

Providing Long-term Care in an Ageing Society - How shall we organize it?

**Queen's University Conference 2011
“Social Policy In An Aging Society: The Multiple
Challenges Of Demographic Change”**

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- I. The need of long-term care (LTC) as a new social risk
- II. Demographic change and long-term care
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I. The need of long-term care ...

... as a **new** social risk

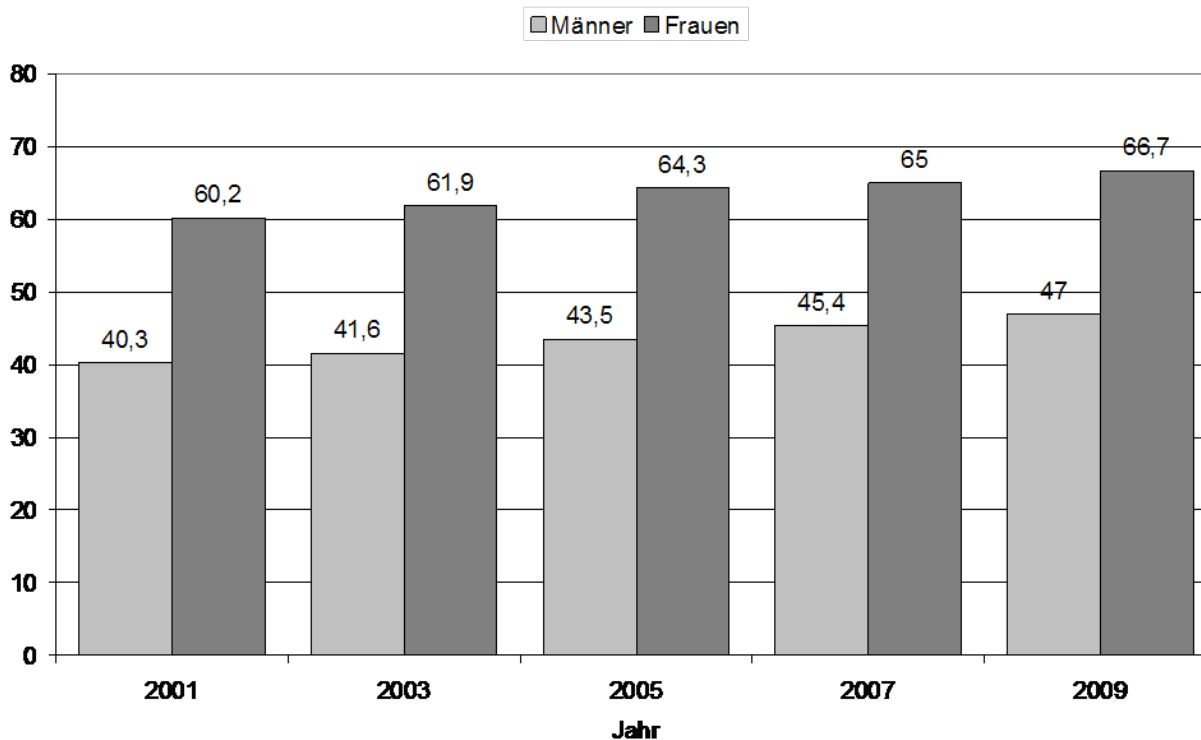
- Dependency in itself is not new, but
 - the numbers of dependents have increased
 - the traditional forms of care-giving seem to loose capacities→ higher visibility → a “new” problem arises
- Welfare states react (late) → constituting a “new” risk
 - In the EU long-term care was not covered as a risk of its own, thus the ECJ had to subsume it under “health” (Molenaar case 1998)
 - With few exceptions national legislation only started in the 1990s

... as a new **social** risk

- is relevant for all parts of the population and
- has a high quantitative relevance

I. The need of long-term care as a social risk: Germany

Share of LTCI beneficiaries among those who died in ...



Only 2.6% of the total population is in need of long-term care

Among the elderly (65+) the risk is at about 10%

But: more than half of all those dying in a certain year are in need of long-term care

→ more than half of us will be in need of long-term care

Long-term care is not a fringe risk, but a social risk that should be addressed

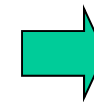
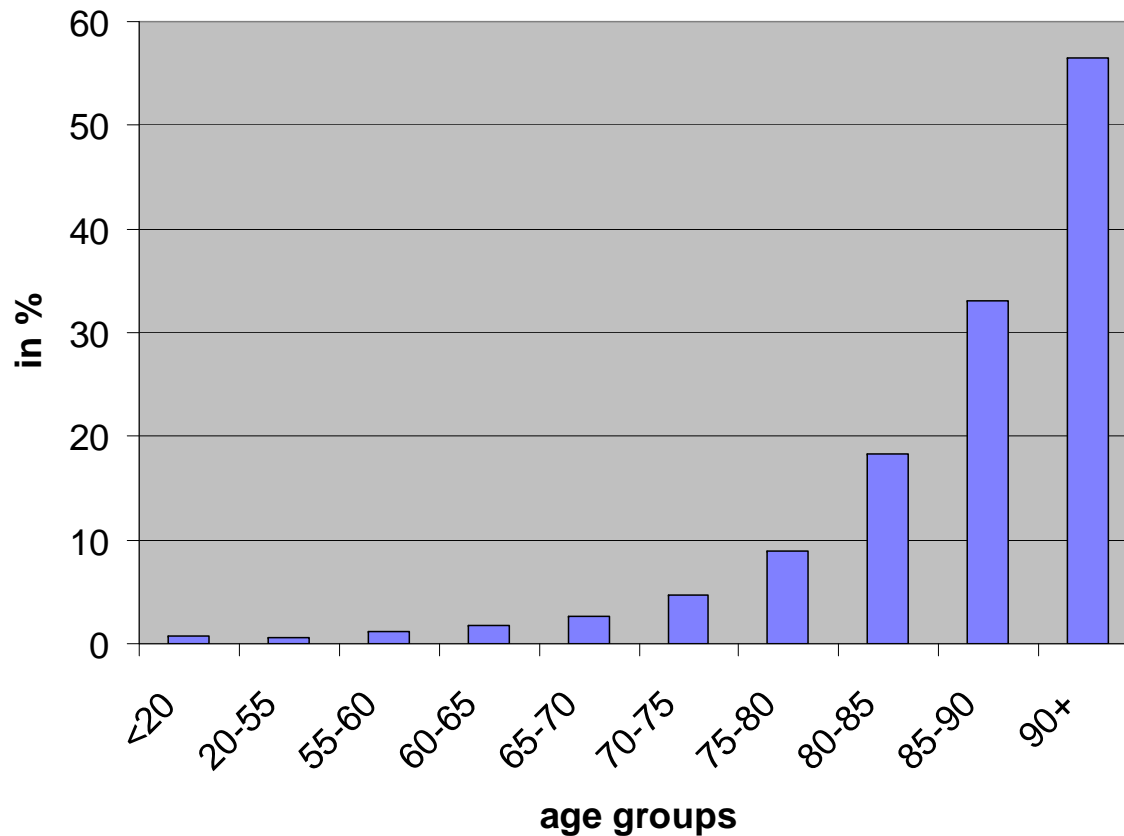
Insufficient coverage is an issue for social policy !!!

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II.1 Need of long-term care (=dependency) is age-related

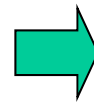
Prevalence of dependency in Social LTCI



Prevalence only increases 10% for those aged 80+



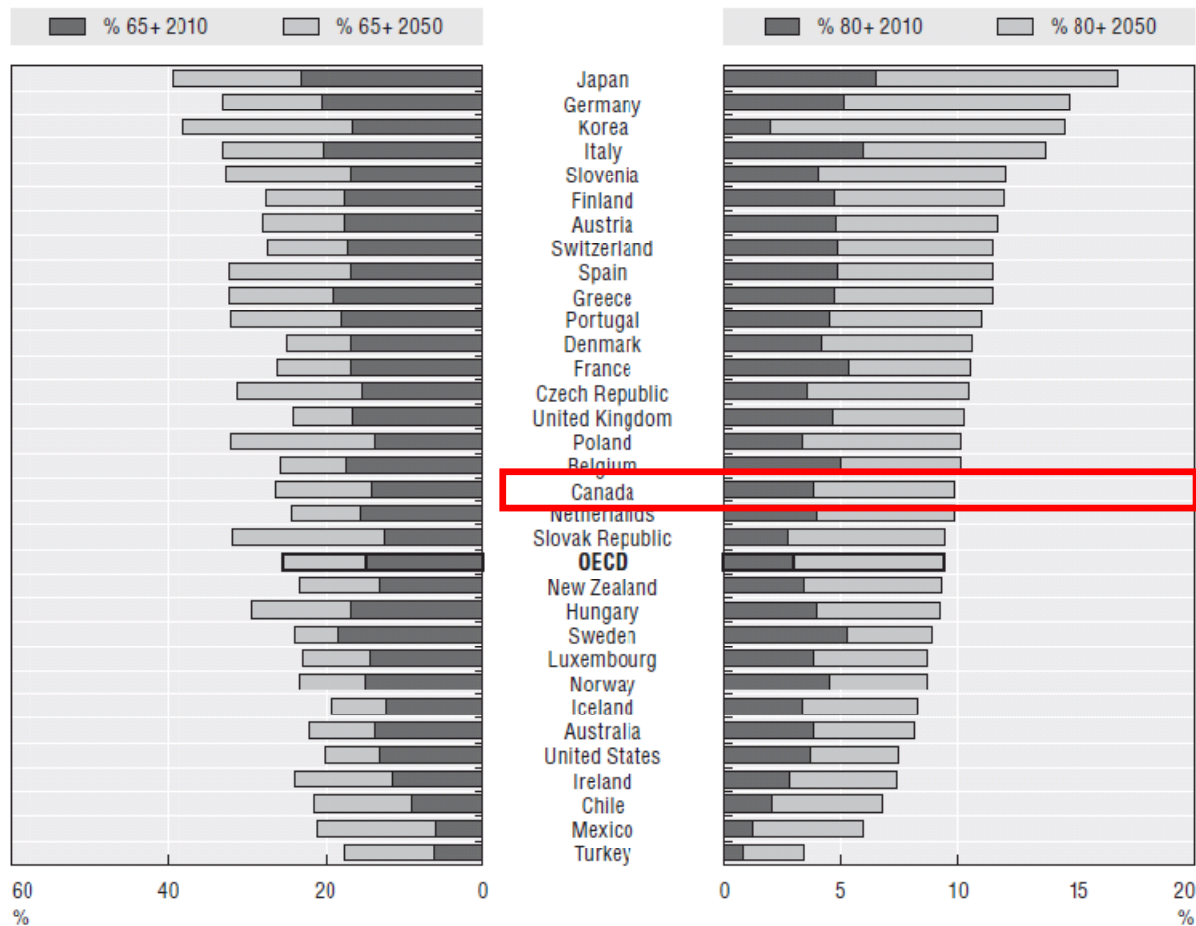
Even today more than half of all beneficiaries of Social LTCI are aged 80 and older



It is the number of person 80+ that is decisive for the amount of dependency!

II.2 Rising share of the very old

Figure 2.2. The shares of the population aged over 65 and 80 years in the OECD will increase significantly by 2050



Source: OECD Labour Force and Demographic Database, 2010.

From 2010 to 2050 the share of population aged 80 + will more than double

- from 4% to 9.4% (OECD)

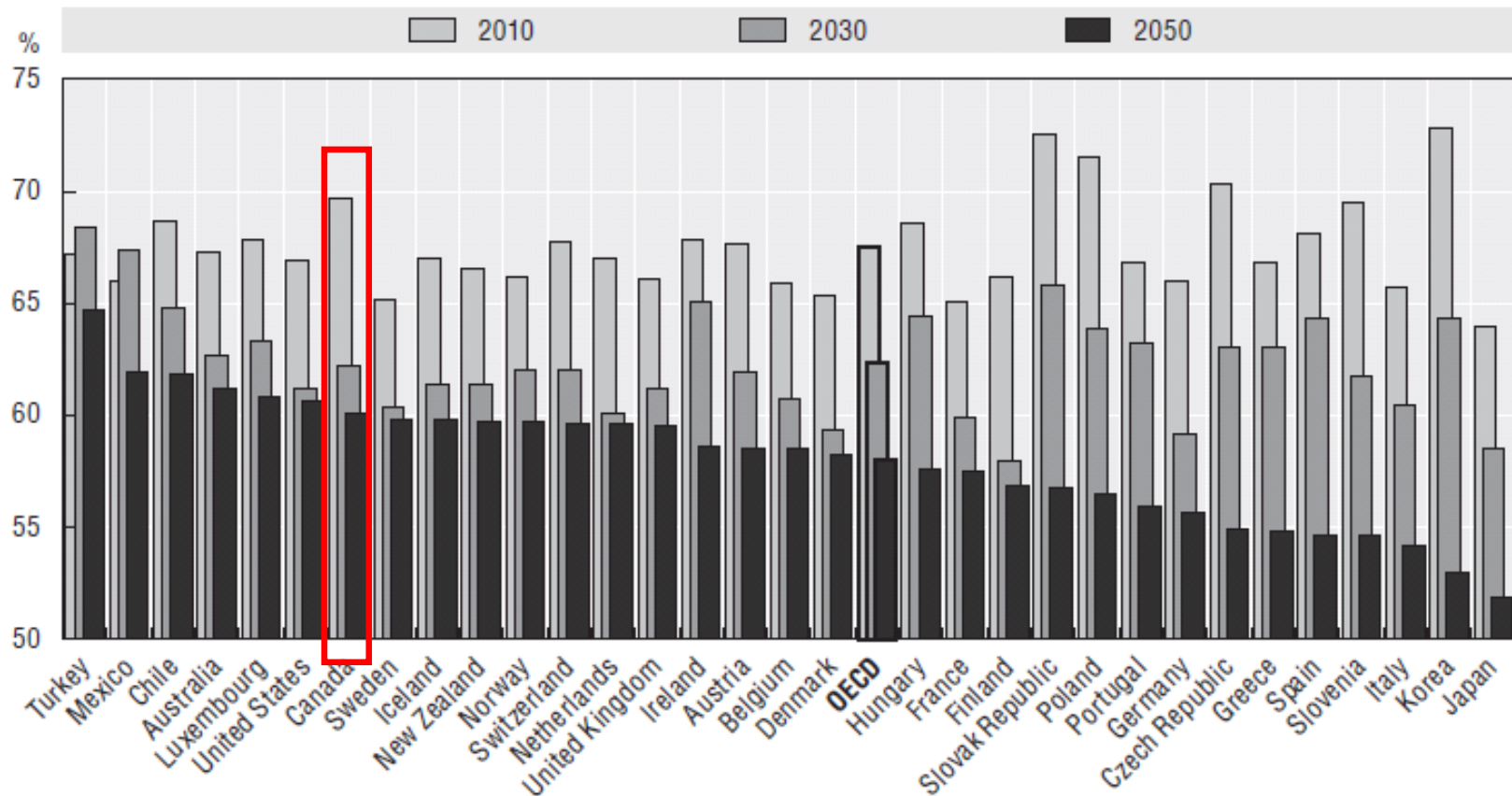
- from 4.5% to 10% (Canada)

Source: OECD 2011: 63

II.2 Declining working-age population

Figure 2.3. **The share of the working-age populations is expected to decrease by 2050**

Population aged 15-64



Source: OECD Labour Force and Demographic Database, 2010.

Source: OECD 2011: 64

II.3 Public LTC expenditure

Table 2.1. Public LTC expenditure expected to rise significantly by 2050

Percentage of GDP, in base year prices

Base year	2050					
	Prevalence of dependency		Changes to the LTC cost structure		Decline in the availability of family care	
	Pure ageing (1 – Baseline)	Healthy ageing (2)	–1% of GDP per worker (3)	+1% of GDP per worker (4)	All home care (5)	All residential care (6)
EU 2009¹	2007					
Austria	1.3	2.5	2.4	2.3	2.7	2.6
Belgium	1.5	2.9	2.8	2.6	3.2	3.1
Czech Republic ²	0.2	0.6	0.5	0.6	0.6	0.7
Denmark	1.7	3.4	3.2	3.1	3.7	3.7
Finland	1.8	4.2	4.2	3.8	4.7	4.5
France	1.4	2.2	2.1	1.9	2.5	2.3
Germany ³	0.9	2.3	2.2	2.1	2.5	2.4
Greece	1.4	3.3	3.2	2.9	3.7	3.5
Hungary	0.3	0.5	0.5	0.4	0.6	0.7
Ireland	0.8	1.8	1.8	1.6	2.0	1.9
Italy	1.7	2.9	2.8	2.6	3.2	3.3
Luxembourg	1.4	3.1	3.0	2.8	3.4	3.3
Netherlands	3.4	8.2	7.7	7.5	9.0	8.4
Norway	2.2	4.5	4.3	4.1	4.9	4.6
Poland	0.4	0.9	0.9	0.8	1.0	1.1
Portugal	0.1	0.2	0.2	0.2	0.2	0.2
Slovak Republic	0.2	0.5	0.5	0.5	0.5	0.5
Spain	0.5	1.4	1.3	1.3	1.5	1.4
Sweden	3.5	5.5	5.3	5.0	6.1	5.8
United Kingdom	0.8	1.3	1.2	1.2	1.4	1.3
OECD-EU average	1.3	2.4	2.3	2.2	2.7	2.5
Case study	2006					
Australia	0.8	1.8	1.6	1.7	2.0	2.0
Canada	1.2	2.7	2.4	2.4	2.9	3.4
Japan	1.4	4.0	3.5	3.6	4.4	4.0
New Zealand	1.4	3.9	3.6	3.5	4.3	4.6
United States	1.0	1.9	1.7	1.7	2.1	2.2
Case study – average	1.2	2.9	2.6	2.6	3.2	3.1
OECD 2006 projections	2006 (actual)					
Iceland	1.9	2.8	2.5	–	–	–
Korea (2007)	0.2	–	–	–	–	–
Mexico	–	–	–	–	–	–
Switzerland	0.8	1.6	1.3	–	–	–
Turkey	–	–	–	–	–	–

Overall growth of public LTC expenditure by 2050

- OECD-EU average: 115 %
- Canada: 183 %

Source: OECD 2011: 74

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III.1 Welfare State arrangements: Introduction of new systems

- Long-term care allowance:
 - 1993: Austria (Pflegegeldgesetz)
 - 1997: France allowance for dependent elderly (PSD) replaced by APA (disability-based cash benefits) in 2003
- Social long-term care insurance (LTCI)
 - 1968: Netherlands (AWBZ)
 - 1995: Germany (Pflege-Versicherungsgesetz)
 - 1998: Luxemburg
 - 2000: Japan
 - 2007: South Tyrole (Italy)
 - 2008: Korea
- Thesis: New (social insurance) system are likely to be created in Bismarckian welfare states

III.2 Welfare State arrangements: Typology

- There is no well established typology of LTC systems; Esping-Andersen's typology is not really useful for LTC
- Attempts for classifications include
 - Anttonen & Sipilä (1996):
 - Scandinavian model of public services
 - mostly Southern European family care model plus
 - Central European subsidiary model and
 - British model of means-testing in the middle
 - Bettio & Pantenga (2004):
 - Southern European countries with much informal and little formal care
 - Northern European countries with universalistic approach and much formal care
 - Timonen (2008):
 - three paradigms according to the role of the state, the role of individuals / families and the role of private care provision

III.2 Welfare State arrangements: Questions to address

Features to characterise LTC systems:

- Financing
 - Taxes
 - Social insurance contributions
 - Private insurance premiums
 - Private savings / out of pocket
- Benefits and care delivery
 - Informal care
 - Formal care
 - at home
 - in a nursing home
- Regulation: Respective role of
 - State regulation
 - Corporatist self-regulation
 - Markets and competition

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IV.1 Financing: There is a case for mandatory LTC insurance

- Private voluntary insurance without a safety net is no alternative as no civilized society will leave elderly without care if they are in need of care
- Private voluntary insurance besides a – tax-financed – safety net is unlikely to work as private insurance is crowded out
 - E.g.: in Germany only about 300 thousand insurances has been sold before mandatory LTCl was introduced
 - On the other hand: 80% of those in nursing homes relied on means-tested social assistance
- Means-tested tax-financed social assistance is no solution as
 - private insurance is discouraged
 - those who buy insurance are exploited by those who don't
 - elderly have to spend down assets and have to live on “pocket money”

⇒ **Mandatory insurance is useful**

IV.1 Social insurance has advantages over private insurance

Financing system: Funding (private) vs. pay-as-you-go (public)

- Advantage of funding:
 - less vulnerable to demographic change, but not independent (age wave-, asset meltdown-debate)
 - Inter-temporal redistribution is achieved – if this is an advantage
- Advantage of pay-as-you-go
 - flexible to changing environments (e.g. German unification)
 - immediate benefits

⇒ Whenever the introduction of LTCI is a response to actual problems some kind of pay-as-you-go financing is unavoidable

⇒ Whenever PAYGO-systems are to be change into funded systems the costs of change are enormous

Premium: risk-related (private) vs. income-related (public)

- Risk-related premium effectively excludes elderly from insurance
- Income-related contributions (vs. capitation) provides another element of redistribution additional to imperfect redistribution via tax systems.

IV.2 Benefits: The role of cash benefits

- Throughout the OECD informal care-giving is predominantly female
- Cash benefits, i.e. care allowances
 - acknowledge informal care-giving, but
 - tend to stabilize gender roles
- Welfare State programmes differ with respect to cash benefits
 - Austria: Pflegegeldgesetz (1993) introduced cash benefits as the only type of benefit
 - Germany: Pflege-Versicherungsgesetz (1994) introduced the choice between cash benefits and benefits in kind (formal care)
 - Japan: LTCI introduced in 2000 does **not** contain cash benefits as the Japanese feminists heavily opposed to it.

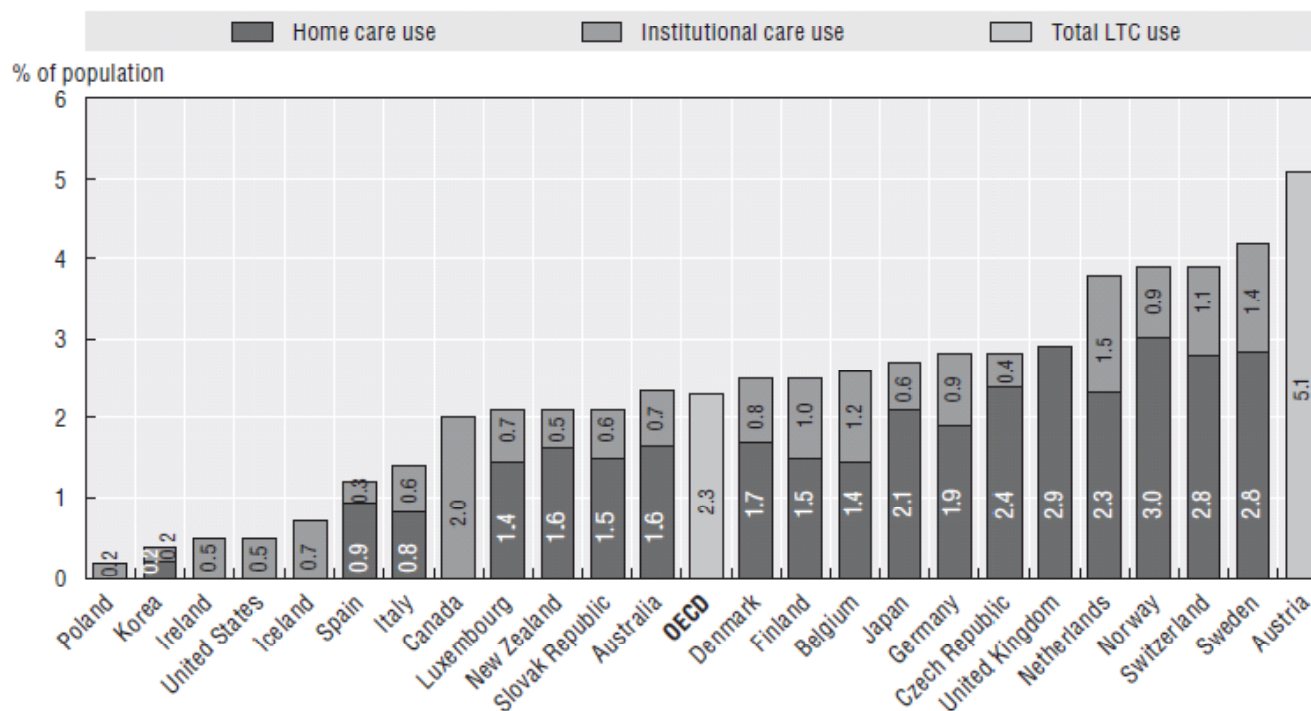
IV.2 Benefits: Formal vs. informal care

- The role of formal care and nursing home care in particular differs among countries
- Informal care is
 - often preferred by the elderly
 - cheaper for the public purse
 - vulnerable as family care-giving capacities decline
- The support of informal care is the only option to
 - limit expenditure
 - create efficiency gains

IV.2 Care Arrangements


Figure 1.2. **More LTC users receive care at home than in institutions**

LTC users as share of the population in OECD countries, 2008



Note: Data for Canada, Luxembourg, Denmark, Belgium and the Netherlands refer to 2007; data for Spain refer to 2009. Data for Japan refer to 2006. Data for Japan underestimate the number of recipients in institutions because many elderly people receive long-term care in hospitals. According to Campbell et al. (2009), Japan provides public benefits to 13.5% of its population aged over 65 years. Czech home-care users include 300 000 recipients of the attendance allowance. Polish data underestimate total LTC users. Austrian data represent recipients of cash allowances.

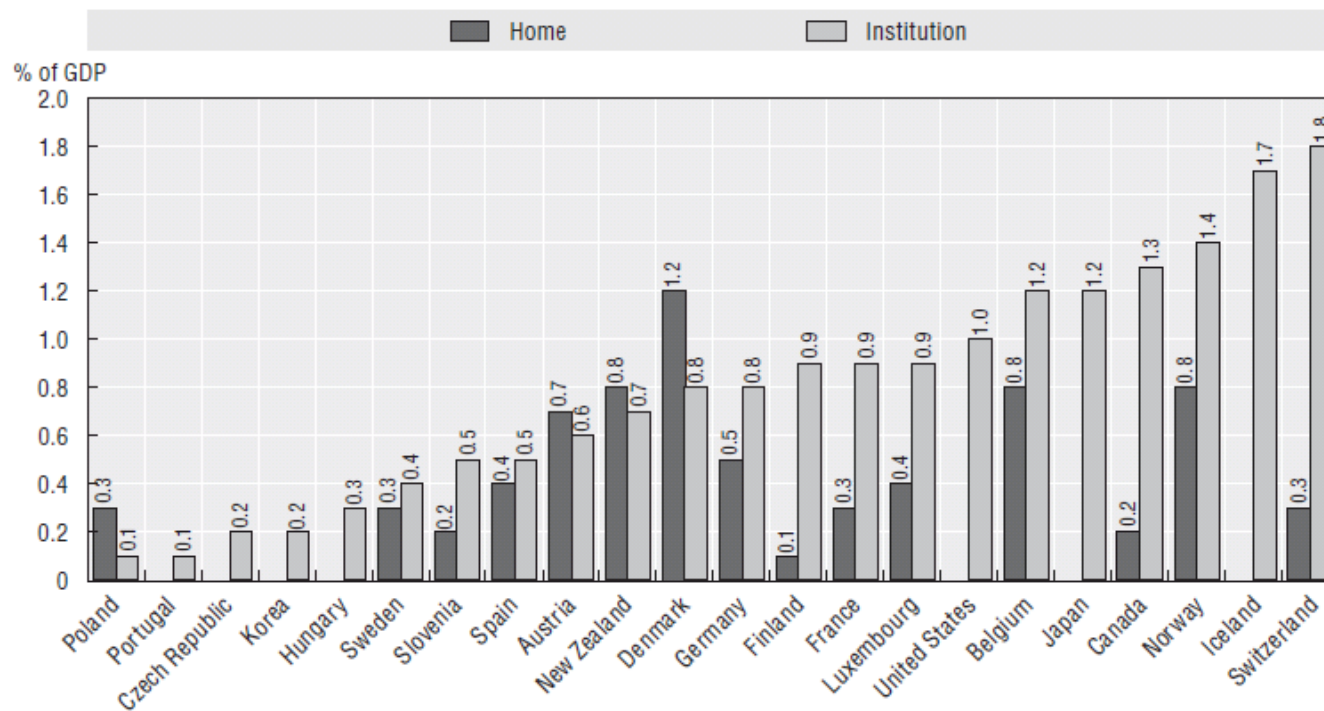
Source: OECD Health Data 2010, the Korean computerised administrative network and additional Australian and Swedish data.

StatLink  <http://dx.doi.org/10.1787/888932400608>

IV.2 Expenditures according to care arrangements


Figure 1.9. **Spending on LTC in institutions is higher than spending at home in OECD countries**

Percentage of GDP, 2008



Note: Home care includes day-care expenditure. Data for Denmark, Japan and Switzerland refer to 2007; data for Portugal refer to 2006; and data for Luxembourg refer to 2005. Data for Poland exclude infrastructure expenditure, amounting to 0.25% GDP (2007). Data from the Czech Republic refer to health-related LTC expenditure only. Social expenditures on LTC are estimated at 1% of GDP (Source: Czech Ministry of Health, 2009).

Source: OECD Health Data 2010.

StatLink  <http://dx.doi.org/10.1787/888932400741>

IV.3 Regulation

- Subjects of regulation
 - Contributions
 - Entitlement
 - Benefits (types, amounts and adjustments)
 - Remuneration of service providers
 - Access to provision
 - Quality standards
- Regulators
 - Hierarchical regulation by federal state, provinces often neglects the knowledge in the field
 - Self-regulation by corporatist stakeholders is successful when happening in the shadow of hierarchy

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 3. Current debates
 - a) Entitlement
 - b) Adjustment of benefits
 - c) financing
 - d) future care arrangements
 4. Notable features of the German system
 5. Lessons to be learned

V.1 Structure of the German LTC system (1/2)

- Coverage:
 - 90% of the population: social LTCl
 - 10% of the population: private mandatory LTCl
- Financing:
 - PAYGO system in Social LTCl, contributions levied on income from wages and salaries up to a certain income cap. Parity between employers and employees, extra contribution for childless since 2004.
 - Funding in private mandatory LTCl, but with strong elements of PAYGO as benefits were also for those already in need of care and premiums are capped (for the elderly)
- Entitlement:
 - According to ADL scheme, differentiated according to three levels of care, no age limit, assessment by Medical Service of Funds

V.1 Structure of the German LTC system (2/2)

- **Benefits:**
 - Cash benefits, in kind benefits (for home care) and benefits for nursing home care with choice for the beneficiary
 - Capped benefits with caps below need, no provision for automatic adjustment of nominally fixed benefits
 - In nursing home care: only capped benefits for care costs, nothing for board and lodging or for investment costs
- **Administration:**
 - Social LTCI is administered by LTCI funds founded as a branch of the respective sickness fund. LTCI is independent but under the umbrella of health insurance
 - No competition between funds as all contributions go into one fund which covers all expenditure
 - difference to health insurance

V.2 Achievements of the system (1/2)

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

V.2 Achievements of the system (2/2)

Capacities of formal care

	Home Care			Nursing Home Care	
	Number of Providers	Employees	Full-time employees	Number of Nursing homes	Number of beds in nursing homes
1999	10,820	183,782	56,914	8,859	645,456
2001	10,594	189,567	57,524	9,165	674,292
2003	10,619	200,897	57,510	9,743	713,195
2005	10,977	214,307	56,354	10,424	757,186
2007	11,529	236,162	62,405	11,029	799,059
2009	12,026	268,891	71,964	11,634	845,007
1999-2001	-2,1	3,1	1,1	3,5	4,5
2001-2003	0,2	6,0	0,0	6,3	5,8
2003-2005	3,4	6,7	-2,0	7,0	6,2
2005-2007	5,0	10,2	10,7	5,8	5,5
2007-2009	4,3	13,9	15,3	5,5	5,8
1999-2009	11,1	46,3	26,4	31,3	30,9

Source: Statistisches Bundesamt 2011: 23f.

V.3a Current debates: Entitlement

- Assessment by Medical Services of long-term care funds (social LTCI) and Medicare (private LTCI) are fairly undisputed
- Definition of “need of long-term care” and thus entitlement to LTCI benefits is regarded as too tight as
 - Definition relates very much to physical care
 - Particular needs of people suffering from dementia are not taken into account properly
- An expert commission has developed a new assessment tool and a new definition of need of long-term care in 2009
- Implementation is subject to the next reform

V.3b Current debates: Adjustment of benefits

- From 1994 to 2008 LTCI benefits have been kept constant – in nominal terms !
- Real purchasing power has been decreasing considerably and out of pocket payments increased
- Only 2008 a first adjustment was introduced
 - Increase: 1.4 per cent per year for 2007-2010, about inflation rate
 - Financed by a raise in contribution rate from 1.7 to 1.95 percent
 - For 2015 onwards: every 3 years adjustment is discussed with ceiling of minimum of inflation and wage rise.
- Though (too) weak, the adjustment marks the end of stabilizing contribution rate by decreasing purchasing power alone!

V.3c Current debates: Cost control and financing (1/3)

- Germany's social LTCI has strong provisions for controlling the contribution rate:
 - A tight definition for the entitlement limits the number of beneficiaries → under discussion
 - The Medical Service is in charge of the assessment; it has no interest in increasing either numbers beneficiaries or levels of need
 - Capped benefits limited expenditure per case
→ They leave room for considerable co-payments
 - no automatical adjustment to benefits

V.3c Current debates: Cost control and financing (2/3)

- In the past: Contribution rate was kept constant by means of not adjusting LTCl benefits
→ this option no longer exists
- If Social LTCl benefits are adjusted properly, contribution rate might increase by 50% till 2050.
- If Social LTCl benefits are not adjusted at all, by that time purchasing power will be less than half of its present value – but co-payments are high even today.

⇒ **Government thus faces a dilemma**

V.3c Current debates: Cost control and financing (3/3)

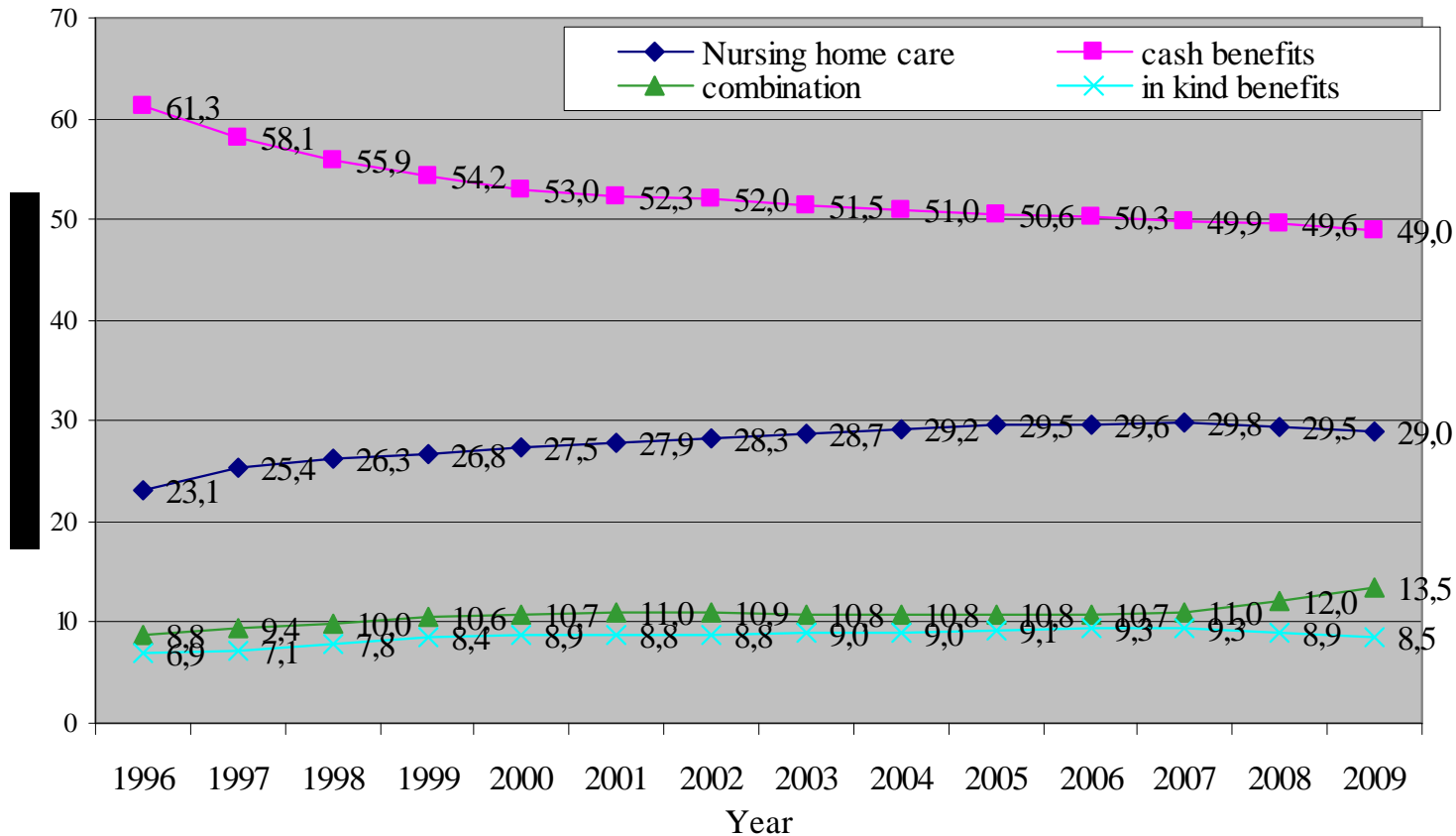
- The 2008 reform has been aiming at a middle way:
 - adjustment is set at minimum of inflation and wage rise, but only if economical sustainable → purchasing power will decline further
 - Increase of contribution rate is only sufficient to finance new benefits → neither regular adjustments nor effects of demographic changes are taken account of
- Further financing reform is needed! Possible option include
 - Integration of private LTCl into Social LTCl
 - Contributions on all kind of income
 - Increasing the income cap for contributory income
 - Supplementary tax financing
 - Introduction of a supplementary funded system

V.3d Current debates: Future care arrangements (1/4)

- LTCI aims to favour family care over (formal) community care over nursing home care
- There are several measures favouring home care, e.g.
 - Cash benefits for family care
 - Pension benefits for informal care-givers
 - Counselling and case management
- Nevertheless, there has been a trend towards formal care, though the rate of the shift is declining

V.3d Current debates: Future care arrangements (2/4)

Type of benefits chosen



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

V.3d Current debates: Future care arrangements (3/4)

- There are good reasons to assume a continuation of this trend
 - Demography: Decreasing share of informal caregivers per dependent elderly
 - Socio-structural change: Increasing share of 1-person households among elderly; children live further away
 - Increase female labour market participation
 - higher opportunity costs of family care-giving
 - Declining “duty to care” felt by families
- On the other hand the workforce for formal care-giving is not growing either. Necessity for
 - measurements to improve attractiveness of nursing
 - a new balance between formal care, informal care and volunteers

V.3d Current debates: Future care arrangements (4/4)

- How to stabilize informal care?
 - 2008 reform: counselling, case and care management, additional benefits for people with dementia, work leave for care-giving
 - Actual debates
 - Reforming the entitlement (new “Pflegebedürftigkeitsbegriff”)
 - Improve possibilities to combine care-giving and work
- How to find enough professional care-givers
 - Improving recruitment, retention, and return after childbirth by
 - Improving the image of the profession
 - Improving working conditions and pay

V.4 Peculiarities of the German system

- Contributions also from pensioners
- Pension benefits for care-givers
- Entitlement by “third party (=MDK)
- Choice between different types of care
- Two distinct insurance systems (social and private)
- Contributions only on wages/salaries

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V.5 Lessons from the German Experience

- A social insurance should include the total population.
- Contributions should be levied on all kinds of income, not just on income from gainful employment.
- Due to demographic and socio-demographic change over time the contribution rate necessarily goes up.
- Considerably co-payments are possible, but proper adjustment of benefits is vital.
- The definition of entitlement should be broad enough to include e.g. people suffering from dementia properly.
- Case and care management is necessary, particularly if beneficiaries may choose between different kinds of benefits.

Thank you for your attention!

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See also:

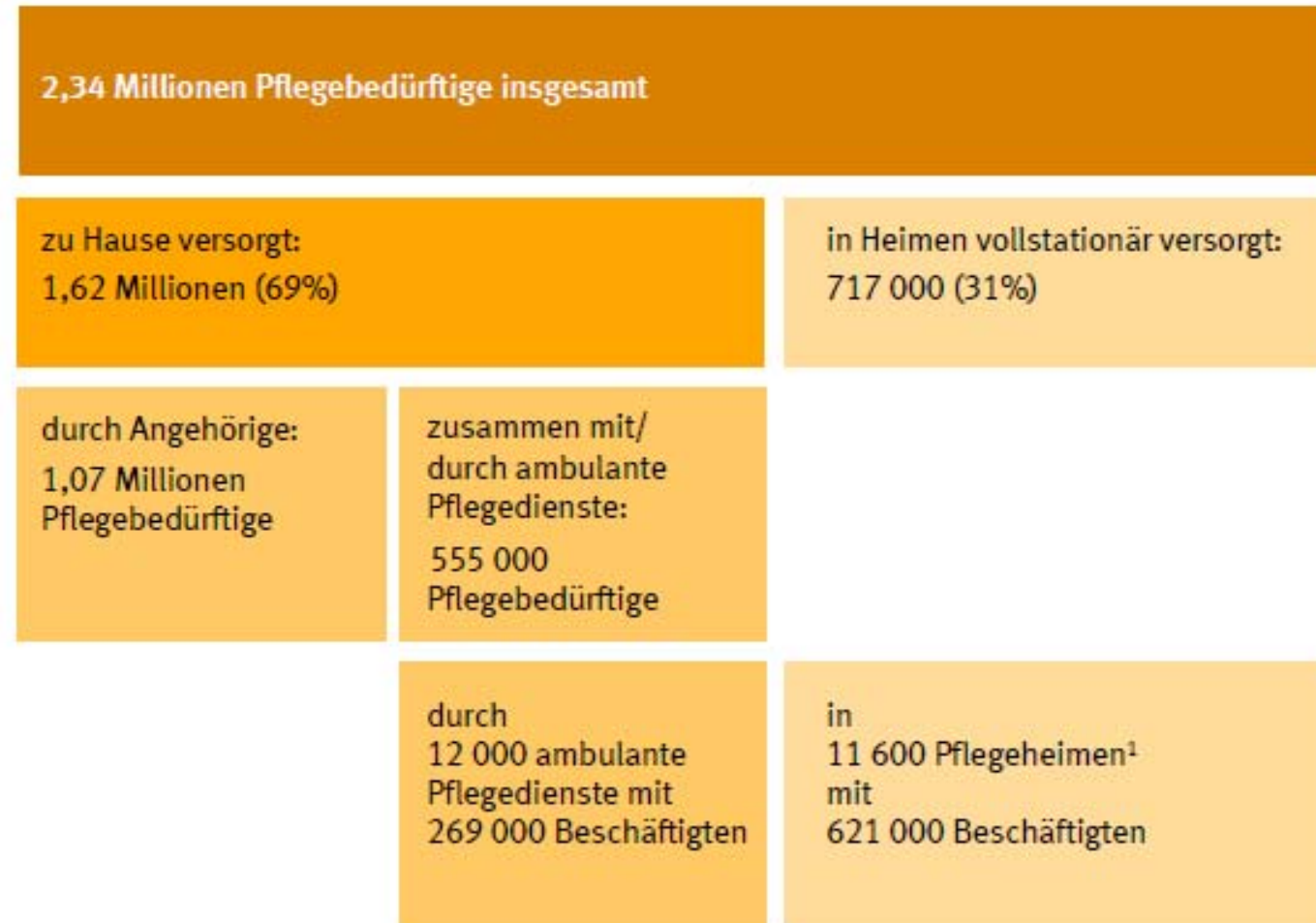
Rothgang, Heinz (2010): Social Insurance for Long-Term Care: An Evaluation of the German Model, in: Social Policy and Administration, Vol. 44, No. 4, August 2010, pp. 436–460

III.1 Reactions according to welfare state types

Typology of some EU countries

Type of welfare state	healthcare financing system		
	Bismarck-Type		Beveridge-Type
	Separate LTCI system	No separate LTCI system	
Social-democratic			Type A Denmark, Finland, Sweden
Conservative	Type B Austria, Germany, Luxembourg, Netherlands ^b	Type C Belgium, France, ^a Italy	
Liberal			Type D United Kingdom, Ireland
Rudimentary		Type E: Spain, Portugal, Greece	

VI.1 Care-giving – today

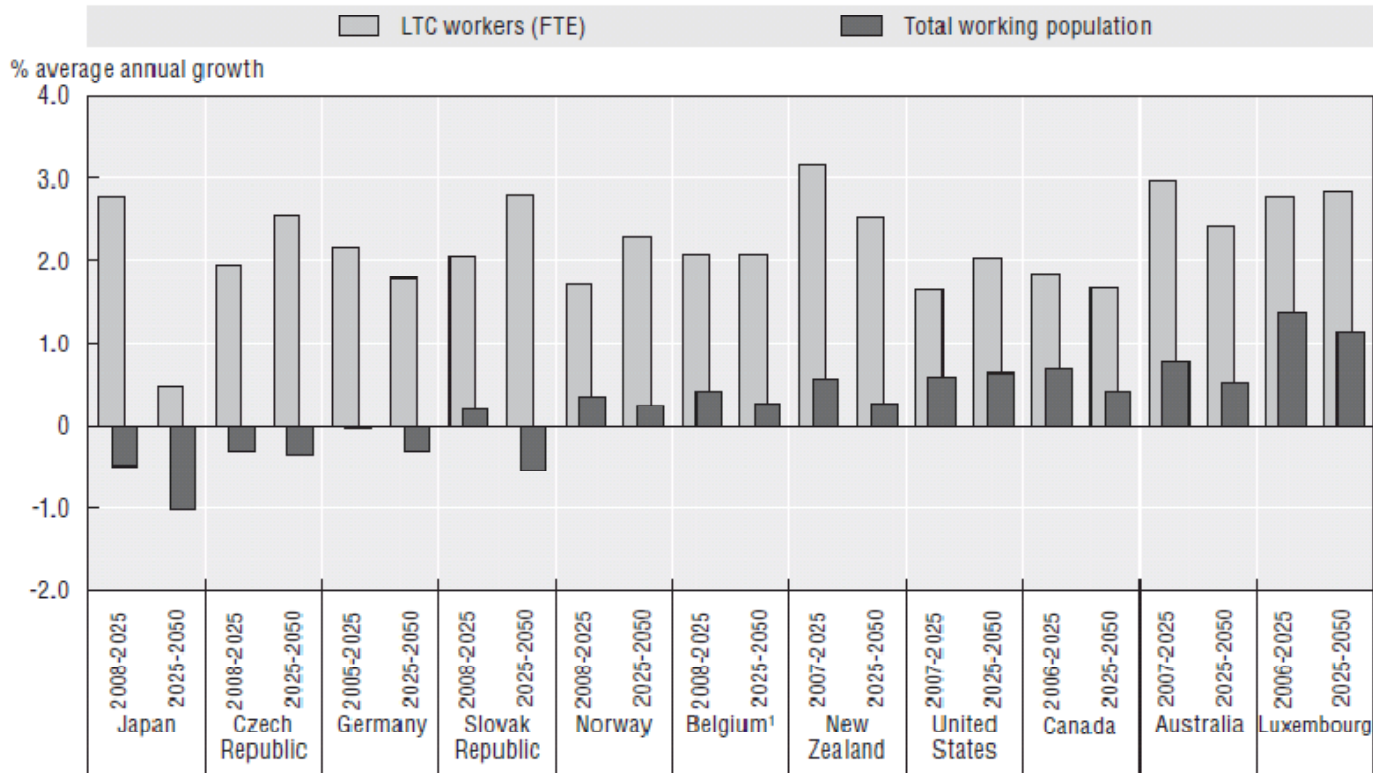


1 Einschl. teilstationäre Pflegeheime.

2011-08-0161

VI.3 Care-giving – the Future

Figure 2.11. **Change in demand for LTC workers and working-age population by 2050**



FTE: Full time equivalent.

1. Refer to FTE nurses and personal carers in institutions only.

Source: OECD calculations based on OECD Health Data 2010; European Commission (2009), *Ageing Report*; OECD Labour Force and Demographic Database, 2010 (pure ageing scenario); and Duval and de la Maisonneuve (2009).

StatLink <http://dx.doi.org/10.1787/888932401064>

VI.3 Care-giving – the Future

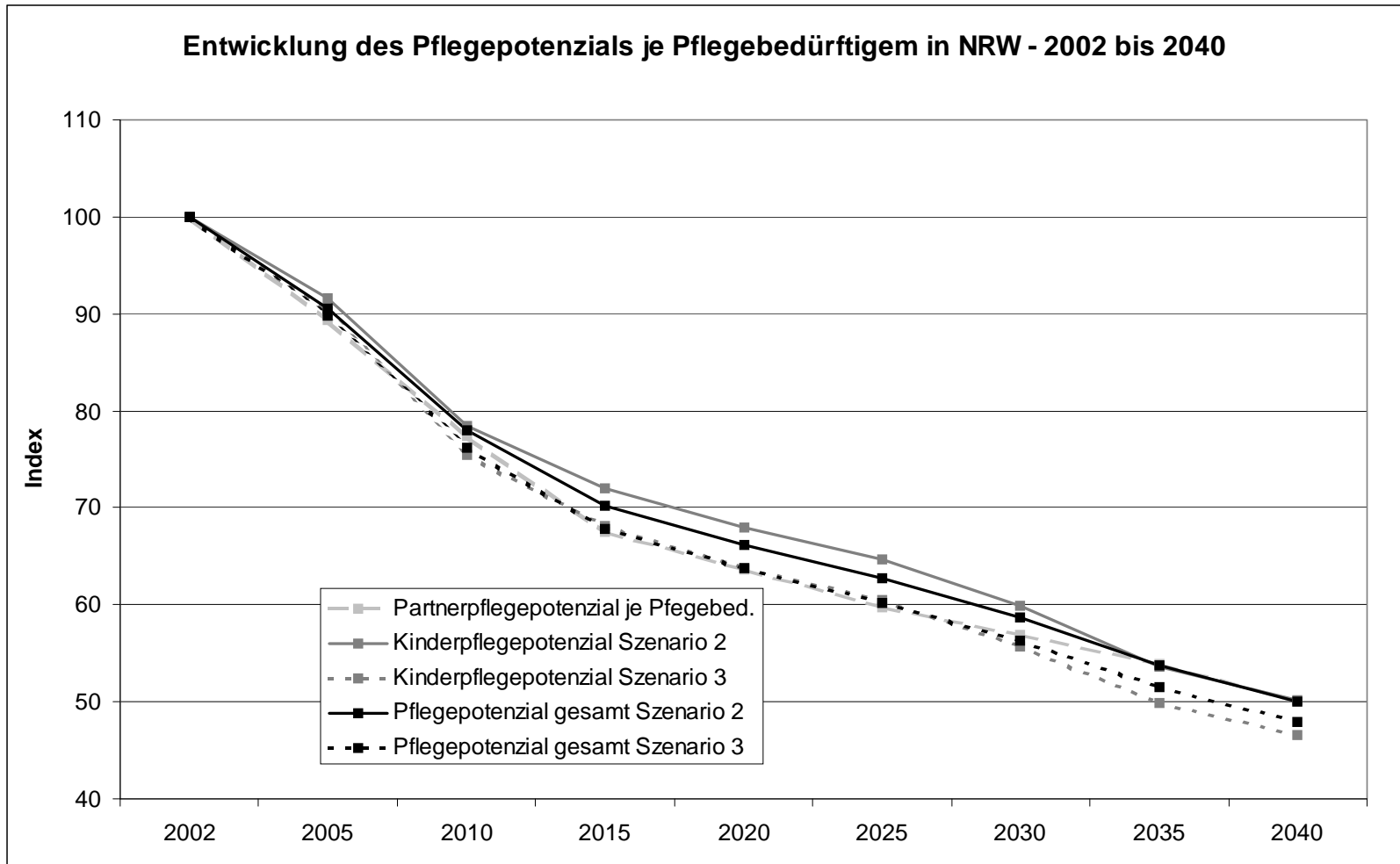


Abbildung 3: Entwicklung der Indizes für das häusliche Pflegepotenzial je Pflegebedürftigem in Nordrhein-Westfalen 2002 bis 2040 im Szenarienvergleich
Quelle: Rothgang 2004.

VI.3 Care-giving – the Future

Status quo

2/3 of all dependent persons are care for in private households

Every 2nd dependent person is cared for without formal care

Informal care is the backbone of care-giving

Future

Relative care potential, i.e. potential informal caregiver per dependent persons, is going to half by 2040

Informal care is going to decline

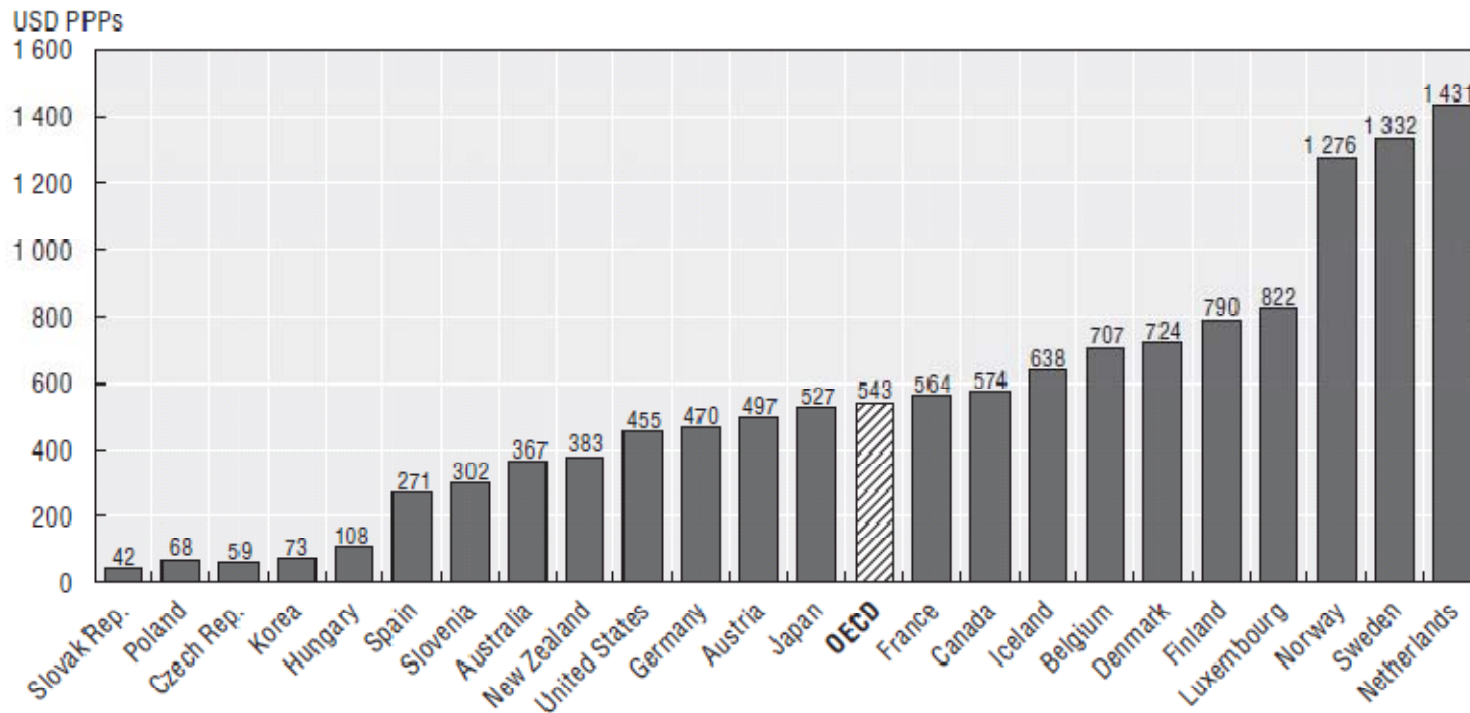
A new balance of care-giving (‘mixed care arrangements’) has to be found

- support for informal care-givers
- new role for formal care (working together with families)
- case management

Growing Expenditure


III.2 Welfare State arrangements: expenditures

Figure 1.10. **Significant variation in LTC expenditure among OECD countries**
Per capita spending in USD PPPs, 2008 or latest available year



Note: PPPs stands for purchasing power parities. Data for the Czech Republic, United States, Austria, Canada, Iceland, Belgium, Denmark and Luxembourg refer to nursing long-term care only. Social expenditure on LTC in the Czech Republic is estimated at 1% of GDP (Source: Czech Ministry of Health, 2009). Data for Australia and Luxembourg refer to 2005; data for the Slovak Republic and Hungary refer to 2006; data for Denmark and Japan refer to 2007.

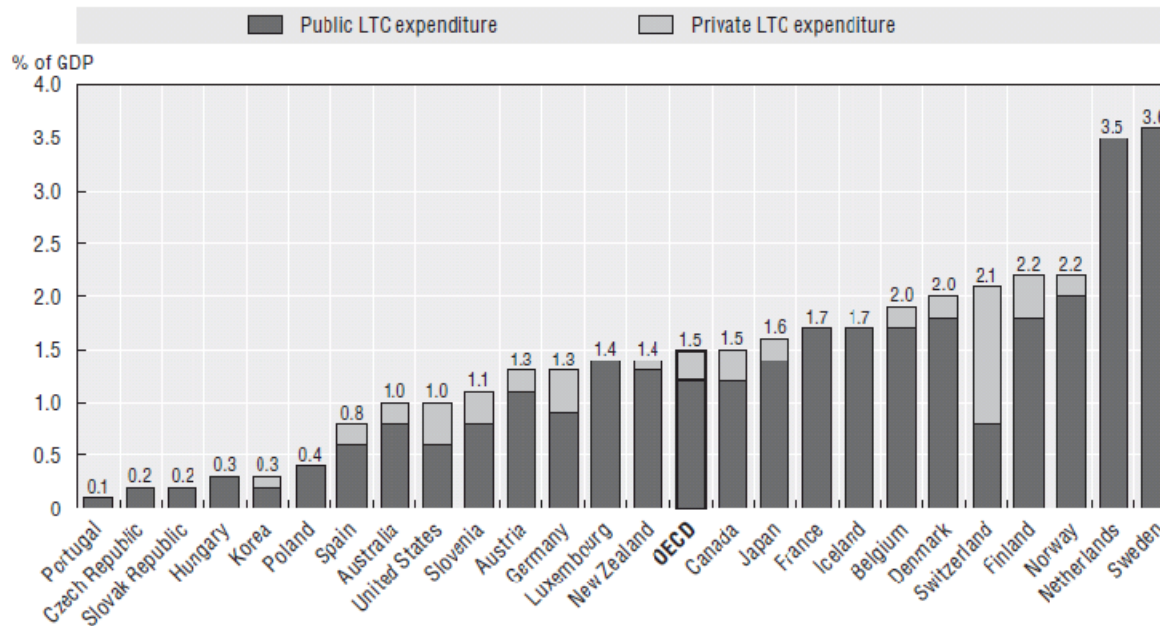
Source: OECD Health Data 2010.

StatLink  <http://dx.doi.org/10.1787/888932400760>

III.2 Welfare State arrangements: public-private expenditure mix


Figure 1.8. The share of public LTC expenditure is higher than that of private LTC expenditure in OECD countries

Percentage of GDP, 2008



Note: Data for Austria, Belgium, Canada, the Czech Republic, Denmark, Hungary, Iceland, Norway, Portugal, Switzerland and the United States refer only to health-related long-term care expenditure. In other cases, expenditure relates to both health-related (nursing) and social long-term care expenditure. Social expenditures on LTC in the Czech Republic are estimated at 1% of GDP (Source: Czech Ministry of Health, 2009). Data for Iceland and the United States refer only to nursing long-term care in institutions. Data for the United States underestimate expenditure on fully private LTC arrangements. Data for Poland exclude infrastructure expenditure, amounting to about 0.25% of GDP in 2007. Data for the Netherlands do not reflect user co-payments, estimated at 8% of total AWBZ expenditure in 2007. Data for Australia refer to 2005; data for the Slovak Republic and Portugal refer to 2006; data for Denmark, Japan and Switzerland refer to 2007.

Source: OECD Health Data 2010.

StatLink  <http://dx.doi.org/10.1787/888932400722>

I.1 LTCI in Germany: Institutional arrangements (2/6)

Definition of dependency

	Level I	Level II	Level III
Need of care with basic ADLs	At least once a day with at least two ADLs	At least thrice a day at different times of the day	Help must be available around the clock
Need of care with instrumental ADLs	More than once a week	More than once a week	More than once a week
Required time for help in total	At least 1,5 hours a day, with at least 0.75 hours for ADLs	At least 3 hours a day with at least 2 hours for ADLs	At least 5 hours a day with at least 4 hours for ADLs

Source: §15 Social Code Book (Sozialgesetzbuch XI, SGB XI).

I.1 LTCI in Germany: Institutional arrangements (4/6)

Amount of LTCI Benefits (Major Types of Benefits) in 2010

Level	Home care		Day and night care	Nursing home care
	Cash benefits	In-kind benefits	In-kind benefits	In kind benefits
I – moderate	225	440	440	1,023
II – severe	430	1,040	1,040	1,279
III – severest	685	1,510	1,510	1,510
Special cases		1,918		1,825

Note: Sums are given in Euros per month

Source: §§ 36-45 SGB XI.

I.1 LTCI in Germany: Institutional arrangements (5/6)

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

	(1)	(2)	(3)	(4)=(1)+(2)	(5)	(6)=(1)-(5)	(7)=(4)-(5)
Level of dependency	Care	Board & lodging	investment	Daily rate (total)	LTCI benefits	Out of pocket care costs only	Out of pocket total
Level I	1.307	608	352	2.267	1.023	284	1.244
Level II	1.733	608	352	2.693	1.279	454	1.414
Level III	2.158	608	352	3.118	1.432	726	1.686

Data from December 2007

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

VI.1 Care-giving – today

Main Carer of Dependent People in Private Households

Share in %	1991	1998	2002	Change 1991-2002
Sex				
Male	17	20	27	+ 10
Female	83	80	73	- 10
Relation of Carer to Dependent Person				
Husband or (Male) Partner	24	20	28	- 9
Wife or (Female) Partner	13	12		
Mother	14	11	12	- 2
Father	0	2	2	+ 2
Daughter	26	23	26	0
Son	3	5	10	+ 7
Daughter-in-law	9	10	6	- 3
Son-in-law	1	0		- 1
Other Relative	6	10	9	+ 3
Neighbor / Friends	4	7	8	+ 4
Residence of Main Carer				
Co-resident	78	73	62	- 16
Separate Household	22	27	38	+ 16

Sources: Schneekloth and Potthoff, 1993, 126; Schneekloth and Mueller, 2000, 52; and Schneekloth and Leven, 2003: 19.