Gray Matters:
Building Sustainable Long-Term Care Systems

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The context:

- Population **aging** is increasing the need and demand for LTC.
- Older people who need LTC are often cared for by **family members**, usually **women**; however, as need level increase, family support systems are being eroded by female labor market participation, smaller family sizes, and trends in migration. Even when informal care is available, **people with complex needs likely to require additional support**.
- Such trends are leading to an increasing **gap** between the need for LTC and its supply. In response, many country governments are looking to strengthen their LTC systems.
- Debates about LTC systems strengthening raise important questions, including on how to provide **adequate coverage** while also ensuring **sustainability**.
- Fiscal sustainability in LTC systems focuses on ensuring current policies don't place an unfair financial burden within and on future generations, while also ensuring adequate LTC coverage, the latter depending on a governments' views on what constitutes an efficient and fair allocation of resources to ensure equitable access.
- Addressing this challenge arguably requires (1) **targeted coverage** of LTC services; and (2) other **financing and regulatory policies** to "find more funds" and "spend better." Question is - how do we think about and do this?

What constitutes adequate coverage is in part dependent on the definition of LTC.

No consensus definition of LTC exists; for example:

OECD: "**A range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living.**"

European Commission: "**A range of health care and social services and assistance, for people who, as a result of… old age, over an extended period of time depend on help with daily living activities, and/or need some permanent nursing care.**"

WHO: "**A broad range of personal, social and medical services and supports that ensure people… can maintain a level of functional ability consistent with their basic rights and human dignity.**"

- **Activities of daily living (ADLs)** include those activities that a person must perform daily; i.e., eating, washing, etc.
- **Instrumental activities of daily living (IADLs)** require more skills vs. ADLs; i.e., cooking, shopping, etc.

Despite their differences, the definitions provide some direction in terms of **target group** and **benefits**. Defining these elements further, however, would be important to move from **discourse to action** – for example, to estimate the level of current and future needs to design, finance, and implement policies.

Nonetheless, there is agreement that LTC can be delivered in **multiple settings**, contrasts with **acute** care, encompasses both **formal** and **informal** care (paid or unpaid), and generally includes **social** and **medical** care.

It is also dependent on the Government's views on fair and efficient allocation.

- LTC for older persons is typically provided by **families**, the **state**, the **private sector** (including faith-based organizations), and the **informal market**. Familial care predominates in most countries.
- Historically, government provision of LTC is a "**last resort**" function, where entitlement to coverage is subject to a "means" test. This typically has unintended effects, such as **task shifting** to where public coverage is provided (e.g., bed blocking in hospitals or nursing homes).
- As the need and demand for LTC increases, however, many governments are starting to take on a "**stewardship**" role of the LTC sector by facilitating universal access to care.
- However, universality does not exclude targeting benefits based on care need. Although views on the allocation of LTC benefits (e.g., to whom, which services, and how much) differ by country, **targeted universalism** can strike a reasonable balance between **fair coverage** and fiscal **sustainability.**
- Many governments are seeking efficiency gains from **choice-based competition** among providers; that is, private service provision financed in part by public financing.
- Many governments are also promoting "**aging-in-place**" as a means of improving efficiency given preferences to stay at home as long as possible and that unit costs of institutional care are relatively higher.

Government stewardship of the LTC sector has various benefits.

Public provision of LTC brings about public benefits:

- **Economic benefits** (i.e., reduced health expenditures though, for example, less hospital admissions; increased labor income of family members who have dependent relatives; and reduced poverty risk)
- **Women's empowerment**
- **Non-quantifiable benefits** (i.e., enhanced older person's opportunities to live with dignity; increased set of choices available to individuals and families, especially women; and improvements in the overall quality of LTC services, including for poor)
- **Other benefits**, such as the "silver economy" (tech, assistive devices, etc.)

Absent state stewardship, there would be challenges:

- Private insurance is not viable because of myopia; moral hazard and underwriting; uncertainty re. future unit costs/high premiums, competing priorities, and because LTC services (housekeeping, meal preparation) are normal goods and are desired by all
- If the government is not a major financier (and does not set prices – not a monopsonist), it is difficult to influence quality and pricing strategy of private providers (which would be driven by profit maximization in a non-competitive market)

Sustaining adequate coverage requires stewardship and systems thinking.

"An LTC system consists of all of the organizations, institutions, resources, and people involved in carrying out LTC activities"
-WHO

Access and eligibility	Benefits and Services	Financing	Organization and Governance	Human Resources
Defining and assessing the need for LTC, and applying a standardized needs assessment and classification of care needs.	Supporting a range of home- and community-based and institutional in-kind care services, in addition to other types of benefits (i.e., cash for care and/or other supports), based on individual needs.	Collecting adequate revenues, pooling resources; "purchasing" benefits and services; providing financial protection against LTC costs; and ensuring equity and value for money.	Making clear the functions at different levels of government, the relationship between the health and social sectors, the quality control mechanisms, and the role of the private sector.	Preparing for a future LTC workforce, including skilled medical staff and less skilled care workers; ensuring flexibility within the workforce while also protecting workers' rights.

LTC Strategy and/or Vision

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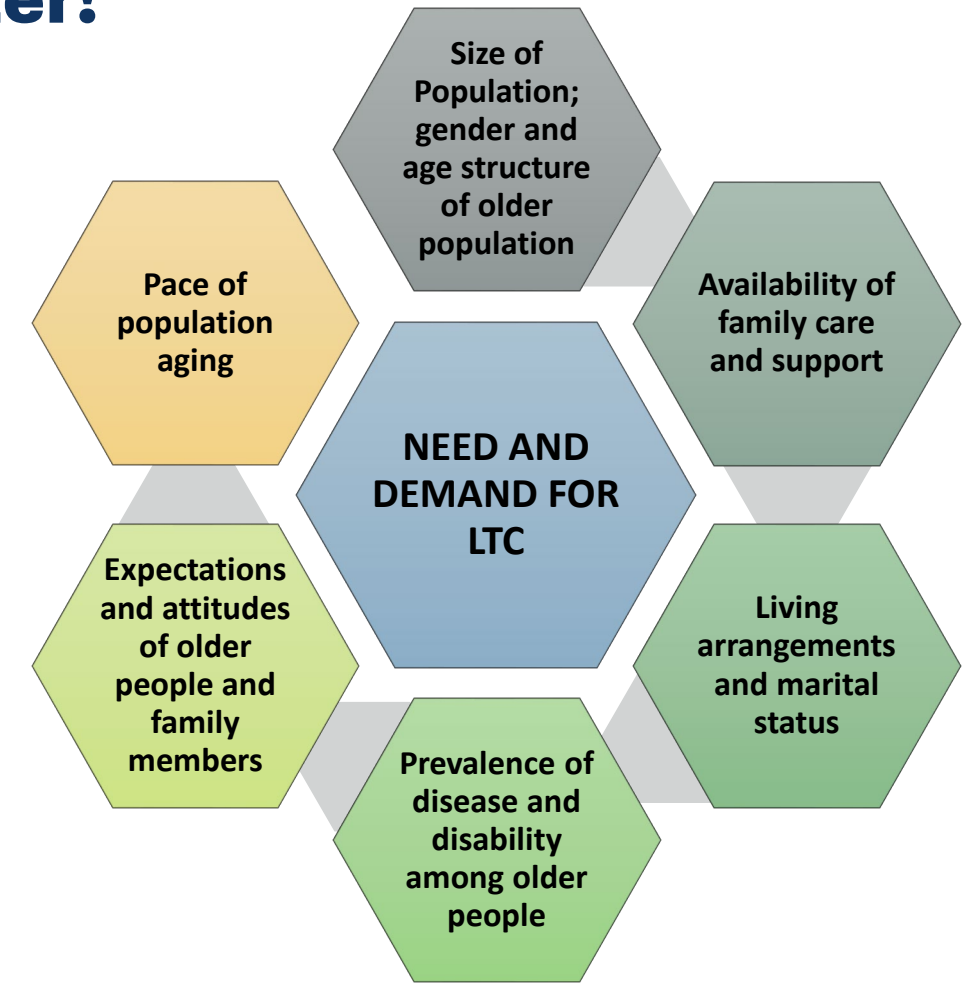
Access and Eligibility: Definitions matter!

Projecting LTC Needs and Demand

What does the future have in store?

- The capacity to assess LTC need and demand is required at both the macro and microlevel to inform policy formulation and service delivery.
- At the policy or macro level, a clear definition of LTC is needed to **project future need and demand for care, project public expenditures on care, investigate future affordability, and guide policy reform**.

- Primary determinants of need include number of older people and their level of independence.
- Measuring independence is based on a person's ability to perform activities of daily living or instrumental activities of daily living using, for example, the Katz Index or the Barthel Index.
- Demand for LTC is influenced by need and other factors, i.e., marital status, labor force participation, etc.



Access and Eligibility

Defining the need for LTC

How to define who needs LTC?

- The prevalence of dependency is commonly used to determine the level of care needs, typically through a functional (versus medical) assessment based on the number of ADLs and IADLs that one can perform. Cognitive impairments are also sometimes considered.
- Assessment results are generally based on a classification of needs.
- In some countries, for example, inability to perform a certain number of ADLs implies need for LTC; in others, ADL- and IADL- based scores are aggregated using different weights. In some countries, more comprehensive definitions of LTC need are used, accounting for also mental and psychological factors.

Linking needs assessments and eligibility

Extend benefits to everyone with LTC needs or a fraction of them?

- Identification of people with LTC needs and the selection of beneficiaries (i.e., based on age or income) are linked due to budgetary factors. Targeted universalism has the potential to provide fair protection sustainably.
- For example, some systems employ, in addition to care needs, factors like age, means, and the availability of informal support as criteria.
- **Needs assessments and eligibility criteria should be dynamic since budget constraints change over time. Moreover, entitlement does not mean no cost-sharing.**

Assessing needs and eligibility, and follow-Up

How should needs assessments be performed?

- Needs assessments should be performed by a multi-professional panel including, for example, social workers and medical practitioners.
- Most systems leverage at least one national/uniform assessment tool; for example, the Barthel Index.
- Assessment responsibility should not be held by those providing care; otherwise, there may be bias towards severity.
- Assessment should also factor in the dynamic nature of needs, with might increase with age or be contained with early interventions.

Benefits and Services

Types of Benefits

Health? Social? Or both?

- Many LMICs have a default financing approach for LTC through the health system, which is costly and inefficient. But this is changing due to the nature of LTC.
- Generally, LTC benefits span the health and social sectors and different settings. While the health sector tends to focus on ADL-oriented care, social sector benefits to be more IADL-oriented.
- The division between sectors, however nebulous, has implications for the provision and funding of services (i.e., task shifting).

Nature of Benefits

Cash or in-kind services, or both?

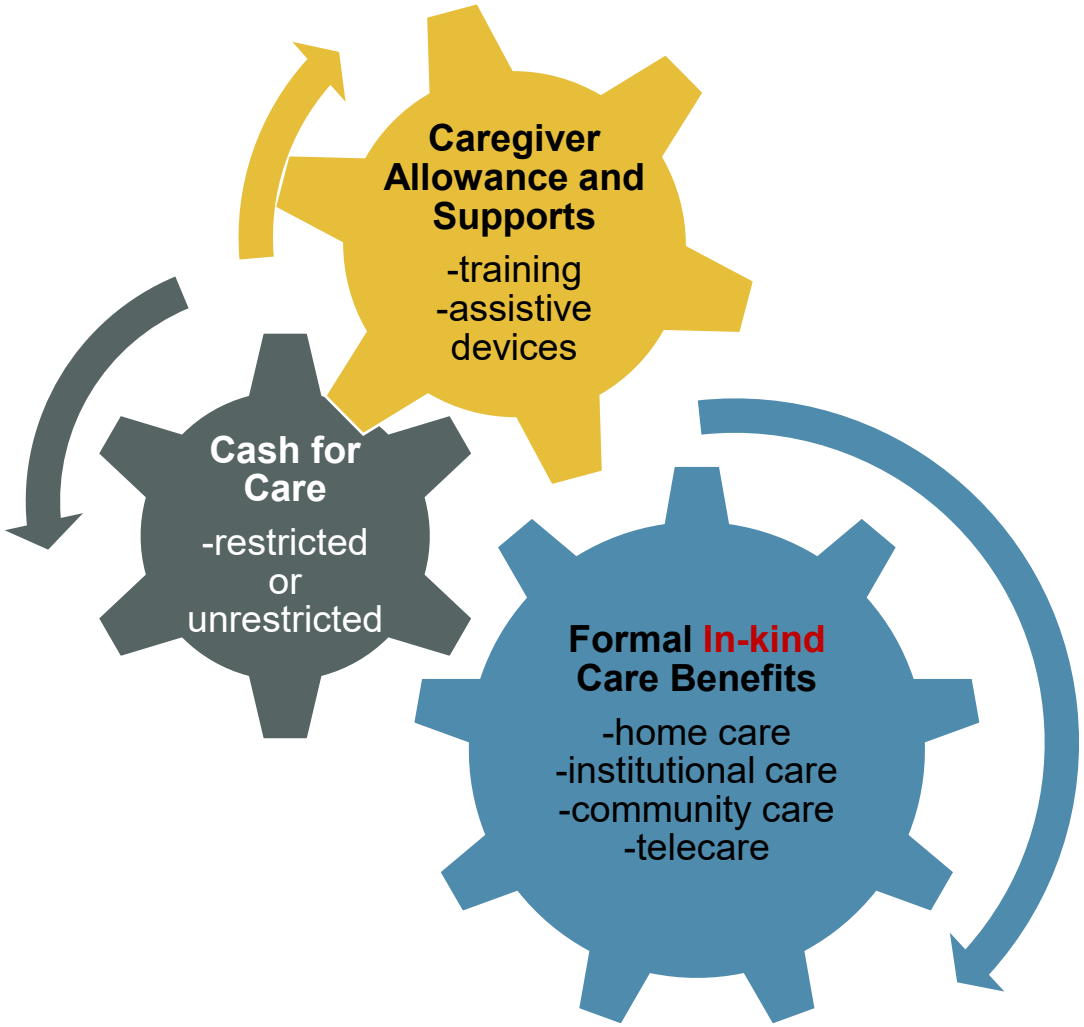
- Generally, there are three options for delivering benefits: in-kind direct service delivery, cash allowances and supports for informal carers or caregivers, and/or cash benefits for care recipients. The latter can be "unrestrictive," or "restricted" to the purchase of select services. These options impose trade-offs in terms of efficacy, user choice, and costs.
- Some LTC systems extend both in-kind and cash benefits; for example, in Slovenia, users can leverage in-kind or unrestricted cash allowances, or a combination thereof. In contrast, other systems are in-kind based.

Generosity of Benefits

Standardized or customized?

- **The generosity of benefits, and their eligibility criteria, impact the financial sustainability of a system. Most governments set minimum and maximum limits to their benefits, balancing coverage, equity and sustainability. Some also offer a range of benefits at different need levels.**
- For example, in Germany, the highest benefit (for highest care grade) is five times that of the lowest benefit; in Austria, it is ten times.
- **Cost-sharing is present in all systems.**

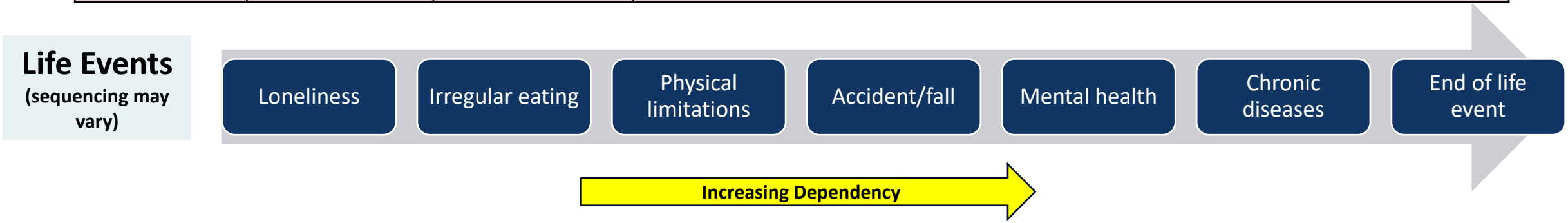
Benefits and Services



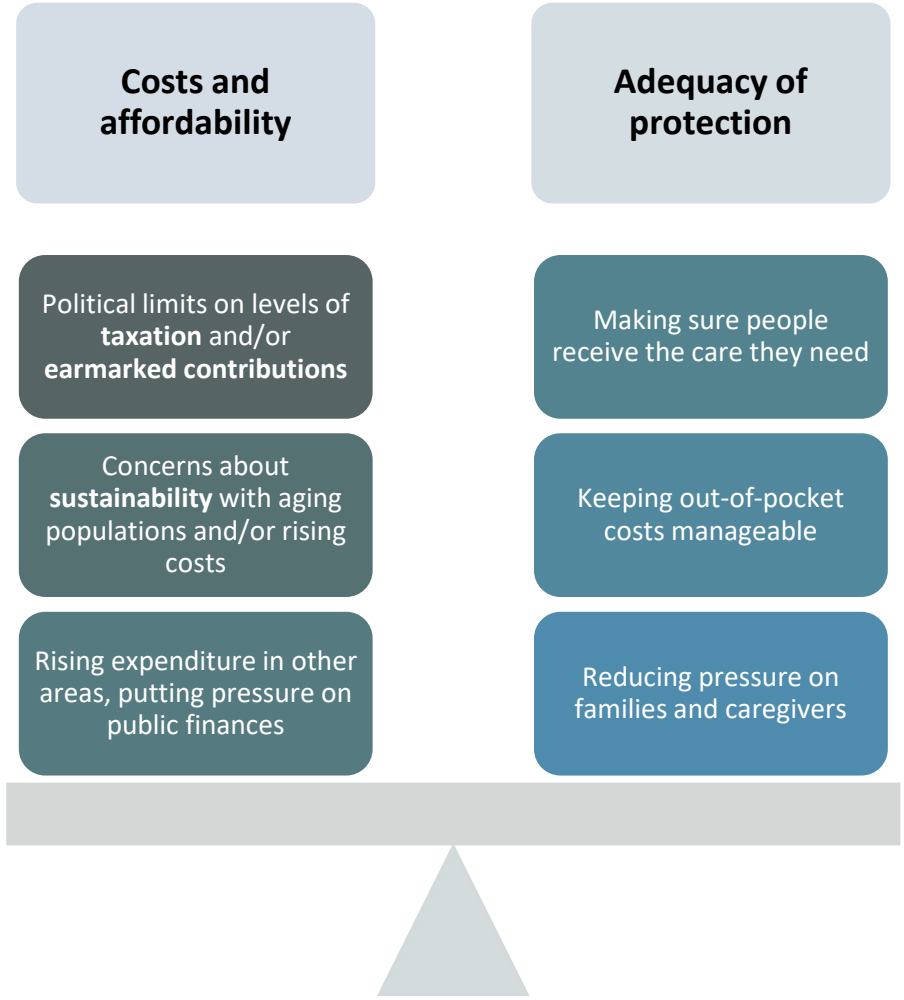
German's LTCI System: A Tiered Benefit System					
Maximum Benefits (euros)	**Care Grade (CG) 1**	**CG2**	**CG3**	**CG4**	**CG5**
Home Care: Nursing Allowance	-	316	545	728	901
Home Care: In-Kind Benefit	125	689	1298	1612	1995
Semi-residential day and night care (can be used in addition to home benefits)	125	689	1298	1612	1995
Nursing Home Care	125	770	1262	1775	2005

Promoting aging in place and ensuring financial protection

What is needed to help people prepare for and live with life events as they age?			
Institutions	Associations, clubs, religious organizations	Associations, clubs, religious organizations	Associations Religious Organizations PHC facilities Long-term care (LTC) facilities Secondary and tertiary care facilities
Financing	Private	Private, some public	Private, Government, Insurance-based health and/or LTC
Formal Services	-Community-based programs	-"Meals on wheels" -Community kitchens	-Hospital care with/without discharge -Home and community-based care (including in-kind and cash-for-care) -Nursing care -Palliative care -Other benefits (i.e. caregiving training, supports) and transport



LTC Financing: Resource mobilization and strategic purchasing



Higher levels of spending on home and community care are not indicative of a better performing system:

- Countries with **older** and **sicker** populations will have a greater need for nursing care
- The assumption that LTC recipients prefer to remain in their homes is not so simple – there are **tipping points**
- Providing services in the home and/or community is not necessarily cost-saving – unit costs are cheaper, but **aggregative savings** may not be realized
- However, while a focus on cost savings is often a necessity, an important focus would be on how to deliver home- and community-based services in the most cost-effective manner; i.e., it would be beneficial for us to also move beyond analyses of costs to consider both **costs and outcomes**
- To enlarge contributory base, governments may need to look beyond income taxes and social contributions; i.e., health taxes, deferred payment models, pre-funding, etc.

Trade-Offs

- **LTC financing varies between countries, in terms of how public funds are sourced and allocated.**
- **When designing their public LTC financing systems, governments need to consider: (1) whether the government should means-test eligibility or offer universal coverage; (2) whether the government should provide services directly or act as a third-party payer; and (3) whether the financing should be structured nationally (centralized) or locally (decentralized). There are pros and cons or each approach, with implications on coverage and sustainability.**
- **Means-test versus universal programs:**
  - Target individuals who are most in need while controlling costs and promoting equitable access
  - However, means-testing creates a group of people whose income is not low enough to qualify for public funding but who are not wealthy enough to afford costs of needed care; comes with a sense of stigma vs. entitlement; can be an administrative burden; does not necessarily prevent catastrophic spending; and depends on GG budgets (unstable)
  - In a financing system aimed at achieving universal coverage (regardless of financing source), everyone pays into the system and receives benefits once certain criteria are met; this creates an entitlement, ensures equitable access and eliminates stigma; however, sustainability concerns if not carefully managed with good systems thinking and targeting

Trade-Offs

- **Direct provision versus third party payment systems:**
  - In financing systems that operate as third-party payers, the government is responsible for developing systems of enrolling eligible providers; determining eligible beneficiaries; setting reimbursement rates; monitoring compliance with quality and administrative standards; and paying providers for services. When the government is the service provider and the payer, inefficiencies in spending and operations can arise (i.e., more operational costs, less innovation, etc.).
  - The transaction costs associated with the former approach may be high, which could offset efficiency gains – so it's important to do them well!
- **National versus local financing and delivery:**
  - A uniform national program helps achieve horizontal equity between geographical areas and may involve lower administrative costs because program rules and systems need to be developed only once. However, a centralized system can be bureaucratic and unresponsive to local conditions, needs and preferences.
  - In more decentralized systems, the planning and delivery of services can be influenced by local circumstances and because local governments are less driven to routinize their processes, locally designed programs tend to be less rigid.
  - A hybrid approach, combining centralized standards and stewardship with decentralized implementation, can help balance these trade-offs and enhance the sustainability of LTC systems.

Governance (spending better!)

Defining Sectoral Roles

How are the health and social sectors coordinated? How are objectives set?

- Coordinated care helps to ensure that, as people age, a continuum of care is provided to them to meet their increasing needs (**healthy aging!**). A good continuum of care may include preventative, curative, rehabilitative, palliative, and social care support. It would encourage a seamless transition across settings, harmonized management across roles (for example, health and care workers, caregivers and family, and timely and non-fragmented care. Investing in system enablers (i.e., information technology solutions) would be key.

Quality Assurance

What quality assurance and improvement strategies are in place?

- Quality assurance includes establishing minimum quality standards; monitoring compliance with said standards across public and private providers; and enforcing compliance in providers not meeting standards. It is important to monitor services provided to very vulnerable individuals.
- Exploring use of **technology** to improve quality (i.e., telemonitoring).

Defining Private Sector's Role

What regulatory mechanisms are in place?

- Outsourced service provision would ideally create a "triangle system," with a public contractor, a private service provider, and the individual.
- When users can choose their providers (i.e., through cash transfers and/or vouchers) competition has two aspects: i) competition between service providers to be selected and contracted by a public contractor, and ii) competition to be chosen by clients who are free to choose their preferred service providers.

Key Takeaways:

- **In a context of population aging, debates about LTC systems strengthening raise important questions, including on how to provide adequate coverage while also ensuring sustainability.**
- **Addressing this challenge arguably requires government stewardship to ensure:**
  - **Targeted universalism**. Adopting targeted universal LTC programs that provide universal access while tailoring benefits based on individual needs. This approach balances equity with efficient resource allocation.
  - **Balanced funding models**. Integrating public funding with private contributions to ensure broad access while maintaining fiscal sustainability. Encouraging public-private partnerships. Budgeting for LTC using a clear definition of LTC. And looking at and beyond income and social contributions.
  - **Local adaptability with central oversight**. Combining centralized standards and oversight with decentralized implementation to ensure quality and equity, while allowing local responsiveness and innovation in service delivery.
  - **Prioritize "aging-in-place" models**. Aligning service delivery with the preferences of elder persons, and reducing reliance on expensive institutional care except for those that need it.
  - **Robust regulatory framework**. Employing systems thinking and strong regulatory mechanisms to ensure quality, integration, and accountability across all LTC stakeholders. Continuous monitoring and evaluation. Spending better.

Thank you.

Questions?

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