Peer Review on "Financing Long-term Care"

Thematic Discussion Paper

Approaches to Long-term Care Financing

Estonia, 22-23 September 2020

DG Employment, Social Affairs and Inclusion

Written by Adelina Comas-Herrera, Care Policy and Evaluation Centre, London School of Economics and Political Science

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Contact: Susanna Ulinski

E-mail: EMPL-SPSI-PEER-REVIEWS@ec.europa.eu

Web site: http://ec.europa.eu/social/mlp

European Commission

B-1049 Brussels

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1 Introduction

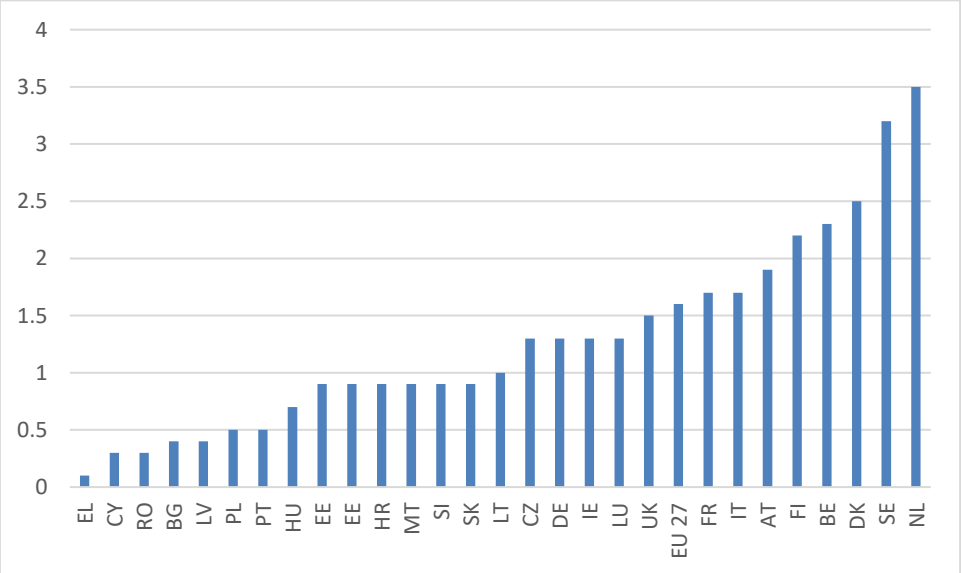
Long-term care (LTC) involves a wide range of activities, from helping people with activities of daily living (such as toileting, getting dressed and undressed, bathing or washing, helping people who have mobility problems, assisting with instrumental activities of daily living (such as shopping, meal preparation, taking medication), to nursing, rehabilitation, supporting social participation, house cleaning and ensuring that the person is safe and treated with dignity (Colombo et al, 2011).

As well as the care and support provided by families, LTC services are provided by health services, public sector social care providers, non-profit organizations, private (for-profit) providers, and paid and unpaid informal carers[1]. Unlike medical care, which typically requires specially trained personnel to deliver it, most LTC is provided by family members, and even when it is provided by paid staff, many of those individuals will have very little formal training (WHO, 2015 and OECD, 2020).

Historically, LTC was mostly a family responsibility except for situations in which people did not have enough family support or resources, and also except for people with more complex needs who may have lived in residential care institutions for a long time. However, demographic, epidemiological and societal changes have made these "residual" care systems increasingly out of date, given that larger numbers of people are able to live longer with care needs, and that patterns of employment and living arrangements have made relying on family care as the only source of care increasingly unsustainable.

In practice, even in the countries with relatively high levels of public LTC expenditure, family care continues to be the most predominant form of care in Europe (Spasova et al, 2018). However, more generous public LTC systems result in fewer family carers needing to provide very high intensity of care and therefore less likelihood of carers experiencing adverse health and financial/labour market outcomes as a result of providing care (Verbakel et al., 2017, Bom et al. 2019).

Figure 1. Public LTC expenditure as a % of Gross Domestic Product (GDP), 2016



Source: Ageing Report 2018 (European Commission, 2018).

[1] To clarify terminology, this paper uses the term informal care to refer to care provided without either formal contracts of employment and/or social protection entitlements. This care may be unpaid (as is often the case with family members) or paid (for example people paid cash-in-hand in the grey economy, or family carers who may receive a cash benefit or compensation for providing care). Formal care is most likely to be paid and would typically be provided by trained carers with a legal employment contract.

A 'traditional' LTC system will typically involve some services provided in kind by the health care system with residential care and some community nursing (and perhaps rehabilitation and preventative care), social services financed through local social assistance programmes for people without family or financial resources, and disability cash payments (pensions) usually linked to the social security system. These different elements will often be the responsibility of different ministries and agencies and also different government levels (Spasova et al., 2018), which makes the coordination of LTC for individuals extremely challenging.

While in some countries the responsibility for LTC falls under a single ministry (for example Denmark, since 2015), typically more than one ministry is involved, usually health and social assistance or social security, as in practice, LTC encompasses elements of health care, social care services and social assistance. In some countries all aspects of care other than nursing are the responsibility of the Social Affairs or Social Assistance Ministries, whereas in others, such as Belgium, the Czech Republic and the Netherlands services such as personal care are part of the health care system (Maarse and Jeurissen, 2016). There are few countries that have a coordinated approach in place to cover all three aspects (WHO Regional Office for Europe, 2019b), but Denmark offers a good example of local level coordination of health and long-term care services, with a strong role of the primary health care system (WHO Regional Office for Europe, 2019c).

In the context of concerns about the economic and fiscal implications of population ageing (Comas-Herrera, 2020), it is increasingly important to consider the LTC system's role in ensuring that people can stay in good mental and physical health for longer, living in their own homes, and that family care provision is supported so that working age carers can continue their professional careers and, particularly for older carers, remain in good health. This requires, for most countries, the strengthening of social protection systems to ensure that the right to affordable long-term care services of good quality, particularly home care and community-based services, can be guaranteed.

Financing LTC involves two key functions: the first is to raise resources to enable the production and delivery of care. The second function is the allocation of those resources. While approaches to raising revenue are a key policy concern in most countries, developing equitable and efficient approaches to resource allocation is essential. As well as establishing their approach to financing for LTC, countries also need to develop a LTC system infrastructure to support care assessments and coordination, regulation and safeguarding, workforce training, etc.

The European Union recognizes long-term care as a social right to be guaranteed by all states through the European Pillar of Social Rights (Principle 18), adopted in 2017. The EU Work-Life Balance Directive[2] (2019) also introduced two measures relevant to carers: the entitlement to five days of leave per year for carers, and the right to request flexible working arrangements. It has also published, in 2010, a Voluntary European Quality Framework for Social Services[3] and the European Social Fund and the Employment and Social Innovation programme (EaSI) are providing financial support for cooperation and improvements in social services.

The huge mortality impact of the COVID-19 pandemic on people living in care facilities in many countries has highlighted long-standing shortcomings in the preparation and resources available to care facilities, and has brought to the fore the importance of ensuring that LTC systems are sufficiently resourced and monitored, and the importance of strong coordination with health care system (WHO, 2020a).

[2] https://ec.europa.eu/social/main.jsp?catId=1311&langId=en

[3] https://ec.europa.eu/social/main.jsp?catId=1169&langId=en#:~:text=The%20voluntary%20European%20Quality%20Framework,a%20high%20level%20of%20service.

2 LTC and risk sharing

An important aspect of how LTC is financed is the degree of protection against risk (or risk sharing) that is offered by the system. The costs of LTC, particularly when people need intensive support for a long period of time, can be very high, consuming entire lifetime savings and pushing families into poverty, becoming catastrophic[4]. A study from the Netherlands showed that costs of LTC could amount to 93% of a household's total lifetime income after 65 in the event that costs would be fully borne by families (i.e. in the absence of a public LTC system) (Hussem et al 2016). In England, Forder and Fernández (2011) found that around a third of people aged 65 and over will spend little on care. However, their estimates also show that, for a small proportion of people, LTC costs will represent so-called 'catastrophic' levels of expenditure: 7% of people aged 65 will face lifetime care costs of at least £100,000, and 5% of at least £200,000.

As well as being potentially very high, LTC costs are unevenly spread by gender. For example, the risk of needing care, which is strongly correlated with costs, has been estimated to be 35% for women at the age of 65 and 16% for their male counterparts in Germany (Rothgang et al 2012), while for Finland the figures are 59% and 36% respectively (Martikainen et al 2014). This difference is due to women having longer life expectancy and living longer with disabilities at the end of their lives than men, as a result of biological, behavioural and social differences between the sexes (Romero-Ortuno et al., 2014).

Since not everyone will need LTC, and some only for a short period, sharing the risk collectively - through a large pool of insured individuals – protects people against the risk of catastrophically high costs of care which could result in the depletion of their life savings, going without the care they need, or excessive costs for family members (Barr, 2010 and Colombo et al, 2011). The existence of some sort of risk-pooling mechanism could alleviate the reliance on family carers, which is also disproportionately distributed along socio-economic and gender lines, as women and those in low socio-economic groups provide larger amounts of care (Rodrigues et al 2018). Pooling of risks could also have a positive impact on healthcare costs, as in the absence of this risk pooling for LTC, older people with care needs may simply seek treatment in (more expensive) acute healthcare settings (Forder 2009).

Insurance for the risk of needing LTC can take many forms. It can be offered by the public sector and include the entire population (through taxation or social insurance funded systems), or by private LTC insurers who offer products that people or groups of employees can buy.

While it is common to think of LTC financing in mostly monetary terms, in practice the largest part of LTC inputs are provided in-kind, by family members; while this care is often provided without the expectation of a financial compensation, it does have important economic and fiscal implications. In practice, families also act as insurers to their members, by providing care and support to their kin in need.

In most developed countries, public and private LTC coverage protection systems coexist and complement each other to different degrees (see, for example, Colombo et al, 2011 and Rodrigues and Schmidt, 2010).

[4] There is no single definition of the size of costs that are considered to be "catastrophic" costs of care, but, for the Sustainable Development Goal indicators, the United Nations defines as catastrophically high costs of health care, care costs that exceed between 10% and 25% of total household expenditure (Wagstaff et al., 2018), in long-term care it is more common to refer to costs that may exhaust a family or individual's income and assets (Guillen and Comas-Herrera).

3 Comparing different approaches to raising resources for LTC

This section provides an overview of the main financing systems for LTC, considering their pros and cons regarding access, coverage, sustainability and distributional effects, and also how they are used in practice. The financing mechanisms are presented according to the size of the risk sharing involved: from the minimal risk sharing at individual or family level, to the full society level.

3.1 Individual and family resources: in-kind care, income and assets

3.1.1 Informal (family) in-kind care

Although unpaid care provided by family carers (or friends and neighbours), by definition, does not involve a monetary transaction, it is far from free. The provision of care does involve direct costs in terms of possible impaired health and wellbeing of carers (Bom et al, 2019) and opportunity costs in terms of lost remuneration from employment opportunities or leisure time forgone, and welfare costs from attention diverted from other family responsibilities (Wittenberg and Malley, 2007). In England, it has been estimated that as much as 42% of all the costs of care for people living with dementia, are covered by unpaid care (Wittenberg et al., 2019).

Access and coverage:

Being able to access family care requires both having family members, and that those family members are able and willing to provide care.

Sustainability:

The sustainability of relying on family care as the main form of LTC, particularly in the case of care provision by people of working age, is increasingly challenged by demographic changes that are resulting in smaller working age populations compared to the size of the population who requires care. Additionally, there is increased awareness of the long-term opportunity costs of withdrawing or reducing labour force participation in order to provide care, as people who step out of the labour market to provide care face difficulties re-entering it, which in turn affects their lifetime earnings and makes them more likely to accrue insufficient pension entitlements (Korfhage, 2019 and Skira, 2015).

Distributional effects:

The relationship between need for care and receipt of informal care is entirely dependent on the availability of potential carers, which means that people with more need for care who lack family support may receive less informal care compared to others who need less care but are 'richer' in family availability. Also, people who provide informal care are most likely to be women, not in the labour market, and have lower incomes (Rodrigues et al, 2017), and there is growing evidence that informal care provision exacerbates existing inequalities, particularly for younger carers (Korfhage, 2019 and Brimblecombe et al, 2020).

The role of informal (family) care in LTC financing systems in Europe:

While informal family care is still considered to be the most important form of LTC in Europe in terms of the amount of care provided, countries are increasingly aware of the importance of ensuring that family carers do not shoulder excessive burdens to their own mental and physical health, and that their financial situation and social security entitlements are not compromised by needing to reduce working time or give up their jobs altogether. There is increasing awareness of the importance of policies that enable family carers to continue in employment and of the fiscal costs of not doing so (Korfhage, 2019, Brimblecombe et al 2018 and Pickard et al 2018)

3.1.2 Savings and assets

Income, savings and assets also play an important role in LTC financing, be it through the direct purchase of privately provided services or through co-payments (out-of-pocket payments) for publicly funded services. In some countries (such as Romania), people over a certain income or assets threshold are not entitled to any publicly financed LTC and need to pay for the costs of their care in full from the income and savings (Oliveira Hashiguchi and Llena-Nozal, 2020).

There are various ways in which individuals may save in order to pay for LTC: many people use shares, deposit accounts, pensions, etc., to build up savings over their lifetime. It is also possible to save through housing equity, by moving to a cheaper property, taking out a home equity plan, or selling the property on entering residential care.

Access and coverage:

Many people, due to their economic and personal circumstances, will not be able to save sufficiently to meet the entire costs of their care and will not be able to rely on family support to meet all of their care needs either. In countries without universal entitlement to LTC, these people have to rely on social assistance. However, where publicly funded services or benefits are only targeted to those with insufficient resources there may be stigma attached to users of services, affecting service users' dignity and possibly leading to lower levels of utilisation than would be efficient (Oliveira Hashiguchi and Llena-Nozal, 2020).

Sustainability:

In the absence of other mechanisms to finance LTC, individuals may either over-save in an attempt to make sure that they have enough savings to cope with the highest possible costs of dementia, and reduce their consumption (Barr, 2010), or, where there are means-tests in order to access publicly funded care, people may put themselves at financial risk by spending down their savings and assets in order to qualify for public care.

Also, , various studies have shown that most people underestimate the risks of needing LTC, and as a consequence they may underestimate how much they need to save in order to meet any LTC costs (Cremer and Roeder, 2013).

In health care financing, out-of-pocket payments were often recommended as a way to dissuade from unnecessary usage, however, this is unlikely to work in the same way in LTC if the public system has a needs assessment system in place to provide access. There is increasing recognition, both in health and long-term care financing that out-of-pocket payments result in unmet needs, with people forgoing necessary medicines and care (WHO Regional Office for Europe, 2019a).

Distributional effects:

Most LTC systems have at least some form of residual support for people who have no family, income or assets. As discussed in the risk sharing section, the absence of a public LTC insurance system would mean that people who need LTC for a long period of time and are not very wealthy may exhaust all their income and assets in order to purchase care services. Particularly in countries where there is public financing for health services, the lack of public financing mechanisms for LTC can result on people with health conditions such as dementia having to fund the entirety of their care, whereas those with other conditions, such as cancer, would have the benefit of public health coverage, resulting in 'diagnostic inequity'[5]. For those in lower socio-economic

[5] Diagnostic inequity is used to describe situations in which the care system eligibility rules mean that people who need care for one condition (say, for example, cancer), have the entire costs of their care covered by the public system, whereas those who need care for another condition (for example dementia), are not covered and have to pay for their own costs. It has also been used to describe situations where care

groups the, costs of care are particularly unaffordable and there is a risk that poorer people will forgo care they need (Oliveira Hashiguchi and Llena-Nozal, 2020).

The role of income and assets in LTC financing systems in Europe:

All European countries have some form of minimal public and non-profit LTC support for people with LTC needs who cannot access family support and have insufficient income and assets to fund their care. Some countries[6] have universal systems, where everyone who has recognized LTC needs can access at least some form of publicly funded support, so that the risk of becoming dependent on others for care is covered in a similar way as the costs of needing health care. In almost all countries there are co-payments for at least some services, but the extent of these out-of-pocket payments varies widely in the size of the co-payments and also whether assets are included in the means-tests (Oliveira Hashiguchi and Llena-Nozal, 2020), for example Austria excluded assets from the means-test in 2018, whereas in Ireland assets are included in means-testing for institutional care.

The types of co-payments in LTC vary widely between countries, although most require people in residential or nursing care homes to contribute to the board and lodging costs of their care. Many countries have caps on the annual or monthly amount of co-payments (Oliveira Hashiguchi and Llena-Nozal, 2020).

3.2 Voluntary private insurance schemes

Unlike annual health insurance policies that pay for the diagnosis and treatment of medical conditions, LTC insurance policies are long-term contracts to help pay for assistance. Health insurance covers services associated with recovery from illness or an accident, whereas LTC insurance covers needs when recovery is unlikely and it also protects against changes in classification risk as individuals age. The benefits can be in the form of cash benefits (as is predominant in France and other European countries) or in-kind (as is more common in the United States). The pay-outs are triggered by meeting certain needs thresholds, normally defined in terms of the level of need for help with activities of daily living.

There a number of problems with voluntary LTC insurance, in part inherent to LTC, which contribute to the costs of voluntary private insurance being very high. These include problems of adverse selection: people who know they are more likely to need care are more likely to wish to buy premiums, this is particularly a problem when people buy premiums later in life. Another important problem is the presence of group (non-independent) risks, caused by uncertainty concerning future changes in care need at population level, and about the future costs of care. There are also concerns about insurance-induced demand for care, and difficulties related to consumer knowledge and the affordability of premiums (Barr, 2010, Glennerster, 1997; Wiener et al., 1994, Comas-Herrera, 2012).

Access and coverage

Voluntary private insurance only covers people who can afford to buy premiums and wish to do so. Voluntary private insurance LTC products are available in many European countries, but it is not the main form of LTC financing in any of them. In Germany there are subsidies for supplementary voluntary insurance products for LTC, but these subsidies appear not to have had a large effect (Nadash et al., 2018).

Sustainability

In the US, where LTC insurance is expected to be the main form of LTC finance for those above the means test, the market has decreased in size in different years

assessments cover only physical disability but not mental or cognitive disabilities (see Glendinning et al., 2004).

[6] For example Austria, Belgium, Denmark, Spain, France, Germany, the Netherlands, Austria, Finland and Sweden

because of problems of increasing affordability (the premia are so expensive that those who can afford to buy insurance are wealthy enough not to need to) and high costs. In the last few years, a large number of providers have withdrawn from the market as falling returns in investment, lower than expected lapse rates and growing unit costs of care (Wiener et al, 2018).

Distributional effects

Private LTC insurance policies are regressive in that only wealthier people are able to afford the premiums and premiums do not vary by financial status. Additionally, groups of people with a higher probability of needing care, who are also likely to have lower incomes, either have to pay higher private premiums (Holdenrieder, 2006) or are unable to purchase it at all, which means that relying on voluntary private insurance would leave those who are worse off without coverage.

In Germany those with highest incomes have the option of opting out of the social insurance system and purchasing private LTC insurance instead (Nadash et al., 2018), this because those who are better off have lower expected costs of care (due to lower risks of disability),

The role of voluntary insurance in LTC financing systems in Europe:

Relying on private LTC insurance as the main source of LTC financing would require very substantial subsidies and that all citizens are required to insure Private LTC insurance encounters important difficulties (mostly a result of lack of affordability) in countries with safety-net types of systems where private LTC policies are expected to cover the full costs of care such as the US. On the other hand, in countries with universal public benefits that cover part of the costs of LTC, private LTC insurance - particularly when sold at employer level - appears to be finding a niche as a top-up or supplementary product, as is the case in France and Germany (Comas-Herrera, 2012).

3.3 Compulsory insurance and public sector schemes

3.3.1 Tax-based financing

Tax-funded financing is the predominant form of public financing for LTC risks in Europe (Colombo et al 2011). Countries like Austria, Spain, England and Portugal provide support to those in need of care that is financed by general taxation. Even countries with social insurance-based systems, such as Germany or Luxembourg, rely on general taxation to finance users whose income or assets are insufficient to pay for LTC after receiving social insurance benefits (see section below on social insurance).

Tax-based systems are financed from taxes levied by the government (local, regional or national), including taxes on income, consumption and special taxes (e.g. inheritance taxes or taxes on specific products or activities, such as gambling). Different types of taxes have different equity implications, for example income taxes are usually progressive (which means that those who have higher earnings pay a higher share of taxes), whereas consumption and "sin" taxes (for example taxes on gambling) are usually regressive (which means that, as those who are worse off pay a higher share of their income in taxes).

Access and coverage

Access and coverage depend on the way in which the system allocates the resources that have been raised through taxation. If there is a national system, there may be set national eligibility criteria based on need and, in some countries, financial means or availability of family care, as for example in Romania, however, this does not always guarantees that services are available. Where care is funded and organized locally, there may be important differences based on where people live, which may result in those living in less affluent areas having less access to care, this has been identified as a problem in Greece, for example.

Sustainability

The broad range of revenue sources is considered to be one of the main advantages of tax-funded systems, particularly in comparison to social insurance systems (Rothgang & Engelke 2009, Rodrigues 2019). However, public spending on LTC - unless the funds have been raised through ear-marked taxes - would need to compete with other areas of public spending that may have stronger political and public support (for example health care, education, defence…), which makes it difficult for LTC funding to increase in line with the growth in need, particularly in countries with strong resistance to taxation or at times of economic difficulties.

Distributional effects

Tax-funded financing is not limited to income from work, but also includes capital gains. This renders tax-based systems arguably more equitable at the societal level in their revenue-generation capacity, although some indirect taxes on consumption like VAT and tax evasion may entail less redistribution (van Doorslaer and Wagstaff, 1999). Tax-based systems are also arguably more adaptable, both in terms of generating revenues and allowing for their allocation to different social benefits. This flexibility may be of special relevance in a context marked by uncertainty brought by demographic ageing (e.g. regarding the future costs of LTC) (Barr, 2010) and other transformations to the economy, such as structural changes to the labour market linked to digitalization or robotics.

Among the disadvantages of tax-funded systems is their perceived lack of transparency in the allocation of revenues. This could impact citizens' willingness to pay higher taxes or render tax-funded systems more vulnerable to discretionary cuts as they may compete for funding with other social protection benefits funded from the state budget (Rothgang & Engelke 2009). Vulnerability to discretionary cuts could be even greater for means-tested benefits, which may be received and gather popular support by a minority with limited political power (Colombo et al 2011). Some of these disadvantages could arguably be addressed by earmarking taxes specifically to finance LTC. Earmarked taxes could thus strengthen the link between taxes paid and entitlement to benefits.

3.3.2 Social Insurance

Social insurance typically means that the costs of care are paid out of social contributions, which usually come from employees and employers and that can only be spent for the particular purpose for which they have been raised (i.e. contributions are earmarked). Contributions are not related to risk. Typically, in an LTC social insurance system, access to benefits is based on contribution records and meeting the eligibility criteria. The system is administered by the state at national or sub-national level, or by institutions such as mutual (or friendly) societies or trade unions.

The main differences between private insurance and social insurance are the latter is usually compulsory (although there may be some exceptions), and there is generally redistribution, so people pay according to their means and obtain benefits according to their needs (Barr, 2010). In Europe there are three national examples of social insurance schemes, with great diversity in their design. In Germany the social contribution amounts to 2.55%, payed in equal shares by employers and employees up to a maximum ceiling (with childless people paying an additional 0.25 percentage point contribution rate); the Dutch LTC insurance (ABWZ) is financed through a 12.15% contribution payed by employees up to ceiling; while the social LTC insurance in Luxembourg is financed through a 1.4% contribution payed only by employees, but including also capital earnings.

One of the most important differences between taxation and social insurance is hypothecation, which ensures that a specified level of resources is guaranteed for a specified purpose, in this case LTC, without having to compete directly with other public services.

It is interesting to note that, once insurance is compulsory and there is public sector oversight to ensure that all residents in a country are covered, the distinction between public and private provision becomes less relevant. For example, the German system has been designed and regulated by the public sector, but the sickness funds that run the system and the majority of providers are private (in the case of the sickness funds, not-for profit).

Access

Although in principle only those contributing to the social insurance system would be covered, in practice all European countries that fund LTC through social insurance have a mechanism to ensure coverage for all citizens or residents. Access to benefits is usually based on an assessment of need based on explicit criteria.

Sustainability

Compared to general taxation, social insurance has some disadvantages, including the risk that higher employment costs may reduce international competitiveness, limited access of the non-employed population unless there are special schemes in place, a narrower revenue base than taxation, and, where social insurance is not mandatory, the risk that employers may try to evade payments (Mossialos, et al, 2002). The revenue base may be even narrower in national contexts with a high level of grey labour, where a sizeable share of social contributions is left uncollected. Revenue growth may also be constrained in periods of increased unemployment, both due to the lower number of people paying social contributions and to the downward pressure on real wage growth. The same issue may arise in periods of real wage stagnation or deflation (Rothgang & Engelke 2009). In other words, the revenue-generating capacity of social insurance is very sensitive to labour market fluctuations.

An important disadvantage of social insurance compared to tax-funding is that it is funded only by the working age population, a demographic group that is expected to shrink compared to the older population. To partially make up for this disadvantage, the German LTC insurance requires both pensioners and those in need of care to also pay social contributions into the system (Holdenreider, 2006).

However, in countries with strong resistance to increases of general taxation, the link between the size or contributions and the benefits paid out may mean that it is easier for policymakers to explain to the public why such increases are required in order to obtain better or more generous benefits. It can be argued that this was done successfully when the Germany LTC insurance system increased contributions in order to increase coverage and benefits for people with dementia (Nadash et al, 2018).

The Germany long-term care insurance system was developed with the requirement that it needed to be self-financing, and this resulted in the benefits being capped at a flat rate that amounts to about half of the costs of services (Nadash et al, 2018).

Distributional effects

Analysis of the redistributive effects of health care financing has shown that social insurance schemes do not necessarily contribute to vertical equity in funding terms (van Doorslaer et al., 1999), as contributions are generally proportional to employment income, have ceilings, and disregard income from other sources (such as capital gains, rents). Those additional sources of income are more prevalent among wealthier people. Additional features of social insurance schemes may contribute to vertical inequity, for example in Germany there are exemptions for self-employed workers and civil servants, and people with high levels of income can opt out of LTC social insurance scheme and take, instead, compulsory private insurance (Rothgang, 2003).

The role of social insurance in LTC financing systems in Europe

Even in social insurance-funded LTC systems, such as those in Belgium, Germany, the Netherlands and Luxembourg, taxation often plays an important role, often covering

the contributions of the non-employed population (this includes not only the unemployed but also people on maternity or paternity leave), those with pre-existing conditions who are unable to work and, when the insurance benefits do not cover the total costs of the care required, possible means-tested (tax funded) social assistance, as is the case in Germany (Rothgang, 2003).

It has been argued that social insurance for LTC seems more suitable for countries with a well-established insurance tradition that already have the infrastructure necessary to collect and manage the funds (Holdenrieder, 2006).

While in Belgium and the Netherlands a substantial part of LTC is covered by the social health insurance system, the German LTC social insurance was created as separate parallel system, with much higher out-of-pocket payments than for the health system, and this separation makes care coordination difficult (WHO Regional Office for Europe, 2019d).

4 Financing arrangements between the national, regional and local governments

The financing of LTC becomes complicated due to the fact that responsibilities are often split across different levels of government; for example in a country, disability benefits may be a national responsibility, health and long-term residential and nursing home care may depend from the regional government and community-based services may be organized and financed at local level. This may mean that, for example in Spain, an individual who requires care may need to approach three different government levels and multiple agencies to address different aspects of their care and support (Zalakaín et al, 2020). In Portugal there are also overlapping mechanisms for needs assessments (WHO Regional Office for Europe, 2019e). Unless there is a strong system to coordinate the different agencies and government levels involved in LTC, it is unlikely that the people who require care will experience person-centred care.

In addition, there is a risk that access to good quality and adequate care will be compromised by difficulties navigating different assessment processes and eligibility criteria, and that the different agencies and government levels have incentives to push service users towards services funded by others, even if these are not the most suitable. For example, there are concerns that the recent reforms in the Netherlands may have increased incentives for cost-shifting between the three different funding schemes (Maarse and Jeurissen, 2016 and Alders and Schut, 2019).

Also there are economic, demographic and epidemiological (as emerged during the Covid-19 related pandemic) differences at regional or local level, which may result in some authorities being in a better financial position to fund care for their local population, thus exacerbating inequalities. Some countries have devised mechanisms to improve coordination between different government levels and to reduce geographical inequalities in care. For example, Austria has a national LTC fund that is financed by the federal government (two thirds) and by the states and municipalities (one third). In Denmark, the LTC costs of the municipalities are covered by governmental grants, local taxes and equalization transfers from other local authorities.

5 Which EU member states use which financing systems?

This section summarises, very briefly, key features of the LTC financing systems of the EU member states, using information provided in the recent EU Joint Report on Health and LTC Systems & Fiscal Sustainability (EU, 2019).

Austria: tax-financed (national, regional and local), with universal cash benefits and co-payments for services (but assets not included in means-test).

Belgium: LTC is part of an integrated system of health care, complemented by social service provision. Medical care is financed by the federal health insurance system, whereas personal care is organized and financed by the regional governments. Cash benefits only play a small role in the system. Co-payments are means-tested and subject to a maximum limit. Additionally, Flanders has a compulsory social insurance system specifically for non-medical help services that provides cash benefits to insured persons with reduced self-sufficiency.

Bulgaria: People in need of care are covered by social assistance, which is managed at municipal level and by disability benefits (as a supplement to pensions of older people, for example). Need to develop governance, financing and regulatory framework.

Croatia: Organised on the principle of social assistance, financed from the state budget with a small share of co-payments. Choice between cash or in-kind benefits.

Cyprus: Social assistance model, with services subsidised for people who receive income support and for people entitled to disability benefits or aged 80 or more.

Czech Republic: some LTC services, such as home care, are covered by the health insurance system (if indicated by a general practitioner). Institutional care costs are mostly paid by out-of-pocket payments.

Denmark: tax-funded system at municipal level, universal coverage. Organized at national level, but local authorities have responsibility for allocation of resources, delivery and implementation of policies. LTC costs are financed through governmental grants, local taxes and equalization amounts (received from other local authorities). Co-payments are relatively small. Strong focus on home care and on local health and social care coordination.

Estonia: LTC is organized and financed at local level, with carer allowances for carers of persons with disabilities. High out-of-pocket payments.

Finland: National level in charge of legislative framework, local level responsible for provision. Universal entitlement to care for all residents. Municipalities have discretion on co-payments and users can choose to have cash benefits instead of in-kind services. Financing from municipal taxation, central government subsidies and user fees. Working to integrate health and social care, through a single budget at county level.

France: The health care aspects of LTC (including health care in care homes or at home) are paid for by the health insurance system. Local authorities fund other non-health costs of care. All people with care needs are entitled to public LTC benefits, but these only cover part of the costs of care. There is an important market for voluntary private LTC insurance that primarily aims to cover the costs of care not covered by the public system.

Germany: compulsory social LTC insurance which covers part of the costs of care. If the person or their family cannot cover the rest of the costs, there is tax-funded social assistance to cover the difference. There is use of voluntary private LTC insurance to cover co-payments.

Greece: highly fragmented system with uneven local (tax-funded) coverage that aims to support those without family or other resources.

Hungary: LTC provided by the health care system (Health Insurance Fund) or the local social system (which are not coordinated despite being under the same Ministry). Shifting towards more home care. Most care provided by private households or informal market.

Ireland: LTC funded and delivered as part of the health services (Health Service Executive). Co-payments for institutional care (assets are included in determining ability to pay).

Italy: LTC is provided by the public health care system (through local health authorities), provision of services by municipalities (generally means-tested) and payments for family carers of individuals with severe disabilities (attendance allowances) .

Latvia: Municipalities are responsible for meeting needs for care (except for people with mental health conditions, who fall under the Ministry of Welfare and the Ministry of Health). Care users typically cover the costs of their care, except those with low incomes, whose care is fully funded by the municipalities.

Lithuania: organised at national level and implemented at local level, up to 120 days of nursing care in healthcare institutions is provided free of charge, after that transfer to social services and co-payments. Health care is provided on the basis of social insurance.

Luxembourg: LTC social insurance system since 1999 (inspired by Germany system), benefits are provided without co-payment but do not cover board and lodging in care homes (social assistance is available to those who cannot pay those costs). The national health insurance covers the medical component of LTC. Reforms to broaden the tax base beyond the working age population may need to be considered to improve fiscal sustainability.

Malta: Central and regional governments involved in public LTC provision, tax-based with means-testing for some benefits.

The Netherlands: Since 1968 the Netherlands have had social insurance to cover LTC under the 'Exceptional Medical Expenses Act', which covers chronic care needs. Co-payments required for board and lodging in care homes. Recent reforms have focused on incentivising use of community-based care and containing costs. In 2015, the Exceptional Medical Expenses Act was replaced by the LTC Insurance Act, a compulsory health insurance policy focusing on a smaller group of individuals with high needs and which includes income-dependent co-payments. The central government tops up the LTC Fund from tax income, if funds are too low. Additionally, the Social Support Act provides community-based social services at local level.

Poland: LTC is fragmented, covered by the National Health Fund, social assistance, family benefits, pensions and rehabilitation (as well as in-kind family support). Strong focus on cash benefits and, within in-kind services, on institutional care.

Portugal: financed jointly (through taxation) by the Ministry of Health and the Ministry of Labour, Solidarity and Social Security, and co-payments for the social care aspects of care (means-tested according to family income).

Romania: combination of financing from the National Health Insurance Fund and social services (from central and local budget), pensions and rehabilitation. Fragmented and complex system, high reliance on family in-kind resources.

Slovakia: health care services (including day care centres and nursing homes) are financed from public health insurance resources, whereas residential homes and other social services are financed by regional and local governments, with co-payments. Means-tested (income and assets) cash benefits are financed by the state. Reforms are under discussion.

Slovenia: nearly half of public spending on LTC is by the health social insurance system, the Health Insurance Institute (mostly LTC for older people). Concern over large OPPs. Cash benefits and institutional care are organized centrally, whereas home

care services are local responsibility. Cash benefits are financed by the Pension Disability Fund and the state budget. Local social services are financed by local and state budgets and user fees. Reforms of the LTC financing system are under discussion, with social insurance under consideration.

Spain: tax-based system, with national eligibility criteria and defined benefits, run at regional level and financed by national, regional and local funding. National funding aims to take into account differences in population need (equalization function). Co-payments are means-tested.

Sweden: mostly funded from local taxation, with a low level of co-payments. There is a national ceiling of fees and, within this, municipalities can set out their own co-payment rules.

6 Discussion and learning

There are relatively few countries that have transitioned from the legacy of residual and fragmented LTC systems, to more coherent LTC financing systems designed with the aim of providing a long-term response to societal changes and preferences.

The form that a 'more coherent' system takes will usually depend on the existing institutions a country already has. For example, in countries where health care is already financed through social insurance, such as in Germany and Luxembourg, the new LTC scheme was able to build on existing institutions. In Denmark, in contrast, there has been a more incremental approach through which LTC has become increasingly well-integrated and coordinated with health care, building on the strong tradition of local government, strong public and political support for LTC, and using national mechanisms to equalize economic and demographic differences between different municipalities (Rostgaard, 2020).

Although there are exceptions in Asia, where social LTC insurance systems have been developed at relatively high speed, in most countries comprehensive LTC reforms have required a relatively long period to build political consensus and societal support. In Germany, for example, the establishment of the mandatory LTC Insurance system took two decades of political debate, which eventually led to consensus across all the major political parties, the unions, employers, and sickness funds as well as private insurers (Götze and Rothgang 2014). In the UK, potential reforms of the public LTC financing system have been under discussion since at least the 1990s.

7 Conclusions

While different LTC financing mechanisms have different strengths and weaknesses, in practice most countries use a mix of approaches to finance LTC. The key is to ensure that the system can work well in the context of existing institutions and infrastructure and that reforms take account of wider societal changes and pressures.

The COVID-19 pandemic has thrown a harsh light onto systemic problems, as many as half of all deaths linked to COVID-19 were care home residents (Comas-Herrera et al., 2020). The effects of the pandemic have been exacerbated by insufficient funding and lack of political support for the long-term care sector in many European countries (Berloto et al., 2020, Kruse et al., 2020, Oven, 2020, Pierce et al., 2020, Schmidt et al., 2020 and Zalakaín et al., 2020).

In order to build political and public support for a well-resourced and sustainable system, it may be helpful to consider LTC within the context of a wider healthy ageing strategy and a positive discourse around ageing itself (WHO, 2020b). Most countries are already working towards increasing home-based and community-based support, in line with the preferences people express for living in their own homes as long as

possible. Denmark, where the LTC system has very strong public and political support, has modernised its approach to LTC with a strong emphasis on prevention and rehabilitation, and a move away from traditional forms of institutional care (Rostgaard, 2020).

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