

# FEDERALISM AND THE POLITICS OF OLD-AGE CARE IN GERMANY AND THE UNITED STATES

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Until the early 1990s, Germany and the United States had similar systems of long-term care. At that time, Germany created a new social insurance program, whereas American reform efforts stalled. As conventional explanations of social policies—rooted in objective conditions, policy legacies, interest group mobilization, and party politics—fail to explain the diverging trajectories, the authors show how differing federal structures shaped reform efforts. German federalism gives states a strong voice and encourages collective responses to fiscal problems, enabling comprehensive restructuring of long-term care financing. In the United States, states lack a political mechanism to compel federal policy makers to tackle this subject. This analysis suggests reform of social welfare issues with weakly mobilized publics is unlikely without proxy actors that have institutional or political means to forcibly gain the attention of policy makers. In addition, scholars should pay more attention to “varieties of federalism” in analyses of the welfare state.

**Keywords:** *welfare state; federalism; long-term care; social insurance; Germany*

**T**he past three decades have been a new era for the welfare states of Organization for Economic Cooperation and Development countries. Although economic slowdown and fiscal pressures have not produced a massive retrenchment of social provision, many of these nations have been reluc-

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tant to take on new burdens and responsibilities (Pierson, 2001). At the same time, the risk profile of these societies has changed and generated new problems and needs, many of which have gone unmet (Esping-Andersen, 1999). One such risk is dependency in old age, or the need for long-term care. The chance that a 65-year-old will require nursing home care at some point during the rest of her or his life is 49% and 72% for home care (Friedland, 2002). Yet aside from some of the Nordic states, which have offered broadly available long-term care services since the 1960s and 1970s, most countries have inadequate provisions to protect people from the risk and concomitant high cost of chronic illness. In most countries, long-term care is provided through means-tested programs that shunt disabled elders into nursing homes when they would prefer to remain at home and force them to give up most of their assets to qualify. Existing provisions are widely viewed as inadequate and demeaning.

Despite this great need, few Organization for Economic Cooperation and Development countries have developed a comprehensive approach to long-term care. One reason is the unusual risk profile of long-term care and the nature of its constituency. The chronically ill and their caregivers are dispersed, unorganized, and politically weak and are, therefore, unlikely to be engines of policy change. Moreover, people vastly underestimate their own risk of needing long-term care and try to avoid pondering the unpleasant subjects of aging, decline, and dependency. This diminishes the likelihood that the traditional forces behind the welfare state—labor unions, business associations, churches, and their related political parties—will feel pressure to take up this issue. In the absence of political pressure, policy makers, who are already reluctant to create new broad-based programs in an era of fiscal strain, simply leave these burdens on families and subnational governments.

This describes the situation in both the Federal Republic of Germany and the United States in the 1980s, when the issue of long-term care came on the political agenda. However, whereas a campaign for long-term care reform in the United States came to naught, similar efforts succeeded in Germany in 1994 as the government created a new social insurance program for long-term care. Why did two nations that faced similar problems, from similar starting points, arrive at such different outcomes?

Existing approaches to the welfare state fail to account for these differing policy outcomes. Instead, we look at the role of federalism in shaping the capacity of state governments to push for long-term care reform. State and local governments in both countries long bore these burdens because they provide the welfare programs of last resort for people devastated by the high costs of chronic illness. Yet the structures of federalism differ markedly in the

two countries, shaping the power and behavior of state governments in national affairs. First, the German Länder had an institutional mechanism for pressing their concerns at the national level: an effective veto of legislation in the Bundesrat that gives them leverage over federal decision making. By contrast, American federalism leaves states relatively impotent and unable to force the federal government to address their problems. Second, the pattern of fiscal federalism in the two countries contributed to the divergent policy trajectories. In Germany, revenues are shared across all levels of government, and the growing burden of nursing home costs affected not only the state and local governments but also the entire pool of fiscal resources shared between governments. A new social insurance program, funded by contributory payments from the public, was viewed as a way to address wider budgetary shortfalls. By contrast, American federalism creates incentives for the federal government to shift policy responsibilities to the states, and the best states can do is try to game the system and maximize federal aid. There are fewer incentives for collective state action in the United States and less likelihood that state fiscal concerns will be heard.

In sum, German reform efforts succeeded because the interests of the weak long-term care policy constituency coincided with those of the Länder, which had an institutional mechanism for pushing reform on the federal government. In the United States, the interests of the long-term care constituency and the states were congruent as well, but the states were powerless to achieve policy change. The importance of the differing federal structures is highlighted by the fact that in each country, there was a political entrepreneur who advocated policy reform—Representative Claude Pepper (Democrat-Florida) in the United States and the Christian Democratic Minister of Labor Norbert Blüm in Germany. Yet only in the German institutional structure could an entrepreneur gain political traction and see his vision for reform come to fruition.

This analysis shows the importance of incorporating federalism into analyses of welfare state politics. Differing forms of federalism are highly consequential, shaping the degree to which social problems are channeled upward to federal policy makers. However, a dichotomous federal/nonfederal distinction, as is commonly employed in the study of public policy, would fail to capture the structural features that were so important in this case. Instead, we show the merits of investigating different features of fiscal federalism and intergovernmental relations. In probing these “varieties of federalism” (Obinger, Leibfried, & Castles, 2005b, p. 8), we can arrive at a more nuanced understanding of the impact of federalism on the politics of the welfare state.

### LONG-TERM CARE IN GERMANY AND THE UNITED STATES

The political and social conditions surrounding long-term care in Germany and the United States prior to the mid-1990s allow us to rule out many alternative hypotheses for the differing policy trajectories. Moreover, the unusual characteristics of this “new” welfare state issue render impotent many of the traditional explanations for these differing policy outcomes. As an issue characterized by profound cognitive biases—the vast underestimation of chronic care need, in particular—long-term care outcomes also cannot be explained by factors with their origins in mass preferences or mobilization, such as the actions of unions, interest groups, and political parties. Thus long-term care presents a challenge to the usual accounts of social policy outcomes.

One explanation for the differing paths of long-term care reform may simply be that preexisting programs and needs were different, resulting in greater pressures for reform in Germany than in the United States. However, the long-term care situation in these two countries was highly similar until the mid-1990s. In Germany and the United States, the level of disability and need was nearly identical: In the early 1990s, approximately 5% of people aged 65 and older were in residential care in both countries, whereas 1% to 3% of elders in Germany and 4% in the United States received professional paid care in the home (Organization for Economic Cooperation and Development, 1995). Yet in neither country was long-term care part of the social insurance system, as neither Medicare nor the German health insurance funds covered much chronic care. Most public provision came through state- or city-run means-tested social assistance programs, which paid for about two thirds of nursing home residents (Schunk & Estes, 2001). In both countries, social assistance programs were criticized for forcing people to spend their assets down to the poverty line to qualify. These means-tested programs also primarily covered the costs of nursing home care, channeling people into institutions when they would much rather be cared for at home (Cuellar & Wiener, 2000; Komisar, Lambrew, & Feder, 1996, p. 53).

Furthermore, in both countries, unpaid family members provided the vast majority of long-term care for the disabled elderly. At the same time, the number of working aged persons per elderly person was declining, and the growing labor force participation of women put pressure on networks of informal care (Ostner, 1998; U.S. Bureau of the Census, 2002). The demographic situation was, and remains, worse in Germany than in the United States; from 1960 to 1990, the number of people aged 80 and older grew 176% in the United States and 196% in Germany (U.S. Bureau of the Census, 2002, p. 18). Rather than necessarily being an imperative for reform, how-

ever, these demographic facts frequently were asserted in both countries as a reason not to expand access to publicly supported long-term care.

Another explanation for the differing policy trajectories could be that reform was simply a path-dependent response to a new social problem. Whereas the size of the German welfare state is in the middle of the pack of advanced industrialized states, it is clearly larger than the American welfare state, and Germany has a long tradition of social insurance. In the United States, by contrast, private market solutions have been favored and gained credence in the past two-and-a-half decades. These varying welfare state traditions are sustained and reinforced by the political parties in power, such as Social Democratic and Christian Democratic parties in Germany, both of which support the welfare state, and the free market Republican and centrist Democratic parties in the United States, both of which are often inclined to favor market-based solutions. Given the mutually reinforcing effects of policy legacies and party ideologies, it is not surprising that the German government would devise a contributory state-sponsored system of long-term care insurance, whereas the United States left this responsibility on families and private insurance.

On closer examination, policy legacy and party ideology arguments could lead us to predict an entirely different set of outcomes. Germany is often labeled a “Christian Democratic” welfare regime that is informed by the principle of subsidiarity—the notion that social responsibilities should be left to the lowest level of society, such as local governments, voluntary associations, and families (Kersbergen, 1995). Moreover, the conservative and familialist orientation of the Christlich-Demokratische Union–Christlich-Soziale Union (CDU-CSU) would lead us to expect they would favor leaving responsibility for long-term care on families, as indeed they have in the case of child care (Morgan, 2003). It is not surprising that the CDU-CSU rejected calls for reform of this area until the early 1990s, instead favoring measures that encouraged families to take care of their own members, such as tax breaks for multigenerational households (Schiersmann, 1991). Thus the conventional literature on the welfare state would have predicted little or no action on long-term care in Germany.

By contrast, although the American welfare state is limited, the one area in which it is quite extensive and generous is in provision for senior citizens. Indeed, the most significant expansion of the welfare state since the 1960s was a new prescription drug benefit for seniors in 2003, which occurred under a Republican administration. Moreover, one of the path-dependent consequences of the elderly oriented welfare state has been to foster political participation and activism of senior citizens (Campbell, 2003). Proof of this is the fact that the United States has one of the best organized senior citizen movements

among Western countries. We could therefore expect the needs of senior citizens for long-term care to be heard more clearly in the United States and that political entrepreneurs would see a political pay-off in addressing this issue.

This is especially the case given the failure of private market solutions to fill the gap. The American welfare regime is characterized by a high degree of private provision, which tends to undercut drives for expanded public programs (Esping-Andersen, 1999; Hacker, 2002). Yet private markets have failed to develop affordable long-term care insurance policies in both Germany and the United States. Although insurance companies have difficulty pricing the risks and costs of these services, consumers find the policies expensive and know neither how much coverage they will need nor whether they will need it at all. By 1994, prior to the introduction of the social insurance law, fewer than 2% of people older than 55 were private long-term care insurance holders in Germany (Schneider, 1999). Even in the United States, where government policy has tried to promote private solutions, only 6% of Americans older than age 45 have purchased long-term care insurance (Moffett, 2002, p. 95).

One reason for the failure of private long-term insurance is the widespread denial and misperception of risk that accompanies the issue of long-term care. Citizens of Germany and the United States alike are guilty of the “5% fallacy”: They correctly assess the cross-sectional likelihood that a person aged 65 or older lives in a nursing home at 5%, but they mistake that for their longitudinal likelihood of nursing home occupancy, which is 10 times higher, or their longitudinal likelihood of needing home health care, which is 14 times higher (Alber, 1996, p. 263; Friedland, 2002). In general, the specter of decline and disability is an unpleasant topic that many would prefer to ignore, and denial is rampant. Indeed, denial and misperception of risk make people unlikely to think about long-term care until they reach an age at which insuring their risks privately is expensive.

This misperception of risk has wider political implications, as it undercuts the conventional forces—including interest groups, political parties, and political entrepreneurs—that should drive expansion of the welfare state. For one thing, there has been little public pressure for long-term care reform. Although survey respondents are supportive of long-term care reform when asked about it,<sup>1</sup>

1. Consistently, 80% to 85% of Americans in the 1980s and 1990s favored a federal program for long-term home care; support remained at 70% when higher taxes were mentioned (Kaiser Family Foundation, 1996; Rovner, 1988). Nor in Germany were there signs of backlash against the elderly and their programs: 78% of former West German and 89% of former East German respondents said that “the authorities in our country do not do enough for elderly people” (*Eurobarometer Survey 37.1*, 1992). In the United States, two thirds of respondents in a Gallup (1999) poll said political leaders in Washington pay too little attention to the needs of senior citizens; just 4% said seniors get too much attention.

cognitive biases otherwise render long-term care a very low salience issue, one which fails to make “most important problem” lists—both general and health care specific (AARP, 2000; Times Mirror & Harvard School of Public Health, 1994). Further undermining public pressure for reform is misinformation: Surveys show that many people in the United States, for example, erroneously believe they have long-term care coverage through Medicare, their employers, or private insurance (Field Institute, 1994). These misperceptions profoundly alter politicians’ calculus concerning long-term care. Given the underestimation of long-term care risks by the public, and resulting lack of public pressure, there are few incentives for political officials to tackle this problem.

The characteristics of long-term care that undermine public pressure with regard to the issue also diminish the roles of the interest organizations typically prominent in welfare state politics, such as unions and other organized interests. Taking the example of pensions, the “risk” of retirement is hoped to be 100%, allowing unions to bargain for pensions as a deferred wage and making workers willing to make payroll contributions that they expect to recoup. With health insurance, risks are perceived as unknown but high (even if not 100%) and so here too, social insurance is seen as a “good deal.” In contrast, because the risk of needing long-term care is less than 100% (and is misperceived by the public as being very low), unions feel little pressure from members to lobby on this issue. The traditional peak associations also have little interest in a problem that generally occurs long after retirement. For example, most of the people requiring extended nursing home stays are women older than the age of 85—not a category that gets any representation in union organizations.

Even elderly interest groups have largely ignored long-term care. In addition to its well-organized senior citizens’ movement, the United States has powerful, organized champions for disability rights that have fought the institutional bias of state long-term care funding and demanded improved access to home-based care. However, mass-based advocacy groups did not play a major role in long-term care reform debates in either country. In the United States, the AARP has always asserted the need for long-term care reform but has done little to actually push this forward. The reason appears to be that long-term care is of low salience to its members, and the unpleasant topic does not fit the AARP’s preferred image of healthy and positive aging (Morris, 1996). In Germany, local senior councils in the *Länder*, organizations of senior citizens within the CDU (Senioren-Union) and the Sozialdemokratische Partei Deutschlands (SPD; aged 60 and older), and the Federal Association of Senior Citizen Organizations (BAGSO) played little role in moving long-term care onto the policy agenda (Alber & Schölkopf,

1999). Just as in the larger political system, the very old lack political voice compared to the recently retired.

The profound implications of the misperception of risk on the politics of long-term care are evidenced by comparison with prescription drug coverage, an issue with a very different risk profile. Both the elderly and their advocacy groups in the United States pushed hard for a new prescription drug benefit for seniors, despite the fact that the expected lifetime cost of long-term care exceeds that of prescription drugs for the average American senior.<sup>2</sup> The key difference is that paying for prescriptions is a risk most seniors face today, whereas long-term care is an unknown and underestimated risk they face (or hope not to face) in the distant future. The Republican Party, eager to diminish the Democrats' advantage on elderly entitlements, seized the political opportunity and passed a new prescription drug benefit in 2003. The difference in risk perception makes all the difference in political pressure and politicians' incentives.

In sum, the usual explanations for welfare state outcomes fail to explain the different reform trajectories. Contrary to actual events, policy legacy arguments would predict continued reliance on family caregivers in Germany in the name of subsidiarity as well as new provision for American elders, who constitute the principal focus of the U.S. welfare state and exert considerable political influence (Campbell, 2003). Similarities in existing programs, demographics, and public opinion about the merit of spending more on the elderly (see Note 1) mean that these factors cannot account for the different reform outcomes. Finally, similar misperceptions of risk in the two countries led to the same difficulties in organizing with regard to this issue. Indeed, in several regards, reform seemed more likely in the United States, as the elderly and disabled were more politically organized and the demographic crisis was less severe. Yet the American long-term care debate of the mid-1980s to mid-1990s came to naught, whereas a new social insurance program was achieved in Germany. With the failure of plausible hypotheses to explain the differences in policy outcomes, another set of explanations is needed.

### FEDERALISM AND LONG-TERM CARE REFORM

The answer lies in the varying structures of federalism and intergovernmental relations in these two countries and how they served to magnify or

2. The expected lifetime costs for a current 65-year-old are US\$12,000 for uncovered prescription drugs and US\$44,000 for uncovered long-term care (Knickman & Snell, 2002).

muffle the voices of subnational governments pleading for relief from the costs of long-term care. The German Land governments are directly involved in federal policy making and were able to serve as an effective interest group for the unmobilized public. The American states had less influence and failed to serve as a similar force. More fundamental, the German system of fiscal federalism, with its extensive revenue-sharing provisions, facilitated and even necessitated a collective response to a growing burden on state and local governments. In such a system, the problems of a few states become the problems of all, encouraging collective responses and propelling issues into the domain of intergovernmental bargaining about the share of budgetary resources. In the United States, by contrast, state governments often are left to struggle on their own to cope with fiscal shortfalls. This leaves them vulnerable to the shifting of burdens from the federal to the state level and in this instance, neglect by the federal government of these pressures on state budgets. With no other powerful interest groups or actors who could force policy-making elites to take seriously the issue of long-term care, they would likely avoid doing anything if possible, particularly as policy change promised to be expensive and to require new revenue sources. In Germany, policy makers did not have that luxury and instead sought ways to turn the reform into a source of political gain and financial stability for the country as a whole.

#### FEDERALISM AND INTERGOVERNMENTAL RELATIONS

Two key differences in German and American federalism shed light on the varying trajectories of reform in these two countries. The first is the power and influence of the German Länder in federal policy making compared to the American states. The main avenue of Länder influence is the Bundesrat, the second federal chamber, which is composed of representatives of the cabinets of each Land government. As delegates are also state-level cabinet members, this ensures the direct representation of state *government* interests in national policy making (Halberstam & Hills, 2001, p. 175). Although the Bundesrat lacks the power to introduce legislation, it must approve, and can veto, any bills that pertain to state government interests. In practice, virtually all significant legislation requires concurrent majorities in the Bundesrat and Bundestag, including all revenue acts.<sup>3</sup> This makes the Land governments an important actor in federal politics whose interests cannot be neglected by the federal government (Wehling, 1989).

3. Currently, the Bundesrat approves about 55% of all federal laws (Leonard, 1999, p. 11).

The American state governments lack a similarly guaranteed role in the federal policy-making process. Originally, the Senate was to be the representative of states' interests in national politics, as its members were selected by state legislatures. The 17th Amendment undermined this function by introducing direct popular election of Senators in 1913. States continue to wield some influence by dint of the Electoral College and the primary system through their representatives and senators and through the decentralized party system. However, these types of influence do more to represent the interests of state residents than state governments. The National Governors' Association and the National Conference of State Legislatures serve as lobbyists for state governments, but for many decades these organizations were weak and had little influence in federal affairs.<sup>4</sup> To some observers, they appeared to have growing influence in the 1960s and 1970s, a time of increasing federal aid to state and local governments and the Nixon revenue-sharing initiative. However, the states' reversal of fortunes in the 1980s revealed how their influence depended on the whim of political elites (Cammisa, 1995, pp. 2-6). In short, although the German Länder are a regular bargaining partner of federal policy makers, the American state governments constitute one interest group among many that must vie for influence in a competitive, pluralist environment.

Indicative of the relative power of the German and American states in federal politics is the extent to which each suffers from unwanted administrative burdens. In Germany, the power of state governments in the Bundesrat helps protect the Länder from onerous administrative responsibilities (Halberstam & Hills, 2001). If federal policy makers wish to have a particular policy objective met, the Bundesrat can pressure them to fund those responsibilities. Protection from unfunded mandates also is constitutionally guaranteed; an article in the federal constitution requires the federal government to provide the Länder with grants to help pay for implementing federal law (Gunlicks, 1986, p. 83).<sup>5</sup> Many grants from the federal government are general-purpose grants, allowing the Land governments to decide how to spend these monies (although they must meet overall objectives specified at the federal level; Rodden, 2000).

4. Other organizations include the U.S. Conference of Mayors, the National League of Cities, the National Association of Counties, and the National Association of State Units on Aging.

5. This should not imply that the German states never face unfunded burdens put on them by the federal government, as they certainly do. Much as in the United States, efforts at burden shifting do not always leave the states with the advantage. Relative to the United States, however, state governments are better able to protect themselves from unfunded mandates.

Lacking a guaranteed role in shaping federal regulations and mandates, the American states are more vulnerable to unfunded mandates from the federal government or to strings attached to the funds they receive (Gold & Wallin, 1999). In response, a number of governors proposed in the early 1990s a constitutional amendment that would enable a vote by three fourths of state governments to nullify acts of Congress—a measure that would approximate the kind of power the German states have to veto Bundestag legislation (Peirce, 1995). This failed to get off the ground, however, and a 1996 law intended to reduce the number of unfunded federal mandates has failed to prevent new financial burdens on the states (Gold & Wallin, 1999, p. 60).

The second key difference in the two federal systems is how fiscal inter-governmental relations create incentives for collective responses to common problems in Germany, but not in the United States. All levels of government in Germany rely on a common pool of fiscal resources that is divided among them to pay for their responsibilities (Voigt, 1989). Thus although the *Länder* and *Gemeinden* (local communities) administer various government programs, the federal government furnishes them with funds to meet these obligations. States and localities have little power to tax on their own; state governments rely on the federal government for much of their revenues, whereas localities depend on both the tax revenues that are attributed to it and grants from the *Länder*. In addition, an extensive system of revenue sharing creates interdependencies between states whose own fiscal health is affected by that of other *Länder* (Wassener, 2002, pp. 70-71). The federal and Land governments equalize resources between regions through vertical transfers from Bund to Land, formulas for the distribution of tax revenues by region, and horizontal transfers from rich to poorer *Länder*. Further transfers take place within the *Länder* to equalize conditions for municipalities. One consequence of this system is that the burdens faced by some subnational governments in the end will affect the rest in that ultimately, they will face pressures to transfer more resources to affected states and cities. This also brings budgetary issues to the attention of federal policy makers, as states and localities will pressure the government for a greater share of the tax revenues if their responsibilities increase.

In the American system, there is greater independence between levels of government and, thus, a tendency by policy makers to shift burdens around rather than confront their underlying cause. Unlike subunits in many federal countries, American state and local governments can raise their own taxes. Federal grants help pay for many state and local government programs, but the federal government can also simply leave it to states to raise the taxes needed to pay for public programs. Indeed, the trend in the past three decades has been toward subnational taxation, with state and local taxes increasing

from 8.5% of GDP in the 1960s to 10.7% in the 1990s (Donahue, 1999, p. 25). In addition, the United States has never adopted the kinds of fiscal equalizing programs used in other federal systems (Donahue, 1999). There is no common pool of tax dollars such that increased burdens in some states will impinge on the fiscal health of others. Instead, each state has an incentive to try to maximize its own share of federal resources, whereas the federal government often tries to shift burdens back onto states as a way to cut federal spending and taxes.

In Germany, the systems of revenue collection and resource equalization make it more difficult for the federal government to continually shift burdens onto state and local governments. Instead, governments have often expanded social insurance programs, which are financed separately from the aforementioned pool of intergovernmental resources (Manow, 2005). In the United States, by contrast, the “nominal sovereignty” of the states (Miller, 1993), and their ability to tax, encourages the federal government to shift costs onto the states, forcing them to either raise revenues or cut programs. Even when American states band together to achieve collective aims, they are often spurned by federal administrations. With their power in the Bundesrat, the demands of the German Länder are much harder to ignore. These differing federal systems shaped the course of long-term care reform in Germany and the United States.

#### GERMAN AND AMERICAN LONG-TERM CARE REFORM

In Germany, the Land governments gave political voice to the diffuse public interest in long-term care reform, championing an issue that otherwise could easily be disregarded by governing elites. Holding federal policy makers’ feet to the fire, the state governments helped ensure attention would be paid to this issue and that the solution would reduce the pressure on state and local budgets. More fundamental, because of extensive revenue sharing between states and across levels of government, all came to see the merit of moving the costs of long-term care onto a social insurance program based on new public contributions—particularly as German reunification shrunk the pool of tax resources available.

In the United States, by contrast, governors’ attempts to put full responsibility for long-term care onto the federal government have repeatedly failed, and state governments were largely absent from debates regarding the extension of the Medicare program in the late 1980s and early 1990s. Lacking a powerful force behind it, long-term care reform quietly dropped off the political stage and has never seriously been addressed since. Medicaid politics involve efforts at burden shifting between states and the federal government

as both try to push responsibilities on the other rather than confront the program's fundamental problems. Although the German Länder successfully shifted much of the cost for long-term care onto the social insurance system, state governments in the United States continue to bear these costs, to the detriment of their fiscal well-being.

### **The German Reforms: The Assertion of State Power**

By the early 1970s, a number of important reports brought West German policy makers' attention to the fact that existing systems of public and private health insurance were inadequate in dealing with long-term care (Schraa, 1994). There were federal efforts to encourage state and local governments to provide more community-based services, such as a 1984 amendment to the social assistance law. Still, the emphasis on institutional care predominated. Furthermore, state governments began experiencing strains on their own budgets due to increasing long-term care costs. Social assistance spending on long-term care trebled between 1970 and 1976 and more than doubled during the next decade (Götting, Haug, & Hinrichs, 1994).

Growing strains on local welfare budgets spurred the German Länder to action in the 1980s (Haug, 1994). A number of Land governments began proposing long-term care reforms in the Bundesrat, although there was little agreement at that point on what the nature of reform should be. Some called for greater federal financing and a new transfer program, whereas others advocated mandatory private or public insurance schemes (Schraa, 1994). Social assistance budgets got some relief in 1988 with the Health Care Reform Act (Gesundheits-Reform-Gesetz), which allowed the use of sickness funds to pay for home care for a small number of people in need.<sup>6</sup> One reason this was included in the Health Care Reform Act was to secure Länder support in the Bundesrat for other cuts to the health care system (Alber & Schölkopf, 1999, pp. 130-131). By 1995, 700,000 people were receiving care through the health insurance system, and this served as a prototype for the larger reform that was later enacted (Götting et al., 1994; Schneider, 1999). Still, the measure did nothing to address the heavy burden of nursing home care on local budgets and, thus, states pressed for a wider reform. In 1990, the government of Baden-Württemberg proposed a mandatory private long-term care insurance system, whereas the SPD called for a separate

6. Following a medical exam to determine eligibility, people could receive DM400 per month for informal care at home, and DM750 per month for professional home care with no means test.

social insurance program in 1991 that was backed by the SPD-run state governments (Schraa, 1994).

Their demands were answered in the early 1990s as the fiscal burdens of reunification sparked renewed efforts to aid the German Länder. Reunification entailed massive transfers of tax revenues to the Eastern Länder; between 1990 and 1994, the West German Länder transferred 5% of their GNP to the East each year. Debt levels reached their highest levels since World War II, and deficits threatened to strangle all levels of government (Heilemann & Reinicke, 1995). Given the nature of revenue sharing in Germany, the effect was to decrease the pool of resources available for all levels of government. The need for fiscal relief for all Länder, old and new, was immediate. In this context, the Länder viewed a redistribution of the burdens of long-term care costs as essential for their fiscal well-being.

The Land governments used their position as partners in federal policy to push the issue of long-term care reform into the political arena (Alber, 1996; Cuellar & Wiener, 2000; Götting et al., 1994). Crucial to this effort was getting the CDU government in power to adopt this as a legislative priority. The turning point came in 1990, when Christian Democratic Minister of Labor Norbert Blüm announced that a social insurance scheme for long-term care would be introduced in the next parliamentary session, thereby establishing this as a policy concern of the CDU. Such a move could simply be interpreted as an extension of the Christian Democrats' commitment to the social market economy. Blüm justified the measure in these terms, calling on the party to renew its identity as a people's party and commitment to solidarity by adding long-term care assistance as a fifth pillar of the welfare state (Christlich-Demokratische Union Deutschlands, 1990, pp. 102-105; 1992, pp. 88-89).

Yet prior to 1990, Blüm himself was strongly opposed to a new social insurance program for long-term care (Alber & Schölkopf, 1999, p. 135). Throughout the 1980s, there was widespread disagreement in the CDU on the blueprint of a new long-term care system as well as whether there should be reform in this area at all (Götting et al., 1994, pp. 292-293). At party conventions in the early 1990s, a number of party officials maintained that there should be no new social initiatives in the West until the full burdens of reunification were paid for. Fiscal responsibility and market solutions were advocated by many within the party, but also among employers' groups, the CDU's coalition partner (the Freie Demokratische Partei [FDP]), and the Bundesbank (Alber & Schölkopf, 1999, pp. 138-139). Despite its evident electoral appeal, the idea of reforming long-term care languished for two decades. Although Blüm had multiple motives, one reason for the shift was concern regarding the fiscal burdens on state governments (Alber & Schölkopf, 1999, p. 142). Blüm himself admitted that one of his goals was to

relieve the municipalities of the costs of long-term care, although he also viewed long-term care reform as a way to leave his imprint on the German welfare state (Christlich-Demokratische Union Deutschlands, 1990, pp. 102-105).

The preferences of state governments also shaped the kind of reform that ultimately would be enacted. Even after Blüm's embrace of reform as a government objective, many within the CDU continued to push for a mandatory private insurance scheme. On the other side of the spectrum, many inside the SPD advocated a new entitlement to long-term care that would be financed through general revenues. This would keep the costs off the social insurance system and ensure the new program could be paid for through progressive taxation (Götting et al., 1994, pp. 292-294). Trade unions, employers, and the managers of the social insurance funds also favored a tax-financed entitlement because they believed contributory taxes already were high and made it harder for employers to create new jobs (Alber & Schölkopf, 1999, pp. 136, 162).

However, state governments, including those governed by both Christian Democrats and Social Democrats, ultimately came together in favor of a social insurance scheme.<sup>7</sup> This would not only diminish the direct costs for long-term care but also remove these burdens from the general pool of revenues shared between states, localities, and the federal government. A tax-financed entitlement would move the burdens back onto the federal government but would continue to drain resources out of the general tax pool. A mandatory private system also would do little for state and local governments in the short-term, as the current generation of elders would not be eligible for coverage. This meant that these governments would have to continue paying for their care, thus, nullifying any of the financial advantages of reform (Alber & Schölkopf, 1999, p. 136). This fact also appealed to federal policy-making elites who were faced with the high burdens of reunification and saw a new, contributory program as a way to avoid further financial burdens on public budgets.

Given this fact, many in the Christian Democratic Party realized that a mandatory private system would yield few political benefits because it would help neither subnational governments nor current retirees in need of long-term care (Schneider, 1999). Land-level demands for reform also moved the SPD toward support for a new social insurance program. Since reunification, the pool of general revenues available to be divided between the Länder had shrunk, making a new commitment of resources to such a program unappealing. With the SPD-led governments strongly behind a new social insurance scheme that would remove much long-term care spending from this pool of

7. Some of the Land governments initially favored a new, tax-financed plan.

common resources, the SPD came to favor such an initiative (Götting et al., 1994, p. 294; Haug, 1994).

SPD-CDU agreement at the state level proved important in furthering the long-term care reform through the legislative process. State governments controlled by both the CDU and SPD concurred on the need for reform and pushed this issue through the political parties. As the main opponent of reform, the FDP, had little influence in the Bundesrat, the chamber also could speak in a unified voice for the reforms during the contentious debates of the early 1990s ("Bund und Länder," 1993). For German political elites, the unified demands of state governments made plain the potential political pay-off of a new social insurance program. Moreover, because the SPD had a majority in the Bundesrat, the CDU-led government had to be attentive to the preferences of the Länder (Götting et al., 1994). The Bundesrat also did not hesitate to veto any bill that did not meet the needs of the states ("Bund und Länder," 1993).

This is not to say that the success of the reform was assured. Many observers at the time expected that the reform effort would founder on the contentious issue of how to distribute the costs of the new program between employers and employees (Bruns, 1994; Forster, 1994). In other social insurance programs, such as health and pension coverage, employers and employees split the payment of insurance contributions. Complaining of an already high tax burden, however, employers and the FDP were strongly opposed to a similar arrangement for long-term care, and they demanded measures that would compensate employers for these costs. After much haggling and debate, a compromise solution was reached that eliminated one mandatory paid holiday.<sup>8</sup>

Despite these difficulties, a positive reform spiral emerged, where one party seized the initiative and others hastened to proclaim their support for the goal, if not the means. Once the reform process started to get off the ground, both the CDU and SPD worked hard to claim credit for a reform that appealed to important constituencies. In addition, federal policy makers saw wider fiscal advantages in creating a new social insurance program for long-term care. Creating a separate social insurance program that relies entirely on the insurance contributions of employers and employees freed up general revenues for other spending needs. Tapping public willingness to pay new contributions for a valued reform, thus, helped raise revenues at a time of fiscal difficulties.

It is ironic, therefore, that the solution to fiscal crisis in Germany at this time was not to cut the welfare state but to expand it. Long-term care reform

8. Each of the Länder decided which paid holiday to eliminate. As Saxony failed to do so, employees there pay 1.35% of payroll, employers pay .35% (Geraedts, Heller, & Harrington, 2000).

both solved state fiscal concerns and provided political pay-off for the parties. All of this came to fruition because the constitutional status and power of the Länder, and the nature of fiscal federalism, moved policy makers to confront the issue of long-term care.

### **Failed Reform in the United States: Medicaid and the Burden-Shifting Game**

The American states also had a strong interest in long-term care reform. Most nursing home costs are paid through Medicaid, the joint federal-state program of health insurance for the poor. Such spending trebled between the late 1970s and late 1980s and was rising by more than 12% a year after 1990 (Kosterlitz, 1988). By 1988, long-term care costs accounted for almost half of state Medicaid spending. Constitutional requirements in most states to achieve balanced budgets exacerbated their fiscal situation (Coughlin, Ku, & Holahan, 1994).

Given the increasing strains on their budgets, the states regularly called for a fundamental redistribution of burdens between the state and federal governments. In the early 1980s, the National Governors' Association proposed a swap that would shift financial responsibility for Medicaid to the federal government and give education fully to the states, and this was followed by Reagan administration proposals to move Aid to Families With Dependent Children to the states. Negotiations concerning these proposals broke down when ideological opposition to a greater federal role in social welfare programs emerged within the Reagan administration and when the states realized they would be getting more responsibilities without sufficient financial support. In a similar manner, the Partnership Act of 1987 proposed raising the federal matching rate for Aid to Families With Dependent Children and Medicaid to 90% and implementing nationwide standards in exchange for the repeal of 14 federal grant programs; the bill was introduced in Congress but never enacted (see Peskin, 1989).

In fact, rather than securing relief from federal mandates, the states were confronted by yet more mandates during this period, particularly concerning Medicaid. Between 1984 and 1990, Congress passed at least one piece of legislation each year expanding Medicaid eligibility and services, causing enrollments and program expenditures to soar. In both 1989 and 1991, the National Governors Association pleaded, ineffectually, for a moratorium on such federal mandates (Advisory Commission on Intergovernmental Relations, 1992, p. 20). The Advisory Commission on Intergovernmental Relations' (1992) report proposes that responsibility for long-term care be transferred to the federal government under Medicare. The proposal went nowhere,

however, and the commission disbanded a few years later. During the 1990s, similar proposals resurfaced to fully shift Medicaid to the federal level, but the federal government rejected them.

The powerlessness of the states is evident in the discussion of long-term care reform in the late 1980s and early 1990s. The issue came onto the national agenda through the Medicare Catastrophic Coverage Act of 1988 (MCCA), which expands Medicare to cover catastrophic acute costs faced by the elderly but adds little long-term care coverage (Himelfarb, 1995). However, during the MCCA hearings, popular Congressman Claude Pepper continually raised chronic care concerns, and the Long-Term Care '88 campaign successfully injected the issue into the 1988 presidential race. These efforts publicized the fact that the "catastrophic" risk older people were most likely to face was the need for nursing home or home health care (Rovner, 1995, p. 164). Indeed, many politicians and analysts believed that a new federal long-term care policy was inevitable given the aging of the population, the growing strain on baby boomers struggling to care for their parents, and the perceived political influence of the elderly (Kosterlitz, 1988; Rovner, 1988).

One option for long-term care reform was to extend the MCCA's financing mechanism to cover a new chronic care benefit. The MCCA was funded by a surtax on elders' income and an increase in Part B premiums rather than by general revenues or an increase in payroll taxes on workers. The progressive, seniors-only financing mechanism was viewed as a way to pay for an expansion of social insurance without hurting lower-income people or imposing greater burdens on younger generations (Himelfarb, 1995, pp. 36, 45). However, it was precisely this mechanism that led to the law's demise. Upper-income seniors liable for the higher premiums protested because for many, the MCCA provided redundant coverage; low-income seniors also objected, convinced by misinformation campaigns by opposing interest groups that they would be liable for the maximum surtax, which in reality only the top 5% of seniors would pay (Himelfarb, 1995). Faced with mounting senior protests, lawmakers repealed the law in 1989.

The collapse of the MCCA made lawmakers cautious about future attempts to expand Medicare, including coverage of long-term care. It was clear that a new program could not be financed entirely by the elderly but instead, would require general revenue funding or an expansion of the original intergenerational bargain behind social security and Medicare. Faced with these alternatives, legislators balked, and there were no organized forces that could prevent them from burying long-term care reform. Although there were numerous interest groups concerned with various aspects of long-term care and seniors' well-being, this community has been fragmented and fairly ineffective in pushing for broad structural reforms. The AARP always pro-

fessed support for long-term care reform but since the 1980s, lobbied for a prescription drug benefit instead. Much as in Germany, the interest group environment was hardly propitious for reform in this area, leaving legislators free to simply ignore what promised to be a complicated policy reform.

Unlike in Germany, state governments were absent from debates concerning long-term care from the mid-1980s to mid-1990s. For example, the MCCA created the Pepper Commission, which continued after the bill's repeal, to consider reforms in both chronic and acute care. Composed of the most influential health policy makers in Washington, D.C., the commission engaged in the most significant national discussion there has ever been on long-term care. Yet the states were absent both from its hearings—no representatives of the National Governors' Association or National Conference of State Legislatures testified before the commission—and from its final report on long-term care reform. The states played a somewhat larger role during the Clinton health reform effort, yet the proposed reform ultimately included only a modest long-term care component that failed to address states' problems in financing these services. When the measure died with the larger reform effort, long-term care was already moribund as an issue in American politics (Wiener, Estes, Goldenson, & Goldberg, 2001).

Given the lack of federal responsiveness or fundamental policy change, states have instead engaged in "Medicaid maximization"—maximizing the federal dollars they receive from the program. The deficit reduction efforts of the 1980s and 1990s encouraged such strategies because they exempted needs-based programs from their sequesters and, therefore, left Medicaid an open-ended federal commitment. These techniques have proven quite successful: Although other grants to the states have fallen in the past two decades, health grants rose in absolute terms (and increased proportionally from 18% of federal grants-in-aid in 1979 to 56% in 1997; see projections in Miller, 1993, p. 107). However, although they help state lawmakers put off tax hikes or painful spending cuts, they only delay the confrontation with the fundamental problems facing state governments with regard to the Medicaid program. Moreover, Medicaid maximization became a game of wits with Congress as states invented new methods of maximizing federal dollars as each previous technique was foreclosed by congressional legislation.<sup>9</sup> The result is increased intergovernmental tension rather than a federal-state partnership to address the fundamental fiscal problems.

In sum, efforts to promote long-term care reform in the United States came to naught. There was little pressure on federal policy makers to take up

9. On these techniques, see Coughlin, Ku, and Holahan (1994, chap. 5) and Coughlin and Zuckerman (2002).

the issue and given the prospect of raising taxes to pay for such a reform, they were glad to bury it. Representative Pepper attempted to include a long-term care component in the MCCA legislation, but House leaders feared the expense of the provision and blocked the bill from reaching the floor; their frantic efforts reflected the fear of many that the bill would pass, given its evident popularity among the public and the importance of elderly voters in an election year (Rovner, 1988). The states had a compelling interest in long-term care reform, but they lacked an institutional mechanism for forcing the federal government to consider their plight. Their reform efforts spurned, the states resorted to individual loophole seeking and Medicaid maximization (Coughlin & Zuckerman, 2002, p. 27). The result is not collective action to solve joint federal-state problems with structural reform but instead, an accumulated hodgepodge marked by intergovernmental tensions, loophole seeking, and exacerbation of benefit inequalities across the states.

### FEDERALISM AND THE WELFARE STATE

This study shows the importance of federal structures in shaping the politics of a policy area that is oft neglected in comparative welfare state research—long-term care. In so doing, this article also reveals the need to revise widespread understandings of the relationship between federalism and social policy. According to a widely held view, federalism is nearly always antipathetic to a large and generous welfare state (Hicks & Swank, 1992; Huber, Ragin, & Stephens, 1993; Swank, 2001). Federal systems are said to create veto points at which social policies may be blocked, including strong, subnational governments and their frequent concomitants in federal systems—bicameralism and a constitutional court (Immergut, 1992; Tsebelis, 1995). More fundamental, federal systems decentralize political power and responsibilities to subnational levels of government, in part because the latter may demand control of social programs as their constitutional prerogative. Yet lower tiers of government often face strong competitive pressures and other budgetary constraints, which should rein in public spending and reduce the overall size of government (Pierson, 1995, p. 457; Qian & Weingast, 1997).

Thus far, however, there has been little appreciation of the many differences between federal systems and how these variations might affect the politics of social policy.<sup>10</sup> In quantitative, cross-national studies of the determinants of social spending, the tendency is to describe and code countries in

10. An interesting new volume purports to do exactly that (see Obinger, Leibfried, & Castles, 2005a; see also Pierson, 1995).

either binary terms—federal versus unitary polities—or to array countries on a scale of strong, weak, or no federalism (Cameron, 1979; Hicks & Swank, 1992; Huber et al., 1993). Although such a simplification may be necessary for quantitative analysis, it obscures important substantive differences in federal systems. For example, in Swank's (2001) analysis of political institutions and welfare state restructuring, Germany and the United States are coded as equally decentralized polities because they are federal states with strong bicameralism. Yet as this article shows, bicameralism is fundamentally different in these two countries, giving state governments considerably greater power in the policy-making process in Germany than in the United States. Federal structures also differ markedly; for example, the risk of a "race to the bottom" in Germany is counterbalanced by a revenue-sharing system that mitigates differences between the *Länder* and promotes uniform living conditions across the country. In short, the complex workings of federal systems necessitate more nuanced analyses of their impact on social provision (Obinger et al., 2005b).

This study provides a number of lessons for thinking about the impact of federalism on the politics of the welfare state. First, we cannot assume that subnational governments always oppose expanded federal responsibility for social policy (Obinger et al., 2005b; Pierson, 1995). Certainly, the Canadian case, characterized by strong Québécois resistance to federal social spending, confirms this belief (Cameron & Simeon, 2002). However, as our study of long-term care policy in the United States reveals, American state governments would gladly yield responsibility for this policy area to the federal government. The frequent demand of governors has been to increase their control of an area such as education while transferring other public programs, such as Medicaid, to the federal government. The same has been true in Germany, where the *Länder* have sought to preserve their discretion over social assistance while allowing the federal government to assume other costly areas of social policy.

In fact, some scholars have interpreted the expansive German welfare state, and its heavy reliance on social insurance programs, as part of an inter-governmental bargain to lighten the fiscal burdens on state and local governments. Manow (2005) locates the origins of the contributory social insurance model in the struggle between Bismarck and state governments—the latter resisting any increase in the Reich's powers of spending and taxation. As contributory finance was less threatening to the states and reduced their welfare burdens, the social insurance model became the foundation of the German welfare state (Manow, 2005). The same was true in the postwar years, as the consolidation of social insurance was largely driven by the need to provide fiscal relief for state governments. The expansion of social insurance

programs in Germany has consistently served to ameliorate burdens on subnational levels of government (Manow, 2005).

Subnational governments may be a potential force for an expansion of federal social policy, but only where they have the leverage to push for these changes. This points to a second lesson in thinking about federalism and the welfare state—the need to examine how different systems of intergovernmental relations affect the power of constituent units in federal politics. This article shows how differences in the German Bundesrat and the American Senate shaped the ability of state governments to influence federal politics. Other federal systems may have their own mechanisms for subnational governments to promote their interests, such as the Australian Premiers' Conference and the Canadian First Ministers' Conference. There may be similar variations in unitary polities, as countries differ in the relative power and influence of local governments in national politics. Christian Toft (1996) contrasts Denmark and the United Kingdom on this score, showing how the powerful Danish municipalities successfully pushed for the expansion of national social insurance as a way to reduce their local welfare burdens. In the United Kingdom, by contrast, the central state usurped responsibility for locally run welfare programs, removing local governments as a force for expanding social insurance (Toft, 1996, pp. 256-257). The British trend in recent years has been to devolve some responsibilities back to local governments without providing them with the means to pay for these services. Long-term care policy has been a prime example of this kind of retrenchment through devolution made possible by the inability of weak local governments to resist this development (Wiener & Cuellar, 1999).

The final lesson concerns the importance of different systems of fiscal federalism—namely, whether state and local governments have some degree of fiscal autonomy or rely on extensive revenue sharing among governmental levels. Revenue sharing implies that social problems cannot easily be shifted to other levels of government, as the overall fiscal burden remains the same. This should influence the politics of retrenchment, which is very much about politicians trying to avoid blame for cuts in social policy (Pierson, 2001). In federal systems with cleaner lines of division between constituent units, and local tax authority, federal governments can impose unfunded mandates, cuts in federal spending, and reduced intergovernmental transfers to push social responsibilities down to lower levels of government. States and local governments are therefore left with the need to raise taxes should they try to provide for these needs. In systems of interlocking federalism, with their extensive revenue sharing and intergovernmental transfers, there may be efforts to shift responsibilities from one level of government to another, but ultimately, this will not solve the overall fiscal problems facing the entire system.

We can see these dynamics playing out in the German and American contexts. In the United States, federal indifference to the fiscal plight of state governments pushed them into one of the worst financial crises of recent memory (Boyd & Jenny, 2003). In Germany, by contrast, fiscal pressures on the welfare state have led to a different kind of burden shifting—from the state and federal budgets to social insurance programs (Manow & Seils, 2000). Thus state and local governments have been able to protect themselves from the costs of German reunification and from other pressures to reduce social spending. It is ironic that fiscal pressures have produced an expansion of the welfare state in Germany, exemplified by the new social insurance program for long-term care, whereas American state governments have faced mounting burdens, shrinking revenues, and resulting cuts in social programs.

## CONCLUSION

This article investigates long-term care reform efforts in Germany and the United States as a way to understand this issue as a political and policy problem facing advanced industrialized states. Although both countries had similar systems of long-term care prior to the early 1990s, the German government created a new social insurance program in 1994 to assure care for the chronically ill. Efforts in the United States to promote a similar reform came to naught. We argue that these different paths reflected the varying structures of federalism, which turned the German state governments into a powerful actor for reform of this area. Such an actor was needed because mass or interest group mobilization of the issue has been minimal. With both caregivers and care recipients distracted, unorganized, and politically weak, the issue of long-term care lacks much salience in public opinion. Elderly advocacy groups, unions, and employers' groups also have not taken up the issue. This left only state governments as potential champions of change. In both countries, rising long-term care costs became a heavy burden on state and municipal budgets, and states demanded federal assistance in coping with these responsibilities.

Different forms of federalism were crucial in shaping the capacity of state governments to promote a vision of reform that would serve their interests. The greater power of the German Länder enable them to push the federal government to confront fiscal problems facing the states. In contrast, the American states lack a guaranteed place at the federal bargaining table that would give them greater voice in debates concerning the distribution of responsibilities between levels of government. Moreover, without the same

kinds of revenue sharing and fiscal interdependencies, there is a tendency in the American system for a downward shifting of burdens. In Germany, reform was achieved because it was in the states' interests, and they had the institutional means to achieve policy change. In the United States, reform was, and continues to be, in the states' interests as well, but they lack the mechanisms to propel this issue onto the national agenda.

This case study of long-term care politics reveals the need for more nuanced analyses of the interaction of federalism and the welfare state. Although much research assumes that federalism constrains the growth of social programs, this article shows how features of some federal systems can actually promote the expansion of the welfare state. Future comparative research could fruitfully explore the complex interactions between political institutions and the politics of social spending.

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