scope of the *general and specific maximum amounts* on the basis of the level of helplessness. As of 1 January 2011, the cantons have been entitled to fix general and specific maximum amounts. The general cantonal maximum amounts must not fall below the following amounts as shown in Table 3:

Single and widowed persons living in their home environment or persons living in their home environment with the spouse being accommodated in a nursing home or hospital, who are entitled to receive a helplessness allowance from invalidity insurance (IV) or accident insurance (UV), obtain an increase of the minimum amount from CHF 25,000.– to CHF 90,000.– in the event of severe helplessness, and to CHF 60,000.– in the event of moderately severe helplessness.[262]

For married couples who live in their home environment with one or both of them being helpless, the minimum amount of CHF 50,000.– increases as shown in Table 4:

The purpose of the specific maximum amount of CHF 90,000.– for severely helpless single persons is to allow persons in need of long-term care and attendance services to live independently in their home environment for as long as possible

[257]Cf. judgment BGer of 25/04/2007 (P 18/06) E. 4 and SVR 1998 EL No. 10 p. 25.

[258]In the Canton of Bern, for instance, a maximum of CHF 9600.– per year may be paid, cf. Art. 15 Para. 3 EV ELG (BE).

[259]Cf. judgment BGer of 11/02/2009 (8C_773/2008) E. 5.2.

[260]Ibid. E. 5.2.

[261]Cf. Art. 14 Para. 2 and 3 ELG.

[262]Cf. Art. 14 Para. 4 ELG and Art. 19b Para. 1 ELV. The same increase is granted also to recipients of a helplessness allowance pursuant to AHV who had previously received helplessness allowance pursuant to IV, cf. Art. 14 Para. 5 ELG.

Table 3 Amounts for persons living in the home environment

Category of persons	Maximum amount
Single and widowed persons, as well as spouses of persons living in nursing homes or hospitals	CHF 25,000.–
Married couples	CHF 50,000.–
Full orphans	CHF 10,000.–[a]
Persons living in a nursing home	CHF 6000.–[b]

[a]Cf. Art. 14 Para. 3 lit. a ELG
[b]Cf. Art. 14 Para. 3 lit. b ELG

Table 4 Maximum amounts for married couples

Number of persons receiving helplessness allowance	Degree of helplessness	Maximum amount
Both spouses	With each of them suffering from severe helplessness	CHF 180,000.–
	With each of them suffering from moderately severe helplessness	CHF 120,000.–
	With one of the spouses suffering from severe helplessness	CHF 150,000.–
	With one of the spouses suffering from moderately severe helplessness	CHF 150,000.–
One spouse	Suffering from severe helplessness	CHF 115,000.–
	Suffering from moderately severe helplessness	CHF 85,000.–

without having to be accommodated in a nursing home. This is why the increase of the general maximum amount of CHF 25,000.– is confined to the reimbursement of costs incurred for long-term care and attendance services.

Unlike the general maximum amount (CHF 25,000.– for single persons), the helplessness allowance is deducted in advance when determining the specific maximum amount (90,000.– for single persons) as the increase in the amount only applies "if the costs for long-term care and attendance services are not covered by the helplessness allowance".[263]

[263]Art. 3d Para. 2bis 2nd clause to Sent. 1 aELG and further judgment BGer of 10/08/2009 (9C_84/2009) E. 4.2.

7 Care Credits

7.1 General

The childcare[264] and (long-term) care credits[265] introduced on 1 January 1997 consist of an annual pension credit for persons who are mandatorily or voluntarily insured according to the AHVG and who care for relatives entitled to a helplessness allowance of a medium degree.[266] In the case of minors, this generally only applies to the period between the ages of 16 and 18, since childcare credits are taken into account for ages up to 16.[267]

7.2 Eligibility Requirements

7.2.1 Recognised Family Carers

The caregiver must be a relative in the ascending or descending line or a brother or sister of the insured, or a spouse, an officially registered partner(ship), a parent-in-law or a stepchild.[268] The care credit is an egalitarian one, irrespective of the intensity of attendance or long-term care, and corresponds to three times the yearly paid minimum full old-age pension as of the date when the person involved becomes eligible for the pension.[269] In the case of married persons, the care credit is split equally during the calendar years of their marriage.[270] If more persons fulfill the requirements regarding care credits, the credits are equally divided between all eligible persons.[271]

7.2.2 (Moderately) Severe Helplessness

The person in need of care must—actually or when required—be entitled to a helplessness allowance granted by AHV, IV or the mandatory UV or MV for *at least moderately severe helplessness*.[272] Whether the allowance is received or not is

[264]Cf. Art. 29sexies AHVG.

[265]Cf. Art. 29septies AHVG and Art. 52 g ff. AHVV, as well as Circular regarding bonuses for caretaking (KSBGS; as per: 01/01/2012).

[266]Cf. Art. 29septies Para. 1 AHVG.

[267]Cf. Art. 29septies Para. 2 AHVG, margin No. 1002 KSBGS.

[268]Cf. Art. 29septies Para. 1 AHVG.

[269]Cf. Art. 29septies Para. 4 AHVG.

[270]Cf. Art. 29septies Para. 6 AHVG.

[271]Cf. Art. 52i AHVV.

[272]Cf. Art. 29septies Para. 1 AHVG.

irrelevant.[273] The supplement for intensive long-term care[274] is put on a par with helplessness allowance.

7.2.3 Being within Easy Reach

Since 1 January 2012 it is sufficient if the person to be cared for is within easy reach,[275] if the caregiver does not live further away than 30 km or if he or she is able to reach the person to be cared for within 1 h.[276]

8 Further Securities

8.1 Tax Deductions

According to the Disability Discrimination Act of 13 December 2002, the disability-related costs of the taxpayer or of the disabled persons he or she cares for, are deducted from the entire taxable income, provided that the taxable person bears the costs him−/herself.[277]

8.2 Cantonal Support of Family Caregiving

Further financial support for family caregiving is granted under cantonal law in terms of *specific tax deductions*[278] as well as *long-term care allowances* in line with the healthcare legislation.[279]

[273]Cf. BGE 126 V 435 ff.

[274]Cf. margin No. 1002 KSBGS.

[275]Cf. Art. 29septies Para. 1 AHVG.

[276]Cf. Art. 52 g AHVV, margin No. 3010.1 KSBGS.

[277]Cf. Art. 9 Para. 2 lit. Hbis StHG and Art. 33 Para. 1 lit. Hbis DBG.

[278]See e.g. § 42 I d StG AG (CHF 3000.–) and Art. 28 lit. g StG BE.

[279]Cf. § 24 lit. c SPG AG and § 21 lit. b SPV AG (care compensation to the amount of the maximum orphan's pension pursuant to AHVG), § 11 SpitexG BS and §§ 6 ff. SpitexVO BS (for care services required starting from 1 h per day and amounting to a maximum of 35% of the highest AHV pension level) and Art. 4 HPflG FR (flat-rate compensation of CHF 25.– per day); Art. 14 Para. 1 ELG.

8.3 Social Assistance

Costs for attendance and long-term care services which are not covered by any other security system must be covered by social assistance. The latter is to be distinguished from emergency aid and is to be regulated by the cantons. Each of the cantons refers in its own social welfare legislation to the guidelines on the form and extent of social assistance.[280] The basic coverage comprises the basic living needs inclusive of health care costs without co-payments,[281] as well as housing costs, plus the health insurance premium.

Situation-related services concerning long-term care and attendance:

- *Expenses relating to illness and disability:* expenses for services which are not part of basic medical care, but are beneficial and useful in specific individual cases.[282]
- *Acquisition costs and expenses for services which are not rewarded in terms of an income:* effective costs which occur in the context of other services which are not rewarded in terms of wages (volunteer or neighbourhood work, family caregiving, participation in integration or qualification programmes, etc.). The effective costs which relate to the additional costs for activities promoted and supported through social assistance have to be taken into account in their entirety when establishing the budget.[283]
- *Integration allowance:* This allowance is granted to persons aged 16 and older who are not engaged in gainful employment and who strive for their own social and/or vocational integration as well as for the integration of people around them. The amount of the integration allowance varies between CHF 100 and CHF 300 per person per month, depending on the service provided and on its significance for the integration process.[284]

9 Critical Appraisal and Potential Future Remedies

9.1 Critical Appraisal

The need for the solidary community to provide for those requiring help and long-term care has been recognised in Switzerland since 1848.

[280]Cf. http://www.skos.ch/store/pdf_d/richtlinien/richtlinien/RL_deutsch_2012.pdf (last viewed on 16.10.2017).

[281]Cf. Subpara. B.2.1 SKOS Guidelines [*SKOS-Richtlinien*] 2012.

[282]Cf. Subpara. C.1.1 SKOS Guidelines [*SKOS-Richtlinien*] 2012.

[283]Cf. Subpara. C.1.2 SKOS Guidelines [SKOS-Richtlinien] 2012.

[284]Cf. Subpara. C.2 SKOS Guidelines [SKOS-Richtlinien] 2012.

By introducing old-age and survivors' insurance (AHV), as well as invalidity insurance, *a change in the system was effected roughly 50 years ago.* In lieu of the supplementary helplessness pension, all social insurance systems introduced a helplessness allowance. This insurance benefit became, and for decades remained, the main compensatory measure relieving assistance and long-term care needs in terms of an allowance, as it made it easier for persons in need of help or care to remain in their homes despite their deficient state of health.

The extension of the material scope of validity of helplessness allowance and the introduction of new insurance benefits for persons in need of help and long-term care has made the Swiss long-term care insurance system quite complex, often at the risk of providing either redundant or deficient coverage, thus causing confusion among insurees and insurers and requiring better coordination.

The sometimes unspecified and confusing definitions of "helplessness" and "long-term care dependency" are factors contributing to the *inconherence of the system*, meaning that ultimately each case must be examined individually to see if the awarded benefit category complies with the actual needs related to the respective definition.

In terms of the rule of law, this is questionable as, for one thing, *no legal certainty* is granted and, for another, legal practice shows that the insurers often, and increasingly so, go into debates with their insurees as to the scope of their obligation to grant benefits in order to effect minimum payouts; often, they also claim that provision of the required help or long-term care benefit is already covered through a different insurance benefit. Since *helpless persons and persons dependent on long-term care are among the weakest in society*, they easily fall victim to such intransparent systems.

A further *disadvantage* is effected by *partial object financing* or the subsidizing of benefit providers. Starting from the legislator's approach in the 1950 to levy contributions in IV for building and operation funding with a view to facilities for the disabled and disability support organisations, object financing was increasingly expanded and has recently been cantonalised on the occasion of the reregulation of the finance equality measures and the introduction of the "new financing solution for long-term care measures".

The coexistence of long-term care insurance benefits and subsidy payments to long-term care institutions has not only complicated the system, but also caused a deficit in autonomy to the extent that persons in need of long-term care, despite receiving some funds, do not receive the entirety of funds that the State spends on their behalf. Such a system only fosters a reduction in the freedom to choose among the existing range of benefits, and impedes patient autonomy.

9.2 Developing New Solutions

The concept of long-term care dependency *requires a new definition*, and it is particularly umbrella terms like "basic care and care treatment" and "activities of

daily living" that must be in the focus of this process. Already in the 1990s was the usage of and *differentiation between the terms 'basic care' and 'care treatment'* deemed *obsolete* from the viewpoint of long-term care practice as well as from a legal standpoint.[285] Even though the two terms were used in the same context in some first course book editions on long-term care in the German language,[286] it has not been used in current, particularly not international, course books provided for long-term care training.[287]

Instead of differentiating, the two categories can be subsumed under the concept of a *long-term care process as a nationally and internationally established categorisation system.*[288] This long-term care process includes the anamnesis (diagnosis[289]) and points at long-term care measures to be taken. What is more, it also includes the evaluation of measures initiated, a point which today is no longer listed in the KLV, but which is becoming ever more important with a view to current quality standards.[290] Another advantage of the concept of a long-term care process is the fact that, by comparison with context-unrelated catalogues listing the individual benefits and their costs, the process-related inclusion of a measure is targeted to a much greater extent at an *approach combining quality and cost optimisation.*

Also the second umbrella term, i.e. the "(instrumental) activities of daily living", dates back to publications from the 1960s.[291] In the literature on long-term care, a number of different models and interpretations are referred to and discussed critically.[292] What is remarkable, on the one side, is the *great variation of activities offered*, ranging from 14 to 6 in number[293] and, on the other side, the fact that already during the early phase of the concept different activities were defined within the 6 ADL.[294]

Also interesting is the circumstance that, as regards instruments that include only few ADL, long-term care measures *focus on the somatically oriented status* and, in this context, primarily outline deficits (bathing, dressing, toilet use etc.). What is not addressed by the focus on these instruments are the communicative functions which serve, above all, to evaluate the measures taken (e.g. evaluation of whether or not a patient is in pain, among other things), and the assessment of social participation capacities, e.g. of how a person keeps active in daily life. Accordingly, today's instruments for the assessment of long-term care dependency must be chosen to the

[285]Cf. Klie (1998), Müller (1998).

[286]Cf., inter alia, Juchli (1973).

[287]See e.g. Menche (2011), Schewior-Popp et al. (2012), Rosdahl and Kowalski (2011).

[288]See e.g. Wilkinson (2012).

[289]Cf. Art. 7 Para. 2 lit. a KLV.

[290]Cf. Bundesamt für Gesundheit (2009).

[291]Lawton and Brody (1969).

[292]E.g. Feinstein et al. (1986), Bennett (1999), Sikkes et al. (2009).

[293]14 ATL in Henderson (1960) and 6 in Lawton and Brody (1969).

[294]Cf. Katz et al. (1963), Lawton and Brody (1969).

extent that they facilitate equal treatment for persons with somatic or, respectively, psychological and communicative-cognitive impairments.

What is common to both umbrella terms is the fact that they categorise functions or, respectively, functional impairments, *without taking account of the context*. The "eating and drinking" category is a good example showing that the mere focus on context-unrelated functions will lead to inaccurate assessments. A person with two broken arms who is otherwise healthy, for instance, will be temporarily dependent on assistance with eating and drinking. In this case, help will have to be offered in the form of repetitive feeding assistance. A person with semi-paralysis who has problems swallowing and chewing will require entirely different help with "eating and drinking" as regards the way this person is fed and the time it takes to offer this assistance.

One example for the combination of somatic and cognitive impairments and for the respective *needs assessment is oral hygiene in dementia patients*. The minimum oral care in this case implies the following tasks: manual assistance of patients if they can still brush their teeth themselves, or performing the entire process on them if they cannot; providing communicative instructions on how to brush their teeth or to open their mouths; examination of the oral cavity; and finally, evaluation of the condition of their teeth and of the mucous membranes of the oral cavity.

In view of these different requirements for one and the same ADL category, it *cannot simply be a case of "basic care"*, since the problematic somatic or cognitive circumstances—often combined with spatial limitations if care is provided in the home of the patient—are sometimes anything but easy. Accordingly, manual activities must be combined with the appropriate behaviour or motivation techniques and continuously adjusted to the progression dynamics of the illness.

The more recent efforts to systematise the definition and content of long-term care dependency have taken this complexity of long-term care dependency into account. In Germany, a new evaluation instrument for the *assessment of long-term care dependency* has recently been developed,[295] preceded by thorough analysis of the term and of international procedures. The eight newly elaborated categories[296] are embedded in an evaluation procedure which is coherent in terms of content and assessment, oriented by resources rather than deficits, and which offers a solid basis for individual planning of long-term care measures.

Since as early as 2001, the WHO, too, has made its "*International Classification of Functionality, Disability and Health (ICF)*"[297] available for general use; this classification can be used - contrary to widespread (mis)understanding—not for the assessment of disability only, but that of *any other health impairment*, too. On the

[295]Cf. Wingenfeld et al. (2011).

[296]The eight categories for the assessment of long-term care dependency are: 1. mobility, 2. communicative and cognitive functions, 3. behaviour and psychological problem-situations, 4. (food) self-sufficiency, 5. ability to deal with illness/therapy-related challenges and strains, 6. management of everyday life and social contacts, 7. out-of-home activities, 8. household maintenance.

[297]World Health Organization, 2001 (see http://www.who.int/classifications/icf/en/ – last viewed on 16.10.2017).

basis of personal and contextual factors, the respective functional impairment is assessed and evaluated. This instrument has become established particularly in rehabilitative health care.

It can be noted that both procedures[298] are not primarily oriented towards the services delivered by professional staff, i.e. towards the care needs, but towards the living environment of the patients. It is, after all, the latter that is relevant for the years or decades during which patients have to be able to live with their health impairments. This is indicative of the increase in *user orientation, and the call for self-responsibility and self-determination* on the part of the patient; these criteria have, for some time now, been stipulated in the health system, and in Switzerland they were entrenched in the new legislation concerning the protection of adults and children on 1 January 2013.

In Switzerland, the reimbursement of help and care services has been designed in terms of a *catalogue listing the individual benefits and services* or, respectively, of a time or tax value for individual services.[299] Such a system may well serve purposes related to one-off, short and clinically foreseeable episodes. However, it is less suitable as a reimbursement system for—from an epidemiological point of view—increasing, long-term and therapy-intensive care processes.[300] The alternative could be a *lump-sum or capitation system*, such as has existed and been practised by Swiss general physicians as a model of prospective reimbursement since the 1990s.[301]

In long-term care provision, the *needs-based "Resident Assessment Instrument" (RAI)* is very common.[302] Integrated in it is a module for "Resource Utilization Groups" (RUG), which in terms of concept is comparable with the "Diagnose Related Groups" (DRG), thus facilitating lump-sum categorisation of benefits/services groups. The RUG module is not, however, integrated in the RAI-Home Care Schweiz software that was adapted for the Swiss Spitex institutions. In long-term care homes, the module is either not used at all or at least not systematically. A mix has become established, however, which allocates the 12 care levels or, respectively, the required time for the service provision as stipulated in KLV[303] to the RAI Groups instead of the Resource Utilization Groups.

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[298]With a view to these two instruments, the Swiss legislator, authorities and expert committees can resort to mature solutions from abroad for a new definition of long-term care dependency and the categorisation of the specific need for help and care, cf. inter alia Schaeffer (2004) and Landolt (2001a).

[299]Cf. e.g. Art. 7 and Art. 7a KLV.

[300]Cf. Carpenter et al. (1997).

[301]E.g. Baur (2005).

[302]The Swiss association for domiciliary assistance and care services (Spitex Verband Schweiz) recommends it as the instrument to be chosen for Spitex (RAI Home Care). As for inpatient long-term institutions, it is the cantons that decide which instrument is to be used (RAI Nursing Home, among others).

[303]Cf. Art. 7a Para. 3 KLV.

The Swiss Federal Court emphasizes that the Resident Assessment Instrument (RAI) was of a recommendatory nature with a view to domiciliary care and particular professions, yet without claiming any normative validity, thus not binding the Court to any obligations. The latter could, however, consider these recommendations in its decision if they were *in line with the interpretation of applicable legal provisions in that they accommodated and justified the individual case.*[304] The RAI can—and should—therefore be consulted for the purpose of long-term care needs assessments both in health and accident insurance.[305]

As a basis for tariff-setting, some cantons allot a certain case level to the Resource Utilization Groups, e.g. reimbursement according to care time spent.[306] This makes it a mix between national provisions stipulated by social insurance legislation and a scientifically developed and internationally established instrument.

Based on experience gained from other OECD countries, it can be assumed that in future lump-sum reimbursement systems and other sorts of new financing methods or reforms in domiciliary and inpatient long-term care will be discussed in Switzerland.[307] Coordination, as of 1 January 2012 listed in the KLV as an individual benefit, will thus be a core element of integrated care. *Lump-sum reimbursement in spitex facilities can work*, as has been shown by a successful model of the New York Spitex service, one of the biggest Spitex services in the world, which has developed an insurance model for long-term care provision in cooperation with the national health insurance for low income population groups (Medicaid) and elderly persons (Medicare).[308]

More recent concepts addressing permanent health impairments also integrate *support for self-management among chronically ill persons.*[309] Thus, long-term care dependency must not exclusively be assessed from the viewpoint of service provision through health professionals. Patients on their behalf can also, according to their capabilities, contribute significantly to the progress of the concept by efficiently integrating the administration of medication into their daily life. In this context, a wealth of knowledge and experience has been acquired since the 1980s, making healthy living and a health-promoting daily routine possible also for chronically ill persons and enabling them to develop the appurtenant competences. For this purpose, patient education has been intensively promoted in Switzerland in recent years,[310] very interestingly so also with the active participation of health insurers.[311]

[304]Cf. BGE 136 V 172 E. 4.3.3 and 124 V 351 E. 2e as well as judgment BGer of 21/12/2010 (9C_702/2010) E. 4.2.3.

[305]Cf. judgment BGer of 12/07/2013 (8C_1037/2012) E. 5.2.4.

[306]Cf. Vettori et al. (2007).

[307]Cf. OECD (2013).

[308]Cf. Bischofberger (2012c), Johnson and McCarthy (2013).

[309]E.g. Kickbusch and Haslbeck (2011).

[310]Cf. Haslbeck (2012).

[311]See on this cooperation at www.evivo.ch, a programme addressing multiple diseases with a view to the promotion of self-management in the case of chronic illness.

Caretakers who (have to) provide care to family members in addition to continuing their gainful activity also require a special form of self-management.[312] Until some years ago, Swiss economy and politics almost completely overlooked the point that work-family reconciliation measures were not only to be directed at parents with healthy newborns and small children, but also at working persons who provided long-term care to relatives. So far, Switzerland has not introduced any comparable statutory provisions regarding the promotion of gainful activity in combination with the provision of care to relatives such as exists in Germany ("*Familenpflegezeit*", family care time), Austria ("*Hospizkarenz*", family hospice leave), or in Canada and the USA ("compassionate care").

Companies must, however, within the framework of labour law[313] and the Swiss Code of Obligations[314] ensure that free time or days of leave are granted to persons who provide care to family members. Human resources managers and social partners have responded relatively quickly to the new issues and challenges for businesses.[315] In order to guarantee a stable working life, it is not only the employers' role that is crucial: health care providers, too, play a major role in order for working persons to be able to pursue their gainful activity without interruptions, say, in the form of unnecessary inquiries at (or disruptions from) work. In this respect, well-coordinated solutions on integrated care also contribute to better social protection or, in other terms, to the *sustainable preservation of employment relationships*.[316]

Another way of making care services provided through family members more official is to *employ the latter through Spitex organisations*. This was examined from the perspective of legal and nursing science not long ago.[317] Employment of family carers is the responsibility of the respective Spitex organisation. Within the context of cantonal approval, the latter is also in charge of supervising the quality of care provided. Responses from Spitex organisations and of employed family carers have been positive so far.[318] From an economic point of view it can be argued that such employment generates additional tax revenue and social insurance contributions.

On the other hand, additional health insurance costs may be incurred in cases where services previously delivered voluntarily through family members are now invoiced by the Spitex organisation. However, the proportion of costs for Spitex services in relation to the overall expenditure of the Swiss health system amounts to a mere 2.8%.[319] This is unlikely to change significantly even in cases where

[312]Cf. Barkholdt and Lasch (2004), Bischofberger et al. (2009, 2013).

[313]Cf. Art. 36 Para. 1 ArG.

[314]Cf. Art. 329 Para. 3 OR.

[315]E.g. Bischofberger and Höglinger (2008), Escher Clauss (2011), Leis (2012), Derrer Balladore (2012).

[316]Cf. Bischofberger (2012a, b).

[317]Cf. Leu and Bischofberger (2012).

[318]Cf. King (2011).

[319]Cf. Weiss Zbinden (2011).

employment is specifically selected. It can be assumed, however, that involvement in long-term care and assistance service provision through family members—previously mainly women, and mostly unpaid—will decrease due to changing family structures, geographical mobility and an increased labour market participation among women.

In order to be able to thoroughly discuss the current practice of the model of "employment of family members by Spitex organisations", four aspects must be examined more closely[320]:

- the quantitative assessment of employment relationships in Spitex organisations and of previous experience,
- the option to have caregiver employment credited to a qualification in the healthcare professions,
- the assessment of experiences from the viewpoint of persons dependent on care services
- the need for further research in the socio-ethical dimension, as caregiver employment creates a new category of family members.

A further possibility of how to secure care services in private households is *care migration.*[321] In Switzerland, a market for social care services has developed in this field in the past years. Many care migrants (mostly female) come from Central and Eastern Europe to render care services in Swiss households for a certain period to persons dependent on assistance and long-term care, often living with them in the same household. This results in a complex relationship between societal and (socio-)political framework conditions with a view to this largely uncontrolled market. Apart from labour law issues it is, above all, questions on how to ensure the quality of service provision that are of interest for this study. In this regard, Spitex organisations could be considered suitable for offering advisory or supervisory services in households where care migrants are employed, thus assuming quality assurance functions.[322]

As regards the reimbursement of services provided by (female) care migrants, the following applies: The search for an assistant in the open labour market is arranged within the context of invalidity insurance or, respectively, assistance allowance. The person dependent on care services can employ the (female) care migrant. The legislator does not prescribe any specific qualifications for the respective care assistant. However, if care migrants are employed through agencies that are not approved by the cantons as service providers, no reimbursement through the

[320]A project on this is currently conducted by Kalaidos University of Applied Sciences (Kalaidos Fachhochschule Gesundheit) or, respectively, by Careum Research (Forschungsinstitut Careum F + E) in collaboration with Spitex Köniz in the framework of support measures by means of a KTI innovation cheque (KTI InnovationsScheck) (see www.careum.ch > Forschung > Patientensicherheit).

[321]Cf. van Holten et al. (2013).

[322]Cf. van Holten et al. (2013).

health insurance is possible for any services rendered. Care migrants thus often perform the same tasks in different households; their services, however, are unequally reimbursed depending on the insurance coverage of their patient. This circumstance is also relevant with a view to quality assurance, the latter of which has been stipulated in KVG. Persons dependent on long-term care and their families must be informed accordingly on reimbursement options.[323]

Since the entry into force of the "assistant budget" pilot project on 1 January 2006 it has been possible for caregiving family members to be employed by their care-dependent relatives at the expense of the invalidity insurance system. Previously and until 2008, this had only been possible for recipients of supplementary benefits.[324] However, utilisation of the employment option in the context of the pilot project did not meet the expectations.[325] With the introduction of assistance allowance in the federal law on invalidity insurance (IVG) on 1 January 2012 this option was cancelled, which means that directly related family members can no longer be employed as assistants. In 2008, the option of supplementary services in health insurance [*ELKV*] was also abolished at federal level.[326] The latter had enabled family members to be employed by their care-dependent relatives. It is now the cantons that rule on this issue by means of regulations. It remains to be seen how many persons will resort to services provided under the new cantonal conditions.

Finally, owing to an initiative of the Swiss Federal Council, a new option in terms of social policy is being discussed that is based on 'making provisions for time" (i.e. a 'care time bank'—*Zeitvorsorge*). For this purpose, the Swiss Federal Social Insurance Office (BSV) commissioned a feasibility study.[327] The aim was to examine to what extent human resources among pensioners can be used directly after retirement, and whether by means of a care time accumulation system the overall costs to be borne by the community for assistance and care services in the home of elderly patients can be contained.

With a view to long-term care provision, results show that there is potential for time units to be offered on a voluntary basis. In parallel to establishing a care time accumulation system, professional in-home care and assistance services must also be expanded, particularly since the benefits catalogue for the provisioning of time units is intended to play a merely supportive role to back up the delivery of care services. It must also be pointed out that owing to insufficient data in Switzerland and abroad, and due to the complex structures of the care time accumulation

[323]Cf. Jähnke et al. (2012); see also the guide on the employment of a helper in the home, issued by the Office for Equality (Fachstelle für Gleichstellung) of the City of Zurich:: http://www.stadt-zuerich.ch/content/prd/de/index/gleichstellung/themen/erwerbsarbeit/haushalthilfe_im_alter/publikationen.html – last viewed on 21 June 2013).

[324]See on this supra margin No. 146.

[325]Cf. Latzel and Andermatt (2008a, b).

[326]Art. 13b aELKV provided for the payment of an allowance for costs incurred in the case of illness and disability for family caregivers and family assistants.

[327]Cf. Oesch and Künzi (2008).

system, its feasibility can only be assessed once a pilot project has been launched and tested. A care time accumulation system is presently being prepared for launch in the city of St. Gallen.[328] Its operative model allows for a maximum of 750 h to be collected by each person collecting time units. These hours are secured on a long-term basis in order to guarantee their availability once a person has retired and needs them. Both service providers and voluntary organisations are involved in a cooperative way in the structural management of the care time accumulation system.[329]

This critical appraisal and the presentation of possible solutions make clear that the system of long-term care provision for very old persons and persons with disabilities requires various changes and developments. The legislator would be well advised to create a *coherent and equal compensation system for assistance services under the responsibility of a social insurance provider in the context of redesigning helplessness and long-term care allowances.* Only this would facilitate a reasonable insurance system; only thus would today's incoherently provided insurance benefits and services 1 day become guarantors for patient autonomy. Current national and international studies under umbrella terms such as "unpaid care work" and "long-term care" shall be leading the way in this context.[330]

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[328]Cf. Jochum-Müller and Harringer (2011).

[329]See also http://www.stadt.sg.ch/home/gesellschaft-sicherheit/aeltere-menschen/zeitvorsorge.html (last viewed on 16.10.2017).

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