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Long-term care – the problem of sustainable financing

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Long-term care – the problem of sustainable financing

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SYNTHESIS REPORT

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Executive Summary

Slovenia is facing a rapidly ageing population and there are growing concerns that its current system of financing long-term care (LTC) needs is inadequate to protect those in need of care. To address these issues, a debate is currently under way in Slovenia regarding possible changes to its LTC system. This Peer Review will contribute to the debate. The current paper is a synthesis of the findings of the Peer Review process on 'Long-term Care – the problem of sustainable financing'. It draws on the discussion paper, on the host country paper, on the comments from the other participating countries and stakeholders, and on the discussions that took place in Ljubljana on 18–19 November 2014. Besides the host country, Slovenia, the following countries took part in this Peer Review: Austria, Belgium, Bulgaria, Croatia, Czech Republic, Denmark, Hungary, Ireland, Latvia, Poland and Spain. Also taking part in the Peer Review and discussion were representatives from AGE Platform Europe, Eurocarers and the European Commission DG Employment, Social Affairs and Inclusion.

This Peer Review process sought to discuss the advantages and disadvantages of different options for financing LTC; the experiences of several countries that have relied on different approaches to financing LTC; the possible alternatives to strengthen intra- and intergenerational solidarity; and the possible issues arising from the need to coordinate health and social care. The proposal for reform of the Slovenian LTC system provided the starting point for the discussion.

Among the findings of this process is a strong consensus on the need for the state to play an active role in financing LTC. This is related to the limitations of private solutions, such as voluntary private LTC insurance. It is also clear that there are limits both to taxpayers' willingness to contribute to the cost of LTC through higher taxes or contributions, and to users' ability to pay out-of-pocket expenses for care. Transparency in resource allocation, the equity consequences of different financing options, and broadening of the tax base were some of the key concepts discussed. Given the interplay between health and social care in LTC, and the division of responsibilities across different levels of government that is characteristic of LTC, governance also featured prominently in the debate. This relates directly to the need to enhance the efficiency of LTC through better coordination between stakeholders. Participants made it clear that there is no 'silver bullet' available to ensure sustainable financing of LTC. Any discussion around the sustainability of LTC must therefore take into consideration the need to influence the demand side (i.e. the needs of an ageing population) through prevention, rehabilitation and adaptations to the living environment.



A. Policy context at the European level

Public expenditure on long-term care (LTC) as a percentage of GDP remains relatively low in Europe, compared to expenditure on healthcare or other age-related social protection (e.g. old-age pensions), and is highly differentiated between countries. Demographic ageing has, however, raised concerns about the future levels of public expenditure and the financial sustainability of current financing arrangements for LTC.

At the same time, there is growing consensus about the need for social protection against LTC needs. This stems from the fact that, from the standpoint of an individual, LTC costs can be considered catastrophic costs. For example, estimates for the lifetime cost of LTC in England are 21,400 GBP (approx. EUR 27,020) (at the median). But the figure is substantially higher for women; and for those in the top decile of the distribution of LTC needs, the estimated cost is more than four times that amount (Forder and Fernández 2009). Self-insurance through savings is not realistic for many people, as both the risk and the cost of LTC are heavily skewed towards those on a lower income. Furthermore, many people will come into working age already in need of care. In the absence of 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 of relying solely on family care does not seem to be popular in many of the EU countries (European Commission 2007). Moreover, family care is not an option at all 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 care for their dependent relatives. Risk-pooling is therefore the preferable option to distribute risk and share payment of LTC costs among a larger group of individuals (Fernández et al. 2009). This can be achieved through social insurance, tax-based (either universal or means-tested) public systems, or private insurance (Rothgang and Engelke 2009). Each of these has certain advantages and disadvantages, and working examples of each are to be found across Europe.

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Social insurance

Social LTC insurance systems have some features that make them more attractive than 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 to 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 since benefits are harmonised, it could be argued that they also have the potential to facilitate access and to limit geographical inequality.
- **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 those



are tied to a particular risk that they consider it 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)”.

Social LTC insurance also has a number of potential advantages over mandatory private insurance (discussed below). 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 periods of unemployment or 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 happens in the case of old-age pensions. The current working-age generation pays for the benefits of current older beneficiaries, on 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 and Engelke 2009).

Finally, the social contribution rate can be changed more readily 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 stem not from the concept of social insurance itself, but from the way in which the system is managed. The ‘intergenerational contract’ inherent in PAYG creates an implicit burden on future generations that demographic ageing only serves to aggravate. The allocation of benefits through a well-defined algorithm may render care packages too standardised and could 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 any earnings generated from capital exempt from payments (Rothgang and 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 fluctuation (e.g. increases in total unemployment in periods of economic downturn and consequent diminished stream of revenue).

In the EU, examples of social LTC insurance systems are to be found in Germany, the Netherlands and Luxembourg, as well as in the Flanders region of Belgium.

Tax-based systems

Tax-based systems are financed funded from the state’s budget (whether of central, regional or local government), 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 the GDP. As capital income also provides a financing source, the system may be regarded 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 the future costs of LTC may be addressed more easily. The potential flipside of this is arguably reduced transparency in the allocation of those same benefits.

A possible disadvantage of tax-based systems over social insurance systems is the potential for inequality between groups of users with similar needs. 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 is dependent on available budgets. When it is left to local governments to determine eligibility or availability of services, this can give rise to inequality based on a 'post code lottery'.

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 is adverse selection, where 'bad risks' (i.e. people at greater 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 an insured person's lifespan (e.g. if dependent older people live longer with LTC needs), the need for LTC might best be characterised as an uncertainty, rather than a risk¹, 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 may opt not to buy insurance. This leads to a lack of personal cover 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 dissuade people from buying private insurance, i.e. the public sector may crowd out private insurance. Finally, private insurance usually requires some capital to be 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 and Engelke 2009). Three issues would nonetheless remain. First, many people – including those on lower incomes, those with pre-existing conditions and those closer to old age – might not be able to afford the premiums (in private insurance, premiums 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

¹ Given the long time horizons of long-term care, one cannot calculate what would be the probability of needing care in 30 years. Therefore, LTC is rather an uncertainty, which cannot be insured. (Barr 2010)



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 premiums, with negative consequences for affordability (Brown and Finkelstein 2007). Alternatively, insurance companies may take a conservative approach and provide only limited benefits that most likely would cover only a portion of the LTC costs. This is indeed the option followed by private LTC insurance companies in countries like France, which provides one of the rare examples in the EU where private LTC insurance is of 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 on a higher income (Courbage and Roudaut 2008). Apart from in France, across the EU voluntary private insurance has only a marginal presence at best (Colombo et al. 2011). In Spain, for example, it is estimated that only around 21,000 people had private LTC insurance in 2013, and in Austria the latest available figure is 60,000 (2010). More recently, private insurance companies in England have introduced 'immediate needs annuities'. These products allow individual users to make a single payment up front for their lifetime costs of care, the amount being dependent on the person's age, health and the costs of the care covered. These annuities are purchased when the care is needed and do away with uncertainty as to the possible lifetime costs of care, thus allowing for better management of any remaining assets.



Table 1: 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, bar 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 revenue 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 (General Exceptional Medical Expenses Act (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) |

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 premiums (or social contributions in the case of public systems) entitles beneficiaries to receive benefits in the event that they require LTC. Therefore these are systems that are usually universal. In tax-based systems there is scope for either universal (Denmark, Spain, Austria) or means-tested access to benefits (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 it is 1.5 hours per day (monthly equivalent of 45 hours) and in Luxembourg it is 3.5 hours per week (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 is 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, the costs of board and lodging are not usually covered by LTC systems (except under means-tested social assistance). This is the case with LTC insurance in Germany and health insurance in Belgium, where these costs are paid by the user out of his or her own pocket. In Ireland, the costs of board and lodging 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 (*Allocation Personnalisée d'Autonomie*) is based on need alone, the monthly amounts of it are adjusted according to the income of the user and can vary from EUR 28.59 to EUR 1,312.67 (Service Public Française 2014). In Spain, the amount of the LTC benefit 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 for 120 hours of care needs per month is eligible for 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 (Table 2).

As is the case with eligibility rules (i.e. breadth of coverage), the depth and scope of coverage are largely unconnected with the way the 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 Austria (17%), and higher even than in Slovenia (around 26%) (European Commission 2014, based on OECD Health Database and national sources). In institutional care, private expenditure constitutes an even larger share of total expenditure across the EU, and in fact most costs are borne by users (Rodrigues and Schmidt 2010).

Table 2: Summary of rules for out-of-pocket payments in institutional care

| | Out-of-pocket payments set as a percentage of | Assets considered for co-payment | Payment by relatives (outside the household) |
|-----------------|---|---|---|
| Belgium | Costs of board and lodging and some types of care | Yes | Yes |
| Bulgaria | User's income (50% to 80% of income) | --- | Yes |
| Czech Republic | Costs of board and lodging | Yes | Yes |
| | | | |
| Denmark | Costs of board and lodging | No | No |
| Germany | Costs of board and lodging and investment costs | Yes | No (a) |
| Spain | User's income (70% to 80% of income) | Yes | --- |
| France | Costs of board and lodging and some types of care | Yes | --- |
| Croatia | User's income | Yes | 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.

In practice, LTC systems combine universal and means-tested features, and in some cases, such as in Slovenia, parallel sub-systems co-exist (Colombo et al. 2011). As is described above, insurance systems such as the Belgian one typically do not cover all care costs (e.g. board and lodging in institutional care) and are therefore supplemented by a means-



tested social assistance component that acts as a safety net for those who cannot afford the out-of-pocket costs of care. Similarly, both eligibility for and the amount 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 who cannot afford care after public benefits. Countries with means-tested benefits have other, parallel, universal benefits designed to support people with LTC needs, such as the Attendance Allowance in England. Other countries, such as Slovenia, Poland and Italy, also provide 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 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 enable better targeting of public benefits on 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 or rich enough to pay for LTC out of their own pockets), create stigma, and potentially increase administrative costs (Rothgang and Engelke 2009; Fernández et al. 2009; Colombo et al. 2011). There are also strong arguments built around fairness, e.g. as regards having to be poor in order to receive support for the cost of LTC needs that are not necessarily connected to lifestyle choices. Linked to this are arguments about the potential disincentive to accumulate savings that arises 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. Across Europe, Spain and the Czech Republic have moved towards universal LTC benefits in more recent years (see part C, below). 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 of 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 for benefits under social insurance takes account of the amount of informal care that relatives should provide (regardless of whether or not they do provide it) in what is termed 'customary care' (Grootegoed et al. 2014). In Latvia, assessment of the informal care that co-residing relatives may be able to provide also forms part of the eligibility criteria for home care. In Sweden, there has been a consistent policy of concentrating public resources on individuals with greater needs (Szebehely and Trydegård 2012).

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



Cost sharing within and across generations

As well as the approaches to financing LTC needs and the issues surrounding breadth, scope and depth of coverage discussed above, there are other issues that are relevant for sustainable LTC financing. These include new sources of financing (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 discussed below.

As Table 2 shows, 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 greatest around retirement age, with a sizeable proportion 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 in the case of older people who need to move into institutional care. However, this is an issue that lacks broad consensus among Europeans, since many people find it unfair to have to forsake their homes in order to qualify for public support for LTC needs (European Commission 2007). Furthermore, this may be regarded as penalising people who have saved over the course of their lives, and may stand as a barrier to rehabilitation in institutional care settings if users have no home where to return to if rehabilitation is successful. Nonetheless, a number of solutions have been proposed that allow the mobilisation of assets invested in a person'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 a person's total assets go to finance care per year; the assets counted include the value of the principal residence, but up to only 22.5% of its value. This payment can be deferred until after death, and there are other safeguards in place to protect surviving co-resident relatives who remain in the principal residence (the above-mentioned cap is also lower in such cases, 11.25%).

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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 sufficient funds to be accumulated before they can 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 PAYG-type social insurance-based systems to finance LTC also have pre-funding mechanisms in place, although the amounts accumulated are equivalent to only a very limited fraction of expenditure; for example, it was equivalent to 24% of annual expenditure on benefits for Luxembourg in 2012 (Ministère de la Sécurité Sociale 2013). In Germany, a recent LTC insurance reform that will come into effect in 2015 introduces 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 cases 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 found, including some that could also mitigate the problem of a potentially reduced tax base. For example, a fixed percentage of VAT could be earmarked to finance these reserve funds (e.g. Portugal for social security as a whole); or a percentage of the tax revenue from other



taxes (such as local property taxes) could be set aside (e.g. France for LTC). In practice, this would increase the tax base for LTC financing. The pre-funding mechanisms and examples discussed here could equally well 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 expenditure.

Pre-funding options and reserve funds also offer ways to strengthen the intergenerational balance in financing LTC. Current generations build up assets for future generations, while using revenue from taxes on consumption ensures that older people also contribute to the financing of 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, too. 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 and Forder 2012). Another way to strengthen the intergenerational balance is to have differentiated payments according to the number of children,² as has been the case in the German LTC insurance system since 2004 (childless people pay an additional 0.25 percentage point on the contribution rate).

² This is, however, a hotly contested issue, with strong moral arguments both for and against (see Tomlin 2014 for a review of some of the theoretical arguments).



B. Host country good practice under review

Slovenia currently has no unified LTC system. Instead, different publicly provided benefits (in-kind and cash) aimed at addressing LTC needs are provided through the healthcare system, social care services and the pension and disability social protection systems. There is therefore no single point of entry to the system, and eligibility is assessed separately under the various benefits. There are a number of cash benefits paid directly to those in need of care (e.g. attendance allowances under the disability and pension social protection systems, assistance allowance for severely disabled people and attendance allowance for war veterans) with overlapping eligibility criteria, although each individual can only receive one cash benefit. In-kind benefits are provided both under the healthcare system and by municipalities and other state agencies.

Financing of LTC in Slovenia reflects this fragmentation of LTC benefits. Approximately 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 components of LTC (e.g. care in the community) are financed through the central government and municipalities, and care allowances are paid to users through the Pension and Invalidation Insurance Institute of Slovenia. A considerable share of total expenditure on LTC in Slovenia is paid by individuals in need of care out of their own pockets: about a quarter of total expenditure is paid privately – 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 partly be explained by the fact that the LTC system in Slovenia provides a broad range of services, albeit to only a small share of the population with care needs, i.e. it has a relatively broad scope, but limited breadth of coverage (European Commission 2014).

Current public expenditure amounts to 0.98% of GDP, while private expenditure – mostly out-of-pocket payments – is equivalent to 0.37% of GDP. A total of 11.9% of those aged 65 and older receive public benefits, with approximately 5% of people aged 65 and older being cared for in institutions.

In its current arrangement, the financing of LTC in Slovenia faces a number of challenges. First, the population in Slovenia is ageing at a significant pace; as a result, the share of people aged over 65 will rise from 17.4% to 29.5% of the total population between 2010 and 2060. The share of those aged over 80 will nearly treble to 12%. Secondly, the share of private sources in total LTC expenditure has been increasing – it grew by 7.3% between 2005 and 2012, while total expenditure in the same period increased by 4.1% – partly as a result of growing needs (Slovenia is lagging in healthy life expectancy) and austerity measures that limited the budgets of the central government and municipalities. Given the incidence of poverty among older people and average pension levels, steady increases in out-of-pocket payments for LTC are deemed socially unsustainable. Thirdly, the system is very much skewed towards institutional care, as nearly half of those receiving care are in institutions. Not only do families have an incentive to use institutional care over community care (payments from the health insurance mean that the former is less expensive for users with higher care needs), but integrated care is available in institutions, whereas it is still absent from community care. Finally, the system lacks a uniform eligibility process and single entry point, and the multiple and sometimes overlapping benefits are deemed inefficient.



To address the above challenges, the reform of LTC financing has been made a priority by the recently elected government of Slovenia. Given the links between health and LTC and the contributions by the healthcare system to finance LTC under the current fragmented system, the process of LTC reform will run in parallel with reform of the healthcare system. Under the new LTC Act under discussion, LTC will be funded by:

- Compulsory (public) social insurance as the main financing source: this will result from merging the existing components of health and pension social insurance³ that currently finance LTC into a separate social insurance branch. It is anticipated that social contributions to LTC will be paid not only by the working-age population (employers and employees), but also by pensioners – a measure that seems to enjoy the support of the Slovenian association of old-age pensioners.
- Private LTC insurance to offer additional protection against LTC risks, or alternatively a levy earmarked to finance LTC: it will be mandatory for individuals either to take out private LTC insurance or to pay the progressive levy calculated as a percentage of income. This levy will replace the supplementary private healthcare insurance that presently covers nearly 95% of the population and that is financed through a flat-rate premium.⁴
- Out-of-pocket payments or alternatively voluntary private LTC insurance: board and lodging costs in institutional care, as well as LTC services that fall outside the defined services covered by the LTC social insurance, will be financed privately through out-of-pocket payments or private insurance.

It is anticipated that there will be a single entry point and uniform needs assessment, which will include 15 criteria linked to Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The new LTC insurance will therefore be universal. The proposal under discussion includes a minimum eligibility threshold of 3.5 hours of care per week to carry out ADLs. Users will participate in a needs assessment process and will be given the option to take the benefit in cash, services (including house adaptation or technical aids) or a combination of the two.

The LTC reform will also aim to improve transparency in the allocation of funds and enhance community care vis-à-vis institutional care.

The governance structure of the new LTC system is still under discussion. However, municipalities will retain responsibilities for developing LTC services within their boundaries, and funding for this will be provided by the central government. One important concern is to avoid geographical inequalities in the provision of services that arise from differences in the resources that municipalities have available. Allocation of funding between municipalities has yet to be decided.

³ As part of the parallel process of healthcare reform, the scope of healthcare insurance will also be tweaked and some 'low value' healthcare may be excluded from coverage.

⁴ The present supplementary private healthcare insurance is taken-out to offset out-of-pocket payments in the healthcare system. Its high administrative costs and flat-rate premium are considered to be too high and thus a barrier for some income groups. The supplementary private healthcare insurance is also taken-out by pensioners, and therefore its abolition and the extension of the duty to pay social contributions to the new LTC social insurance are interconnected.



C. Policies and experiences in peer countries and stakeholder contributions

Concerns about the financial sustainability and the social adequacy of LTC systems have led a number of the peer countries to undertake substantial reforms of their own LTC systems in the past decade.

In 2007, Spain introduced a universal (i.e. based on assessed needs) tax-based public LTC financing system that aims to increase the coverage of LTC needs in a gradual manner. The benefits are provided on the basis of need, but individuals contribute to the cost of their care depending on the type of services used, their income and assets – although the principal residence is excluded from these calculations. The benefits may also be taken in the form of cash – an option that was supposed to be used exceptionally, but that accounts for 42% of benefits provided. Under the new system, Autonomous Regions retain their powers in terms of the provision of LTC services, and they also determine the level of out-of-pocket payments – which has led to significant differences in social protection between regions. The deep economic crisis and fiscal consolidation efforts led, however, to successive reforms that have delayed the full implementation of the 2007 reform and have reduced some of the benefits.

Austria has had a tax-based universal LTC allowance in place since 1993. It can also be taken as a cash benefit and used to pay informal carers. After extended public debate, Austrian regions (Länder) recently abolished the provision that obliged working-age children to contribute to the cost of care of their parents, if the latter had insufficient resources. Although the LTC allowance is paid by the federal government, Länder are responsible for developing LTC services. Additional tax-based transfers from the federal administration were made available to the Länder and municipalities from 2010 onwards, to spur the development of these services.

In 2007, the Czech Republic also introduced a universal LTC allowance to cover LTC needs, similar to the Austrian LTC allowance, i.e. based on assessed need, financed from taxes and also liable to be used to pay for informal care. The reform left unaddressed the division between health and social care services and the financing of health and social care services, leaving users to face different out-of-pocket payments according to the type of institution in which they receive care (these are lower in the case of institutions managed by the healthcare system and could constitute an incentive to institutionalisation). A new LTC Act is currently being discussed to address these discrepancies.

The Flanders regional government (Belgium) introduced a compulsory (from the age of 26) supplementary social insurance in 2001. This scheme pays beneficiaries a monthly flat-rate benefit and is financed by additional social contributions (the system is also available for those residing in the Brussels region, but on a voluntary basis only). Both additional contributions (EUR 25 yearly) and benefits (EUR 130 monthly) are relatively modest, and the benefit does not vary according to care needs – a deliberate decision to keep expenditure under control. However, the Flemish social insurance plays only a supplementary role in covering LTC costs. Although it can be used to pay for institutional care, its amount is too low to really offer adequate social protection, and assets and contributions from working-



age relatives are still routinely used to cover LTC costs. This was the only example of an LTC social insurance among the peer countries.

Ireland also introduced significant changes to its LTC system in the second half of the 2000s. In home care, the approach followed since 2006 has been to concentrate benefits on people in hospital settings who have severe care needs and who have been assessed as in need of institutional care, but who are deemed able to remain at home if they receive the right care services. Moreover, there is no out-of-pocket payment for home care – the system seems to be aligned with the goal of supporting the frailest people to remain at home. In institutional care, the Nursing Homes Support Scheme (NHSS) was introduced in 2009. This scheme in effect capped the lifetime contribution based on the principal residence of users in need of institutional care at 22.5% (11.25% in the case of couples) of the value of the house (other assets beyond a certain threshold are fully considered for the costs of LTC). Even this contribution can be deferred until after the death of the user or the spouse, to ensure that users do not need to sell their home during their lifetime to finance institutional care.

Denmark represented the Nordic approach to the financing of LTC. This is based on universal LTC benefits, provided mostly in-kind, with limited out-of-pocket payments from users (contributions from working-age children or assets are not among the sources of financing). Public expenditure on LTC in Denmark is therefore among the highest in Europe. Municipalities are fully responsible for the financing (and often the direct provision) of LTC benefits. This is done through municipal taxes – which, unlike in other countries, play a significant role in financing LTC – and transfers from the central government budget, which aims to provide some redistribution between municipalities with different income structures and needs profiles.

The other peer countries – Poland, Croatia, Bulgaria, Latvia and Hungary – all have relatively low public expenditure ratios and tax-based fragmented LTC systems, with eligibility for public benefits based on income and often assets tests. As with Southern European countries, working-age relatives are also liable to contribute to the costs of their dependent parents' care. Low availability of services, lack of coordination between health and social care services and reliance on informal care are reportedly concerns in these countries. In spite of this and an ageing population, only Poland is seriously debating reform of financing for LTC, spurred in part by concerns about the impact of informal care on the employment rates of women and the potential of LTC as a job creator.

The limited availability of LTC services and the subsequent overreliance on informal carers was also highlighted in the contribution from Eurocarers. The gaps in coverage of home care services are all the more important when there is a growing shift in LTC policies towards ageing in place; in the absence of adequate services, this is likely to mean a transfer of responsibilities to informal carers. In some countries (e.g. the above example of Slovenia, but also Spain) austerity measures may have further constrained the availability of home care services or families' ability to pay for care services.

AGE Platform Europe noted the extreme diversity of European arrangements to finance care. Although some of the above-quoted examples from peer countries report LTC reforms that have sought to expand social protection (e.g. Spain, Ireland, the Czech Republic and the Flanders region of Belgium), AGE Platform Europe pointed to other examples of reforms that led to welfare retrenchment in LTC. One example is that of the Netherlands, which plans to

reduce the coverage of its long-standing LTC social insurance and to transfer responsibility for financing back to municipalities and users. It was also noted that a number of countries have legal mechanisms in place to make contributions from working-age children to the costs of care compulsory if their frail parents lack the necessary means. This risks creating a sort of intergenerational transmission of disadvantage or poverty, since these mechanisms are likely to affect less-affluent families disproportionately.



D. Main issues discussed during the meeting

Governance of LTC systems and its impact on financing was one of the main topics discussed during the meeting. The topic included the issues of horizontal coordination between health and social care, on the one hand, and vertical coordination between central government (or social insurance funds) and municipalities, on the other hand.

Regarding the former – horizontal coordination – several examples were adduced to illustrate the possible inefficiencies or perverse incentives that lack of coordination between healthcare and social care could spawn. Chief among these were prevention and rehabilitation (where gains or savings are accrued by the social care sector, while expenses are usually covered by the healthcare sector) and the incentives to go down the route of institutionalisation (see above on the Czech Republic and Slovenia).

Vertical coordination has to do with the potential for cost-shunting that decentralisation could imply. The introduction of the LTC allowance financed by the federal government in Austria in 1993 was accompanied by a pledge by the Länder to use the savings that the new LTC allowance brought (LTC is mainly the responsibility of the Länder) to develop care services. In practice, this did not happen and the additional tax transfers to the Länder from 2010 onwards (see above) are an attempt to correct this and spur the development of care services. In Denmark, municipalities will soon become responsible for part of the cost of healthcare, in an attempt to increase efficiency in the discharge of frail older people from acute hospital settings to LTC. LTC reforms often need to adapt to the existing government structures, even if these can pose additional coordination problems: the Spanish reform of LTC had to take account of the Autonomous Regions' responsibility for LTC that is enshrined in the Constitution, as was also the case in Austria.

There was general consensus about the need for public financing of LTC needs in order to protect individuals against the catastrophic costs of LTC. At the same time, the limits on the potential to increase taxes and taxpayers' social contributions were also clearly acknowledged. For instance, in Austria the discussion around introducing a social insurance scheme for LTC met with strong opposition, on the grounds of its impact on already high labour costs (via the payment of additional social contributions). In this context, increased transparency in the use of tax revenues or social contributions was an initiative welcomed by peer countries.

Of the alternative sources for financing LTC needs, some clearly met with more support than others. Voluntary private LTC insurance plays a marginal role in the peer countries, and this picture is not expected to change any time soon. Their premiums, based on risk profiles, were deemed to be unaffordable by lower-income groups, which are precisely those more likely to need LTC. There were also serious reservations expressed about individuals taking out private LTC insurance voluntarily, not least because of lack of trust in insurance companies and negative experiences with private pension insurance funds in the wake of the economic crisis. Encouraging voluntary take-up through tax allowances raised several equity issues. On the supply side, there was reportedly little interest by private insurance companies in providing cover for LTC risks, given the uncertainty surrounding future costs. This was reflected in premiums that were deemed too high. An alternative to voluntary

private LTC insurance could be the mutualisation of risks through non-profit mutual funds, similar to those used in healthcare.

Contributions from working-age families to the cost of care for their frail parents are already a feature in many of the peer countries (see Table 2). Some of the stakeholders present raised the issue of the possible equity consequences of these contributions, as they may in effect tax less-affluent families. With demographic ageing, these family contributions may also come to fall increasingly on children who are themselves already retired and have limited earning capacity. The idea of earmarking revenues from inheritance tax – which is still in place in many of the peer countries – was deemed potentially fairer. Ultimately there was consensus that, if they are to be regarded as a solution, any contributions to costs that are drawn from users' income or assets and from their relatives have to be set at a level considered fair by society. In the Slovenian example, old-age pensioners seem willing to pay extra contributions earmarked for an LTC system.

Pre-funded buffer funds could ease the costs of the demographic transition and enhance intergenerational solidarity. They were, however, seen as hampered by the risk of political capture (i.e. the fear that governments might use them to make up for public sector deficits, for example) or by policy myopia (i.e. their benefits would only be felt well beyond the current or near political cycle).

Given the above constraints surrounding supply-side solutions to LTC (i.e. in the financing of LTC), it is advisable to look carefully at the demand side (i.e. needs). The possible pathways to addressing LTC from the demand side that were discussed by peer countries and stakeholders included reducing need by investing in prevention and rehabilitation. In parallel, investment in adapted housing and the living environment could enhance independent living, even in the face of rising LTC needs.

Ultimately, the *laissez-faire* option of leaving LTC risks unaddressed would mean that the burden would fall on informal carers. This would ultimately entail other costs at the individual and societal level in terms of forgone employment or health. Despite this, the issue of LTC financing is not very high on the policy agenda in many of the peer countries (e.g. in Latvia, Croatia, Hungary, Bulgaria), and particularly not among those with lower availability of LTC services. It seems plausible that in those countries informal carers are called upon to fill the gap of LTC needs.



E. Conclusions and lessons learned

In view of the limitations of individual solutions or risk-pooling based on voluntary private LTC insurance, there was a strong consensus among peer countries on the need for the state to play an important role in ensuring that individuals or their families are not left alone to face the costs of LTC. Slovenia has recognised the salience of LTC as a new social risk, and it is currently debating the best way of addressing it. Other European countries should follow the Slovenian example. The diversity of the financing arrangements for LTC in Europe should provide an important pool of experience on which countries aiming to reform their LTC systems can draw.

There were no strong preferences for either social insurance or tax-based systems to finance LTC. The peer countries and stakeholders nonetheless agreed on the importance of a broad tax base as the means of ensuring both sustainability and equity in financing LTC. This includes not only revenues from taxes on capital, but also the collection of social contributions from older people.

During this Peer Review process, it was equally clear that there are also limits both to the amount that states can allocate to LTC and to taxpayers' willingness to pay. The participatory nature of the Slovenian LTC reform process was highly praised by the peer countries and stakeholders. As the Slovenian example seems to show, the involvement of representatives of users (in this case, old-age pensioners) may enhance willingness to pay extra to finance a new social risk, if it is deemed fair and transparent. Participation on the part of society and consensus building could thus be key factors in constructing socially sustainable LTC financing systems.

In balancing contributions from users (particularly those based on assets), it is important to provide some degree of safety and predictability, and to ensure that users and their families do not need to leave their homes to pay for care during their lifetime. The Irish Nursing Homes Support Scheme, which combines deferred payments and caps on contributions based on the value of the principal home, is a good example of this. Alternative sources of financing, such as earmarking revenues from specific taxes, particularly inheritance tax, also met with support from peer countries.

Reform of LTC financing has often come about in piecemeal fashion, with limited attention paid to governance issues. In all participating countries, both health and social care contribute to the provision of LTC to dependent older people, with local levels of government playing an important role in this provision. Still, ensuring appropriate incentives for the use of the most suitable services (e.g. institutional or home care) depends greatly on how horizontal coordination (between health and social care) and vertical coordination (between central and local levels of government) are organised. Improving coordination could greatly reduce inefficiencies and improve the outcomes and experiences of users. Judging by the experiences of peer countries, much remains to be done at this level.

Addressing governance would go a long way towards enabling LTC systems to impact on the needs of users through a more comprehensive and better use of prevention, rehabilitation and adapted living environments. Investing in prevention and rehabilitation has attracted

considerable attention and support, but apart from in Denmark, few steps have been taken in this direction.

Finally, this Peer Review process also highlighted a gap in comparable statistics regarding public and private expenditure on LTC. Despite growing concerns regarding the fiscal sustainability of LTC, many countries still do not have reliable statistics on public expenditure on LTC – also a symptom of the lack of coordination between the health and social care systems that make up LTC. Regarding private expenditure, data are even less reliable or comparable. Lack of adequate data is a powerful obstacle to the pursuit of sound public policies, and this persistent gap regarding LTC should be addressed at the European level by the European Commission.

Financing of LTC continues to be a salient topic in the context of an ageing population and the on-going adaptation of social protection systems to new social risks. The peer countries and stakeholders urged the European Commission to use its recent report on LTC (European Commission 2014) as a starting point for further discussion on the financing of LTC, and to keep this as one of the main topics for discussion in the Social Protection Committee.



F. Contribution of the Peer Review to Europe 2020 and the Social Investment Package

Addressing population ageing is one of the main concerns of the Europe 2020 Strategy. The themes addressed in this Peer Review can contribute further to the fulfilment of at least two of the targets of the Europe 2020 Strategy: increasing the employment rate, and fighting poverty and social exclusion.

Concerning the former, the Europe 2020 Strategy recognises that social protection can play a role in fostering employment and growth. This is the core rationale of the Social Investment Package (SIP). The SIP calls for policy reforms that make social protection systems, including LTC, financially sustainable and also socially adequate, by supporting the needs of people at critical points in their lives.

Both the Europe 2020 Strategy and the SIP place a strong emphasis on the creation of jobs and increased labour market participation, mainly of older women of working age. Sustainable financing of LTC can contribute decisively to this goal in two ways.

First, in the absence of a public system to finance the costs associated with LTC needs, dependent older people are forced to rely on their families to receive the care they need. This means that for many families, and particularly their female members, the decision on whether to provide informal care or to be active in the labour market is not a matter of choice. If highly educated women are forced to leave the labour market as a result, this is inefficient at the societal level.

Secondly, ensuring adequate financing of LTC needs (i.e. adequacy and coverage) can also be seen as an investment in the creation of jobs in LTC. In countries with more developed LTC services, these account for an important share of jobs, most of which are occupied by women. Affordable LTC services can thus foster employment rates both through improved reconciliation of care and paid work and through direct job creation.

Concerning social exclusion, the need for LTC can entail significant costs for individuals and their relatives, even when public systems are in place, due to out-of-pocket payments required from users. As discussed in this Peer Review, these payments often extend to children. This means that the need for care may also translate into increased risk of poverty not only for frail older people, but also for their relatives. A way of financing LTC that is both fiscally sustainable and socially adequate is necessary to address this risk.

LTC systems can minimise the consequences of demographic ageing and contribute to reducing the risk of needing care through prevention and rehabilitation. Concerning the latter, the flagship initiative European Innovation Partnership (EIP) on Active and Healthy Ageing is of particular relevance. Sustainable financing of LTC can contribute to the EIP

triple-win objective: to enhance active and healthy life, e.g. through the aforementioned investment in prevention and rehabilitation; to improve the sustainability and efficiency of health and care systems, e.g. through improved coordination between health and social care; and to create new opportunities for businesses, e.g. through the development of innovative solutions for ageing in place. Sustainable financing of LTC can also make a significant contribution to the EIP objective of extending the average healthy life expectancy of Europeans by two years by 2020.



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Long-term care – the problem of sustainable financing

Host country: **Slovenia**

Peer countries: **Austria – Belgium – Bulgaria – Croatia – Czech Republic – Denmark – Hungary – Ireland – Latvia – Poland – Spain**

Like most of Europe, Slovenia faces rapid population ageing. This places huge strain on long-term care (LTC) in particular, and the country has no unified system for providing it. Slovenia is preparing a major reform of its fragmented long-term care (LTC) system introducing long-term care insurance. A Peer Review held in Ljubljana on 18–19 November 2014 brought 12 Member States and stakeholders together to discuss the question on how to ensure adequate and sustainable financing of LTC.

