Long-term care – the problem of sustainable financing (Ljubljana, 18-19 November 2014)[1]

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1. Introduction

Demographic ageing has placed social protection systems of EU countries under increased pressure and raised concerns regarding the sustainability of current financing arrangements pertaining to age-related social risks. Among the social risks affected by demographic ageing is the risk of requiring long-term care (LTC) in old-age. Slovenia is not an exception in this. In the recent past the country has come to recognise the need for LTC as an emerging social risk and has engaged in the debate on how to best finance social protection against this type of risk. This follows a recommendation issued from the European Council in the context of the European 'Semester' – the annual cycle of policy coordination introduced with the 'Europe 2020 Strategy' – to Slovenia to contain LTC expenditure by targeting benefits to those most in need and refocusing care provision from institutional to home care.

This Peer Review is part of the ongoing debate on how to finance LTC in a fair and sustainable manner as highlighted in the 2014 Report on Adequate Social Protection for Long-term Care Needs in an Ageing Society (European Commission 2014). It builds on previous Peer Reviews that focused on the same issue albeit from slightly different perspectives, namely the Peer Review organised by the Netherlands on 'Long-term care: How to organise affordable, sustainable long-term care given the constraints of collective versus individual arrangements and responsibilities', in 2009; and more recently the Peer Review organised by Sweden on 'Closing the gap – in search for ways to deal with expanding care needs and limited resources', in 2011. Both produced discussion papers from which important insights into the topic of LTC financing can be derived (cf. Rothgang & Engelke 2009; Riedel 2011). In both of these previous Peer Review processes, Slovenia was present as a participating country.

Besides the concerns regarding fiscal sustainability of LTC, the Europe 2020 Strategy also recognises that social protection can play an important role in fostering employment and growth and thus contribute to achieving the targets of increasing employment rates from 69% to 75%. This is the core rationale of the Social Investment Package (SIP), which calls for policy reforms that strengthens the efficiency and effectiveness of social protection systems, including LTC. The SIP also calls for social protections systems that are socially adequate and able to support the needs of people at critical points in their lives. Given that LTC costs at the individual level can be very high, sustainable solutions to finance LTC costs can also contribute to achieving another of the Europe 2020 Strategy's goals: lifting 20 million Europeans out of the risk of poverty and social exclusion.

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This discussion paper highlights the common challenges regarding financing LTC and builds on examples from several EU countries to discuss the different financing possibilities for LTC, the trade-offs associated with each option and recent trends. This is done against the backdrop of the aforementioned Europe 2020 Strategy and the SIP.

1.1. Contents and structure of this discussion paper

For the purposes of this discussion paper, LTC is defined as care provided to people who need assistance to carry out their everyday activities for a prolonged period of time. The scope of the analysis is restricted to older people, i.e. those aged 65 or older, although some of the national LTC systems described and discussed in this paper may also cover disabled people of working age. This discussion paper will not address specifically issues related to informal care, except where salient for the discussion on financing LTC – though it is recognised that care provided by unpaid informal carers (e.g. family members) still forms the backbone of LTC provision in EU countries.

This discussion paper will begin by succinctly presenting the arguments that make financing of LTC a salient policy issue and by providing an overview of public expenditure in Europe. The second section will begin by providing a comparative overview of different conceptual models to finance LTC; it will then address the issues of breadth, scope and depth of coverage of LTC systems; discuss new forms of cost sharing within and between generations; and debate the coordination of LTC with healthcare and pensions. The final section presents some conclusions.

1.2. The case for social protection against long-term care needs

LTC costs vary substantially according to the level of LTC needs and quality of care, among other factors, but from an individual's standpoint they can easily be considered catastrophic costs. For example, estimations of the lifetime costs of LTC in England place these at 21,400 GBP (at the median) (approx. EUR 27,020), but this value is substantially higher for women; and for those in the top decile of the distribution of LTC needs the estimated cost more than quadruples (Forder & Fernández 2009). At the same time, the risk of needing care is relatively high with estimates ranging from 50% for a person's entire life span in Germany, to 76% for those surviving till the age of 65 in England (Rothgang & Engelke 2009; Forder & Fernández 2009).

Given the costs involved, a single individual would need to accumulate significant life savings in order to self-insure. This option is not realistic for many people. Both risks and costs are very much skewed as people with lower income have a higher probability of needing care. Furthermore, many people will come into working age already in need of care. Self-insurance is also inefficient as many people do not end up requiring LTC, rendering some sort of risk-pooling (i.e. insurance) the preferable option in order to distribute risk and share payment of LTC among a larger group of individuals (Fernández et al. 2009).

In the absence of self-insurance or a risk-pooling mechanism, those unfortunate enough to need LTC can find themselves entirely reliant on family members. This means that the need for LTC can have repercussions beyond the individual and may affect the earning capacity of working-age children. The option to rely solely on family care does not seem to be popular in many of the EU countries (European Commission 2007), not to mention that family care is not an option for many older people who do not have close relatives. Finally, reliance on informal care can also be inefficient at the societal level if highly educated women are forced to leave the labour market to provide care for their dependent relatives.

1.3. Overview of public expenditure on LTC in the EU

Public expenditure on LTC as a percentage of GDP remains relatively low in Europe when compared to healthcare or other age-related social protection expenditures (e.g. old-age pensions). Furthermore, public expenditure on LTC remains highly differentiated between countries, reflecting different societal needs (i.e. differences in the share of older people with LTC needs in the total population) and different degrees of benefit generosity (Table 1). The latter includes how much national LTC systems rely on families to meet the costs with care through private out-of-pocket payments or to provide (informal) care.

Table 1: Current and projected public expenditure on LTC, in percentage of GDP.

Country	Public expenditure in 2010	Projected public expenditure in 2060 – AWG Reference Scenario	Range of projected public expenditure in 2060, taking into account improved disability and policy changes
Belgium	2.3	5.0	4.7-6.2
Bulgaria	0.5	0.8	0.7-1.4
Czech Republic	0.8	1.5	1.3-2.0
Denmark	4.5	8.0	7.5-9.1
Germany	1.4	3.1	3.0-5.9
Estonia	0.5	0.8	0.7-1.3
Ireland	1.1	2.6	2.5-3.3
Greece	1.4	2.6	2.4-3.5
Spain	0.8	1.5	1.4-3.1
France	2.2	4.2	4.1-6.9
Italy	1.9	2.8	2.7-4.6
Cyprus	0.2	0.3	0.2-0.3
Latvia	0.7	1.0	0.9-4.4
Lithuania	1.2	2.3	2.1-4.7
Luxembourg	1.0	3.1	2.8-4.8
Hungary	0.8	1.4	1.3-2.0
Malta	0.7	1.5	1.3-4.3
Netherlands	3.8	7.9	7.4-9.0
Austria	1.6	2.9	2.7-4.1
Poland	0.7	1.7	1.6-2.8
Portugal	0.3	0.6	0.6-1.3
Romania	0.6	1.7	1.4-3.2
Slovenia	1.4	3.0	2.8-5.6
Slovak Republic	0.3	0.7	0.6-2.3
Finland	2.5	5.1	4.8-5.8
Sweden	3.9	6.4	6.1-7.1
United Kingdom	2.0	2.7	2.5-3.9
EU 27	1.8	3.4	3.2-5.0

Source: European Commission, (2012).

Notes: The range of projected expenditure presents the lower and upper projections for public expenditure in LTC according to various scenarios.

Box 1: LTC in Slovenia

In Slovenia, around half of public expenditure on LTC is financed by the compulsory health insurance and serves mainly to finance institutional care (European Commission 2014). The social component of LTC (e.g. care in the community) is funded through the central and local governments and care allowances are paid to users through the Pension and Invalidity Insurance Institute of Slovenia. A considerable share of total expenditure in LTC in Slovenia is paid out-of-pocket by individuals in need of care: about ¼ of total expenditure is paid privately, which is a relatively high share in the context of the EU (Colombo et al. 2011). Moreover, the share of private expenditure has been steadily increasing over the years. The high share of private expenditure might be partially explained by the fact that the LTC system in Slovenia can be characterised as financing a broad range of services, albeit to only a small share of its population with care needs, i.e. to have a relative broad scope but limited breadth of coverage (European Commission 2014).

Two characteristics stand out in LTC financing (and provision) in Slovenia. Firstly, as mentioned before more than half of (publicly financed) LTC is financed by the compulsory healthcare funds. Most of this public expenditure is allocated to institutional care and here resides the second outstanding characteristic of LTC in Slovenia: almost as many older people are cared for in institutions as they are in their homes or communities. In 2013, an estimated 5% of the older population received care in institutions against 4.7% that received home care and 2.1% that received cash benefits (country annex on Slovenia in European Commission 2014). The share of total users of LTC that is cared for in institutions is thus relatively high in the EU context, particularly given the level of public expenditure on LTC in Slovenia (Rodrigues et al. 2012).

Among the challenges facing LTC in Slovenia are a relatively fast demographic ageing (Slovenia is in the upper third group of the EU in terms of share of the population aged 65 and older), the un-coordinated nature of the LTC system with often overlapping benefits and no single point of entry, and increases in out-of-pocket payments that risk rendering LTC unaffordable for many older people and increase unmet needs.

Projecting future LTC needs is subject to a high degree of uncertainty regarding the future path of major drivers of expenditure, not to mention the macroeconomic performance of countries (i.e. future GDP growth) over the long time periods that are usually involved in making these projections. Nonetheless, the European Commission has been publishing estimations of future public expenditure on LTC in its *Ageing Report* prepared jointly by the Directorate General for Economic and Financial Affairs (DG ECFIN) and the Economic Policy Committee (AWG). The latest available figures (European Commission 2012) attest to the potential for steep increases in public expenditure on LTC (Table 1). By 2060, Slovenia, whose current public expenditure levels are slightly below the EU27 average, is forecasted to double the share of its GDP that is devoted to publicly financed LTC.

The projections displayed in the reference scenario do not take into consideration the foreseeable increases in public expenditure that some EU countries may experience as they attempt to address what are currently (too) low levels of public resources devoted to LTC (the higher figures displayed in the fourth column of Table 1 mostly reflect this scenario of public expenditure catch-up). In fact, in the past decade a number of countries besides Slovenia have held internal debates about how to best finance LTC services and many have either recognised LTC as a social risk or have taken important steps to improve the social protection of those in need of LTC (Barnett et al. 2010). Spain introduced a universal (i.e. based on assessed needs) tax-based public LTC financing system in 2006 that aims to

increase the coverage of LTC needs in a progressive way. In 2007, the Czech Republic also introduced a universal LTC allowance to finance LTC needs, similar to the Austrian LTC allowance. The Flanders regional government (Belgium) introduced a compulsory (from age 26) supplementary social insurance in 2001 that pays beneficiaries a monthly flat rate benefit and is financed by additional social contributions. Ireland has introduced the denominated Nursing Homes Support Scheme (NHSS) in 2009, which in effect capped the lifetime contribution based on the principal residence of users in need of institutional care.

Having established the salience of LTC financing, the next section of this discussion paper will analyse the several options available for financing LTC in depth and the implications of each option.

2. Financing LTC needs - policy and developments at European and Member States level

2.1. Financing of LTC systems in the EU

Having already discussed the issues surrounding self-funding of LTC and its limitations in section 1.2, this section focuses on the following approaches to funding LTC (Rothgang & Engelke 2009):

- Social insurance;
- Tax-based (either universal or means-tested) public systems;
- Private insurance.

2.1.1. Social insurance

Social LTC insurance systems have some features that make them attractive when compared with tax-funded systems discussed below. Notable among these are:

- Allocation transparency: the allocation of benefits usually follows a defined algorithm rather than depending on the discretionary power of care managers or on available resources. Thus, social insurance arguably provides greater assurance regarding entitlement of benefits. Also, by making care a social right linked to past payment of specific social contributions, it does away with potential issues of stigma surrounding take-up of benefits. Since social insurance systems are usually accessed through one unique point of assessment and benefits are harmonised, it could be argued that they also have the potential to facilitate access and limit geographical inequalities.
- Financial transparency: social insurance is typically financed by social contributions (payroll taxes) that are assigned specifically to the system and not to the general state budget. Not only does this create a reliable and predictable financing stream, but it may also enhance people's willingness to pay additional social contributions if they are tied to a particular risk they consider worth being protected against – not a trivial advantage when seeking to ensure the social sustainability of the system (i.e. that the system enjoys public support) (Fernández et al. 2009).

When compared with mandatory private insurance discussed below, social LTC insurance also has a number of potential advantages. First of all, social contributions used to finance social LTC insurance are income-related, making them affordable to all individuals through an implicit redistribution from wealthier to poorer individuals. This same redistribution allows for the notional payment of social contributions during unemployment or periods of inactivity.

Secondly, with social insurance it is possible to pool risks not only at the societal level, but also between generations with the pay-as-you-go (PAYG) system, as it is

done in the case of old-age pensions. The current working-age generation pays for the benefits of current older beneficiaries with the understanding that future generations will in turn pay for their benefits when they reach old-age. This 'intergenerational contract' allows benefits to be paid from the beginning of the programme (Rothgang & Engelke 2009).

Finally, the social contribution rate can more readily be changed at any given point to reflect and accommodate changes in risks and costs, rendering social insurance more flexible in accounting for uncertainty in LTC needs and costs.

However, social insurance systems also have potential disadvantages. Some of these do not stem from the concept of social insurance itself, but rather from the way the system is managed. The 'intergenerational contract' inherent to PAYG creates an implicit burden on future generations that demographic ageing only aggravates. Allocation of benefits through a well-defined algorithm may render care packages too standardised and leave little room for them to reflect the particular needs of individuals – although the possibility of receiving the benefit as a cash payment could add flexibility to the system, e.g. by allowing users to hire their own personal assistants or pay informal carers as is the case with the social insurance systems in the Netherlands, Germany and Luxembourg. By linking social contributions to wages, social insurance systems have a limited tax base, which raises issues regarding their equity as they tend to leave capital earnings exempt from payments (Rothgang & Engelke 2009). Furthermore, social contributions levied on wages increase the tax on wage earnings and can have distortion and competitiveness effects. This also leaves the financing of the system vulnerable to economic fluctuations (e.g. increases in total unemployment in periods of economic downturn and consequent diminished stream of revenues).

Examples of social LTC insurance systems among EU countries can be found in Germany, the Netherlands and Luxembourg, as well as in the Flanders region in Belgium.

2.1.2. Tax-based systems

Tax-based systems are financed from the state's budget (whether the central administration, regional or local governments) and as such their revenues are drawn from the taxes levied by the state. Herein lies one of the greatest strengths of tax-based systems: they have a broader tax-base and therefore financing is not limited by the share of wages in GDP. As capital earnings are also a financing source this can be seen as more equitable at the societal level, although this ultimately depends on the relative importance of the different types of taxes (e.g. indirect taxes on consumption typically involve less redistribution than proportional income taxes).

Another potential advantage of tax-based systems is their flexibility and adaptability in providing benefits, which means that uncertainty regarding future costs with LTC may be more easily addressed. The potential flipside of this is arguably reduced transparency in the allocation of those same benefits.

Another potential disadvantage of tax-based systems in comparison with social-insurance systems is the potential for inequalities between groups of users with similar needs to arise. Unlike social insurance, in tax-based systems there is no pre-defined algorithm to define eligibility and this is often left to the discretion of care managers or dependent on available budgets. When local governments can determine eligibility or availability of services this can give rise to inequalities based on 'postal code lottery'.

2.1.3. Private insurance

Voluntary private insurance for LTC faces various obstacles to implementation (Pauly 1990; Fernández et al. 2009; Rothgang 2010; Barr 2010; Comas-Herrera et al. 2012). Chief among these obstacles is adverse selection, where 'bad risks' (i.e. people with higher risk of needing LTC) will buy insurance while 'good risks' will not, thus driving premium prices higher and ultimately causing the market to collapse. The United States Community Living Assistance Services and Support (CLASS) Act – a public insurance mechanism introduced in 2009 but based on voluntary enrolment – provides an example of the effects of adverse selection on a voluntary insurance system. Given the scope for improvement in health treatments and changes in care costs over the insured person's lifespan (e.g. if dependent older people would live longer with LTC needs), need for LTC might best be characterised as an uncertainty rather than a risk, which would render actuarial insurance impractical (Barr 2010). Despite the mountain of evidence pointing to a high probability of needing LTC at some point in the course of a lifetime, younger people may be myopic in their assessment of LTC risks and opt not to buy insurance. This leads to a lack of personal coverage when they reach old-age, a problem that ultimately public systems of last-resort may have to address. Lack of awareness on the part of potential purchasers of private insurance has long been considered one of the main barriers to take-up of private LTC insurance (Comas-Herrera et al. 2012). The existence of a public system of last-resort may itself prevent people from buying private insurance, i.e. the public sector may crowd-out private insurance. Finally, private insurance usually requires that some capital is accumulated in the form of paid premiums before benefits can be paid out.

The above-mentioned problems related to adverse selection and myopic behaviour can be addressed by making private LTC insurance mandatory (Rothgang & Engelke 2009). Three issues would nonetheless remain. First, many people, including those with lower incomes, with pre-existing conditions and those closer to old-age, might not be able to afford the premium (in private insurance, premia reflect differences in risk rather than income) and this would require public subsidies. Subsidies would also be necessary during periods of unemployment or inactivity (e.g. when studying), when people do not have sufficient sources of income. Secondly, the need for capital accumulation (pre-funding) would remain, meaning that the current older generation would not be covered. Thirdly, the issue of uncertainty about risk and associated costs would remain. Regarding this last issue, this could lead insurance companies to raise insurance premia with negative consequences for affordability (Brown & Finkelstein 2007). Alternatively, insurance companies may take a conservative approach and provide only limited benefits that most likely would cover only a limited portion of the LTC costs. This is indeed the option followed by private LTC insurance companies in countries like France, which is one of the rare examples in the EU where private LTC insurance holds some importance with an estimated 5.5 million people privately insured in 2011 (FFSA 2011). Even there, however, private LTC insurance is confined to a supplementary role, concentrated among older workers and those with higher income (Courbage & Roudaut 2008). Across the EU, voluntary private insurance has only a residual presence at best, with the aforementioned exception of France (Colombo et al. 2011). In contrast, in Spain it is estimated that only approximately 21,000 people had private LTC insurance in 2013, while for Austria the latest available figure is 60,000 (2010).

Table 2: Summary of advantages and disadvantages of the main financing approaches to LTC.

Financing approach	Advantages	Disadvantages	National examples
Private insurance	Theoretically neutral for the public budget	Limited tax base May require subsidies for low-income or inactive (if mandatory) Adverse selection (unless mandatory) Difficulties in assessing risk Pre-funding imposes a 'waiting period'	No country in the EU, barring France, has a private LTC insurance that is anything but residual
Social insurance	Transparency: by creating an explicit entitlement to benefit (less stigma) and dedicated financing Reliable and predictable revenues Affordable contributions (if income-related) No waiting period (if PAYG)	Rigidity in benefits awarded Limited tax base Implicit debt (if PAYG)	Germany, Luxembourg, Belgium (Flanders), the Netherlands (AWBZ)
Tax-based system (universal)	Broader tax base No waiting period (if PAYG) Potentially greater flexibility in benefits awarded	No direct link between revenues and benefits Less transparency in allocation of benefits (may ultimately depend on available budget) Implicit debt (if PAYG)	Sweden and Denmark (without cash benefits) Austria and Czech Republic (with cash benefits)

Box 2: Integrating different types of financing mechanisms

In reality, LTC systems usually combine different types of financing mechanisms, often linked with different eligibility rules.

While social insurance systems can provide an adequate form of financing LTC needs for the general population, they are unlikely to cover the full costs of care (e.g. board and lodging in nursing homes), in which case they need to be supplemented with a public system of last resort (i.e. means-tested) financed through general taxes. Tax-financed mechanisms are also more appropriate to finance the contributions of those who cannot afford to pay social contributions (e.g. unemployed, people on sickness or maternity leave), or that do not fulfil the eligibility criteria for social insurance benefits. The French *Allocation Personnalisée d'Autonomie* (APA) provides an example of a benefit that is financed through a combination of social contributions and taxes.

Private voluntary LTC insurance can also play a supplementary role in financing the components of care that are not covered by the public LTC system, or to finance additional care options (e.g. amenities in nursing homes). It is worth bearing in mind, however, that private insurance is likely to be crowded-out by public LTC systems. Private insurance is also likely to be taken-up by wealthier individuals (who can afford to pay the extra premium and who are likely to be more aware of LTC risks) and therefore attaching tax subsidies to the use of private voluntary LTC insurance will likely have regressive effects.

In the current proposal for reform of the LTC financing system that is under debate, Slovenia also takes a mixed approach to financing LTC. The proposal considers a social insurance-based model as the main system to finance LTC, with the social contributions to be paid by working-age individuals as well as pensioners. This will be supplemented by a mandatory private LTC insurance to offer additional protection against the risk of needing LTC, or alternatively, by a levy (calculated as a progressive tax on income) earmarked to finance LTC. Out-of-pocket payments will remain in place, namely to cover costs with board and lodging in institutions, but voluntary private LTC insurance may cover for these costs.

2.1.4. Breadth, scope and depth of coverage of LTC systems

A related issue concerns the breadth of LTC benefits, i.e. the eligibility for LTC benefits and whether access to these benefits is universal (i.e. based on need only) or means-tested. By definition, in insurance-based systems the payment of premia (or social contributions in the case of public systems) entitles beneficiaries to receive benefits in the event they require LTC. Therefore these are systems that are usually universal. In tax-based systems there is scope for either universal access to benefits (e.g. Sweden, Spain, Austria) or means-tested access (e.g. England, Latvia, Croatia, Hungary). Still, eligibility thresholds for accessing LTC benefits or the breadth of LTC systems can vary markedly between countries, even among those with universal LTC systems. As an example of this variation, in Austria the minimum threshold for eligibility is 60 hours of care per month, while in Germany is 1.5 hours per day (a monthly equivalent of 45 hours) and in Luxembourg 3.5 per week (a monthly equivalent of approximately 15 hours).

Existing public LTC systems seldom cover the full cost of LTC, which means that the scope of coverage (what needs or services are financed) and the depth of coverage (what share of costs are publicly financed) of LTC systems can vary significantly and are not necessarily linked to whether the system is financed through social insurance or taxes. Regarding the scope of coverage, costs with board and lodging are not usually covered by LTC systems (except under means-tested social assistance). This is the case with the LTC insurance in Germany or the health

insurance in Belgium, where these costs are paid out-of-pocket by the user. In Ireland, the board and lodging costs are defined according to the income and assets of the user.

Some national LTC systems adjust the depth of coverage to the income of users. In France, although eligibility for the APA is based on need alone, the monthly amounts of the APA are adjusted according to the income of the user and can vary from 28.59 Euros to 1,312.67 (Service Public Française 2014). In Spain, the amount of the benefit for LTC also varies according to the income and assets of the user. In Austria, access to subsidised care falls short of the assessed hours of care, e.g. someone assessed with 120 hours of care needs per month is eligible to a maximum of 60 hours of subsidised care in Lower Austria (Leichsenring et al. 2009), which leaves a substantial part of the costs to be covered by the user's own resources. Finally, out-of-pocket costs may be levied not only on the user but also on relatives, or alternatively children's income may be taken into consideration for determining eligibility to social assistance (Table 3).

Table 3: Summary of rules for out-of-pocket payments in institutional care

	Out-of-pocket payments defined as a percentage of	*Assets considered for co-payment*	*Payment by relatives (outside the household)*
Belgium	Costs for board and lodging and some types of care	Yes	Yes
Bulgaria	User's income (50% to 80% of income)	---	Yes
Czech Republic	Costs for board and lodging	Yes	Yes
Croatia	User's income	Yes	Yes
Denmark	Costs for board and lodging	No	No
Germany	Costs for board and lodging and investment costs	Yes	No (a)
Spain	User's income (70% to 80% of income)	Yes	---
France	Costs for board and lodging and some types of care	Yes	---
Ireland	User's income (approximately 80% of income)	Yes (b)	No
Italy	User's income	---	Yes
Latvia	User's income (up to 90% of income)	Yes	---
Lithuania	User's income	Yes	---
Hungary	User's income	Yes	Yes
The Netherlands	User's income, but subject to maximum out-of-pocket payment	No	---
Austria	User's income (approximately 80% of income)	Yes	No
Poland	User's income (up to 70% of income)	---	Yes (b)
Finland	User's income (approximately 80% of income)	No	No
Slovak Republic	User's income	---	---
Slovenia	User's income	---	Yes
Sweden	User's income, but subject to a maximum out-of-pocket payment	No	No

Source: Adapted from Rodrigues et al, (2012, p.101).

Notes: (a) Children's income is considered for calculation of user's payment.
(b) Not in institutions under the healthcare system.

As with eligibility rules (i.e. breadth of coverage), depth and scope of coverage are not closely associated with how LTC systems are financed. There is therefore a mixed picture in terms of the share of total expenditure that is financed privately across countries and financing systems. Despite its social LTC insurance, private expenditure on LTC in Germany represents one third of total expenditure on LTC, much higher than in Denmark (10%) or in Austria (17%), but also higher than in Slovenia at around 26% (European Commission 2014 based on OECD Health Database and national sources). In institutional care, private expenditure makes up for an even larger share of total expenditure and in fact most costs are borne by users (Rodrigues & Schmidt 2010).

In practice LTC systems combine universal and means-tested features and in some cases, such as in Slovenia (see Box 1), parallel sub-systems co-exist (Colombo et al. 2011). As described above, insurance systems, such as the Belgium one, typically do not cover all costs with care (e.g. board and lodging in institutional care) and are therefore supplemented by a means-tested social assistance component that acts as safety net for those that cannot afford the cost of care paid out-of-pocket. Similarly, the eligibility and amounts of the tax-based Austrian federal LTC allowance are determined on the basis of need, but a means-tested social assistance component exists in parallel at the regional level to support those that cannot afford care after public benefits. Countries with means-tested benefits have in parallel other benefits meant to support people with LTC needs that are universal, such as the Attendance Allowance in England. Other countries such as Slovenia, but also Poland or Italy, provide also care allowances in parallel with other benefits meant for older people with LTC needs.

In recognition of the several caveats attached to means-tested systems, there seems to be a trend towards moving away from means-tested LTC systems as the main form of providing public support for LTC needs in European welfare states (Colombo et al. 2011). Despite the fact that means-testing may allow for a better targeting of public benefits to those with limited financial resources, it is now increasingly accepted that means-tests may create significant unmet needs (especially among those sick enough to require care, but not poor enough to qualify for public support nor rich enough to pay out-of-pocket for LTC), create stigma, and potentially increase administrative costs (Rothgang & Engelke 2009; Fernández et al. 2009; Colombo et al. 2011). There are also strong arguments built around fairness, e.g. regarding having to be poor in order to receive support for the costs of LTC needs that are not necessarily connected to lifestyle choices. Linked to this are arguments about the potential adverse incentives to accumulate savings arising from means-tests. At the individual level, means-testing also creates additional incentives for individuals to attempt to replace means-tested LTC services with healthcare services that are free at the point of use – a substitution effect that may not be cost-effective at the societal level. As described above – section 1.3 – Spain and the Czech Republic have moved towards universal LTC benefits in more recent years. England is also planning to introduce significant changes to its LTC system, which will include a cap on the total out-of-pocket contribution of the user, thus limiting the user's contributions to the costs with care (Commission on Funding of Care and Support 2011).

In parallel to this shift away from means-testing, there has been a move towards ensuring greater targeting of public resources, even in universal social insurance or tax-based systems. In some cases this targeting has involved reducing the breadth of LTC systems, e.g. by making even social insurance-based systems not 'carer-blind'. In the case of the Netherlands, eligibility to benefits under social insurance takes into consideration the amount of informal care that relatives should provide (regardless of whether they provide it or not) in what is termed as 'customary care'

(Grootegoed et al. 2014). In Latvia, assessment of informal care that co-residing relatives may be able to provide is also part of the eligibility criteria for home care. In Sweden, there has been a consistent policy to concentrate public resources in individuals with greater needs (Szebehely & Trydegård 2012).

In other cases the greater targeting has involved changes to the depth of coverage, i.e. changes to the private contributions to the costs of LTC. For example, in Germany the amounts of the LTC insurance paid to eligible users are lower in the cases where they opt to use them to pay for informal carer. As described above, in France, the amounts of the public universal benefit, the *Allocation Personnalisée d'Autonomie* (APA), are adjusted according to the user's income, in what has been dubbed as 'progressive universalism' (Fernández et al. 2009, p.14ff).

2.1.5. Cost sharing within and across generations

In addition to the approaches to financing LTC needs and the issues around breadth, scope and depth of coverage discussed above, there are other issues that are relevant for sustainable LTC financing. These include new financing sources (e.g. accumulated assets such as housing stock) and building mechanisms that ensure the adaptability of LTC systems to societal and demographic changes (e.g. pre-funding mechanisms and other forms of intergenerational financing). Each is debated below.

As depicted in Table 3, a number of countries include assets such as housing in means-testing to determine eligibility for LTC services (Rodrigues et al. 2012). As individual wealth is usually maximised around retirement age with a sizeable portion of that wealth taking the form of property (Colombo et al. 2011), assets could be seen as a potential source of financing for LTC needs, particularly for older people who need to move into institutional care. This is an issue without broad consensus among Europeans, however, as many people find it unfair to have to forsake their home in order to qualify for public support for LTC needs (European Commission 2007). Furthermore, this may be seen as a penalty imposed on people who have saved over the course of their lives, and may stand as a barrier to rehabilitation in institutional care settings. Nonetheless, a number of solutions have been proposed that allow for the mobilisation of assets invested in one's own house while protecting most of its value and without requiring its sale (e.g. reverse mortgages) – a relevant issue for those in need of home care. In Ireland, up to 7.5% of total assets are used to finance care per year, including the value of the principal residence, but only up to a cap of 22.5% in the case of the latter. This payment can be deferred till time of death and there are other regulations in place to protect surviving co-resident relatives who continue to reside in the principal residency (the above mentioned cap is also lower in these cases, 11.25%).

As was discussed before, one advantage of PAYG systems is that payment of benefits is immediately possible from the moment such a system is put in place. Conversely, funded systems require that sufficient funds are first accumulated before being able to pay out benefits. This fact notwithstanding, pre-funding through reserve funds could smooth out the effects of demographic ageing by limiting the amount of implicit debt that is passed on to future generations in the context of a PAYG system. Other possible advantages of having pre-funded elements built into LTC financing systems include smoothing over possible changes to benefits or contributory rates to meet the costs of care over time (Colombo et al. 2011). A number of countries that have implemented social insurance-based systems to finance LTC that are managed as PAYG also have in place pre-funding mechanisms, although the amounts accumulated are equivalent to only a very limited fraction of expenditures; e.g. this was equivalent to 24% of annual expenditures on benefits for Luxembourg in 2012, while this was 48% in 2008

(Ministére de la Securité Sociale 2013). In Germany, a recent LTC insurance reform that will come into effect in 2015 will introduce a 0.1 percentage point increase in the contribution rate. The resulting funds will be set aside in a buffer fund that will only be spent from 2035 onward in order to level the effects of the country's demographic transition (BMG 2014).

In the case of Germany and Luxembourg depicted above, a fixed percentage of annual revenue is set aside in these pre-funded reserves, but other solutions might be implemented including some that could also mitigate the reduced tax base problem of social insurance mechanisms. For example, a fixed percentage of the VAT tax could be earmarked to finance these reserve funds (e.g. Portugal for Social Security as a whole) or a percentage of the tax revenue of other taxes such as local property taxes (e.g. France for LTC), which would in practice increase the tax base of LTC financing. The pre-funding mechanisms and examples discussed here could equally be implemented in tax-based or social insurance systems. One issue remains and that is the possibility of the accumulated funds being captured to finance government deficits or expenditures.

Pre-funding options and reserve funds also constitute ways to strengthen the intergenerational balance in financing LTC. Current generations build up assets for future generations, while using revenues from taxes on consumption ensures that older people also contribute to finance LTC needs. The Flemish LTC insurance system discussed above and the German LTC insurance model are two examples of systems that specifically levy social contributions on older (retired) people also. Demographic ageing will increase the share of older people in the total population, as well as the relative size of the share of income or assets held by older people, making it less defensible to rely on taxes or contributions levied on a diminishing pool of working-age people alone (Colombo et al. 2011; Fernandez & Forder 2012). Another form of strengthening intergenerational balance is to have differentiated payments according to number of children[3], as has been the case in the German LTC insurance system since 2004 (childless people pay an additional 0.25 percentage point contribution rate).

2.2. Integrating sustainable financing for LTC with healthcare and pensions

Older people in need of LTC, and in particular those with multi-morbidities or those suffering from chronic diseases are liable to require a mix of healthcare and LTC services provided along the continuum of care. This raises the issue of how to provide integrated care and how to design financing mechanisms that foster (or at least do not significantly hinder) such integration.

On the one hand, fully merging LTC with the healthcare system is not a viable solution for it risks leading to overutilisation of expensive healthcare facilities and undervaluation of the social components of LTC needs (e.g. socialising) *vis-à-vis* medical needs (Colombo et al. 2011). This has been referred as one of the weaknesses of LTC in Slovenia – i.e. an overly strong focus on medicalisation, reflected not only in the limited development of community care, but also in the focus on health needs instead of independent living – and could likely be traced back to the relevance of healthcare funds in financing LTC (European Commission 2014).

On the other hand, creating separate LTC financing schemes opens the door to 'cost-shunting' between different sectors. Different mechanisms governing financing of different types of care in Germany – with funding for some types of care being

[3] This is however, a hotly contested issue with strong moral arguments in favour and against (see Tomlin 2014 for a review of some of the theoretical arguments).

pooled across LTC insurance funds while others fall on individual funds – have provided opportunities for this cost-shunting to take place (Rothgang & Engelke 2009). In Austria, the introduction of DRG (diagnosis-related groups) funding for inpatient care shifted pressure on utilisation of services from the healthcare to the LTC sector without an accompanying shift of resources (Leichsenring et al. 2009). Rehabilitation is another oft-quoted example of a service where costs are usually borne not by those benefiting from the improved outcomes (Rothgang 2010). One alternative is to make re-ablement services free of charge for a period of time following the assessment of needs, as proposed in England (Commission on Funding of Care and Support 2011).

Cost-shunting may also happen within the LTC system between different levels of governance. The introduction of a tax-based LTC allowance financed by the federal government in Austria freed up significant financial resources at the regional level.

These resources were supposed to be channelled to the development of LTC services by those same regional governments, which in reality seldom occurred (Grilz-Wolf et al. 2004). Different LTC financing sources may also create difficulties in accessing adequate and cost-effective care by multiplying access points and assessment procedures (Commission on Funding of Care and Support 2011). This has also been reportedly the case in Slovenia, where LTC is financed through a number of uncoordinated different sources (European Commission 2014).

These difficulties are compounded when there are different financing arrangements between healthcare and LTC or parallel systems in operation to address LTC needs. This is most noticeable when LTC is means-tested and healthcare is universal because it creates added difficulties in determining financial eligibility (Leutz 1999). This can be viewed as another argument in favour of universal LTC financing systems. Having similarly operating health and LTC financing mechanisms is also likely to facilitate their integration. Perhaps unsurprisingly, most countries that have implemented social insurance-based LTC systems already had similar systems for healthcare in place, as was the case in Germany and the Netherlands (Fernández et al. 2009). An exception to this rule is Austria which has a comprehensive tax-based LTC system operating alongside pre-existing social health insurance – nor does it guarantee seamless operation across systems, as the above examples on Germany show.

Despite the challenges in integrating financing for healthcare and LTC, there is also room for optimism. Those more likely to come into repeated contact with health and LTC systems, or to require care on a continuous basis and thus to require better integration of financing of healthcare and LTC services, constitute a minority with particularly severe or compounding conditions. Existing evidence shows that full integration of care services for all people is likely not achievable, yet full integration in some cases is a more attainable goal (Leutz 1999).

Another alternative is the development of pooled budgets across health and LTC systems. In England, the pooled budgets established under Section 75 of the NHS Act 2006 allow not only health and LTC providers to achieve savings through joint commissioning and administration, but crucially allow for planning of interventions and allocation of resources across the health and LTC divide (INTERLINKS 2014). Again, this might be facilitated by having similar types of financing systems for healthcare and LTC.

3. Conclusions and Recommendations

There are strong arguments in favour of pooling resources to finance LTC needs, both as a way to protect individuals from the potentially catastrophic costs associated with LTC, and as social investment for the creation of jobs. The several solutions for financing LTC have different strengths and weaknesses and a decision on which to implement should consider these.

In setting up public solutions for financing LTC needs in the context of tightening public resources, social insurance-based systems may be advantageous in fostering tax-payers' willingness to pay as there is a clearer link between contributions paid and benefits provided. The contribution rate, however, must be set in a way that allows for sufficient funds to be collected to cover LTC needs and to account for predictable short- and medium-term changes in LTC needs. Similarly, the tax base on which to apply the contribution rate should be as broad as possible (e.g. without caps on the wage income liable for social contribution payments). The sustainability of social insurance systems ultimately depends on the pooling of risks across the population, which is why offering individuals the possibility to opt-out should be considered with great caution if this risks self-selecting healthier individuals out of the public system.

Tax-based systems allow for a broader tax base to finance LTC needs and offer a greater scope for redistribution within society by collecting taxes on capital earnings and not just on labour income particularly when the latter's share in GDP is shrinking. This makes a strong case for having at least some component of a public LTC system financed through taxes. These can be used to finance contributions of those that cannot pay them, to finance a safety net mechanism to be used as a last resort, or as part of an earmarked transfer to a reserve fund (e.g. allocating a fixed percentage of taxes collect on consumption or capital).

For countries that already have a sizeable portion of their population in need of LTC, solutions based only on pre-funding may come too late to address present LTC needs, a situation that favours a financing mechanism based on PAYG. Supplementary pre-funded components, such as a reserve fund, could be considered as a means to smooth over future demographic transitions, e.g. if a particularly large cohort of people is expected to reach old-age at some point in the future. Social contributions or taxes paid by current pensioners, childless individuals or earmarked tax revenues from other taxes could finance such a fund and strengthen the inter- and intra-generational solidarity of the system.

Private voluntary insurance has too many problems to be considered as the main option to finance LTC. It can, however, play an important supplementary role in financing additional costs of care or allowing individuals with different preferences (e.g. more amenities in care homes) to be financed outside of the public system. One of the greatest barriers to take-up – lack of awareness of LTC risks – is likely to be reduced if private voluntary insurance is introduced into public discourse in the context of LTC and its financing. However, it is likely that private LTC insurance will always be bought primarily by wealthier individuals. Other solutions to increase its take-up, such as subsidies or opting-out clauses from the public system, should be considered with great caution on equity grounds.

Besides the decisions around the model of financing of LTC needs, defining the breadth, scope and depth of coverage of LTC benefits is also important for the fiscal and social sustainability of LTC systems. As it was apparent from several national examples, several combinations are possible between different financing systems (social insurance or tax-based) and how benefits are structured (e.g. eligibility, share of private contributions to costs, cash vs. in-kind benefits).

Finally, LTC systems do not operate in a vacuum and financing of LTC needs is only one element of such systems that have been emerging across Europe in particular over the past two decades. Any debate on funding options therefore needs to consider also

- the organisational structure (supply) of LTC and its links with the healthcare system, but also with the built environment, information and communication technologies;
- the governance of LTC, including the interplay between different levels of government or stakeholders responsible for financing and steering LTC provision;
- the human resources involved both in terms of formal care provision (key-word: lack of care professionals) and in relation to the role of informal care (key-words: support for informal carers, reconciliation of care and employment).

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