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Chapter 7

Public Long-term Care Financing Arrangements in OECD Countries

With population ageing and reductions in family care, utilisation of formal long-term care for disabled people is growing in all high-income countries. Higher demand for formal services is emerging also because of people's expectations for high-quality care. These factors are pushing up the cost of formal long-term care across OECD countries and raise questions about who should pay more prominent in policy discussions. This chapter offers an overview of public long-term care (LTC) coverage in OECD countries. For illustrative purposes, countries are clustered into three main groups, ranging from universal and comprehensive to means-tested system or systems with a mix. Over time, coverage systems are evolving towards universal systems or benefits and more user-choice models, with, in many cases, increased targeting of care benefits to those with the highest care needs.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

7.1. Collective coverage of long-term care costs is desirable on efficiency and access grounds

There are powerful rationales for creating long-term care (LTC) coverage mechanisms to complement family and volunteering care arrangements. First, the cost of care can be high and thereby place a significant burden on users, especially those living on low-income or with high levels of dependency. For example, in the United States, the cost of formal care averages USD 75 000 per year in a skilled nursing facility and USD 20 per hour for home health aides (Gleckman, 2010), nearly three times as much the average disposable income for a person aged 65 years. LTC coverage, especially public systems, provides old-age support, helping seniors face dependency costs. Second, there are significant uncertainties for individuals about the need for long-term care, especially the time the need will develop, as well as its duration and intensity. It is understandable that they will wish to cover this risk but cost can be high and access reduced when covered by actuarial insurance mechanisms (Bar, 2010).

Mechanisms for pre-payment (*i.e.* raising contributions to pay for cost that may arise in the future) and pooling (*i.e.* sharing of the risk and of the cost across a broad "pool" of covered individuals) for LTC costs, such as LTC insurance, allowances and targeted assistance, provide an answer to high uncertainty and high cost. They pool risk and ensure protection against potentially catastrophic long-term care cost. They help to protect disposable income and assets of users, therefore offering a safety net and preventing care-dependent people from falling into poverty. They also enable access to LTC services by offering compensation for the cost of such services, thus helping to prevent deteriorating health and increased dependency and being deprived of necessary care due to lack of financial resources. By sharing costs across individuals within the pool, they can also respond to demand for intergenerational equity.

The formal LTC sector is still relatively small in OECD countries (as a share of GDP), especially when compared to the estimated value of family care and expenditure on health or pension systems. However, it is a sector in evolution. LTC expenditure – particularly public LTC spending – has shown a faster upward trend than health care spending.[1] The expected increases in formal LTC use are pushing ahead discussions about how to improve equity and efficiency in the financing of long-term care. These discussions often concern public schemes because, in most OECD countries, the risk of dependency is mainly pooled through publicly financed mechanisms. Private coverage is, for a number of reasons discussed in Chapter 8, a niche market.

This chapter informs those discussions by offering an overview of public LTC coverage in OECD countries. The next chapter (Chapter 8) discusses private coverage arrangements, their possible role as a complement to public LTC systems, as well as the reasons for limited market development to date. A third chapter (Chapter 9) considers future directions and useful country experiences to address two main policy challenges in LTC financing: providing fair and adequate access to care; and controlling cost growth.

7.2. Public long-term care coverage for personal care can be clustered in three main groups[2]

While LTC coverage comprises a complex mix of services, benefits, and schemes, it is still possible to distinguish clusters of countries with similar approaches.[3] The taxonomy is derived looking at variation in support for personal care – that is help with so-called activities of daily living (ADL) – whether at home or in institutions. This is because ADL support is the type of care for which more variation in public coverage arrangements exists across OECD countries. Reference is however made in the following section of this chapter to how coverage for skilled nursing care, board and lodging cost and other LTC services varies across the OECD. Where a country has multiple benefits for older and younger disabled, the description typically refers to the frail elderly. Benefit schemes for young disabled people may therefore not be properly reflected in this typology. Coverage is often more comprehensive for young disabled people, relatively to older groups. In France, for example, disability benefits (*Prestation de compensation du handicap*) targeted to young people are higher than those under the dependency allowance (*Allocation Personnalisée d'Autonomie*) targeted to older people. Countries with no or very little public LTC coverage are not discussed.

The classification uses two main criteria to distinguish across country types:

- the *scope of entitlement* to long-term care benefits – whether there is universal[4] or means-tested[5] entitlement to public funding; and
- whether LTC coverage is through a *single system, or multiple benefits, services and programmes*.

Three broad country clusters can be identified based on these two criteria:

- universal coverage within a single programme;
- mixed systems;
- means-tested safety-net schemes.

It is also possible to distinguish additional sub-groups, depending for example, on: *i)* whether the sources of funds are earmarked taxes/contributions or general revenues; *ii)* whether the programme is or not part of health systems; and *iii)* in mixed systems, the nature of the programmes that constitute the mix.

Each LTC scheme has specific features, such as the target population group (the elderly only or the whole population), or the type of benefits provided (whether a cash subsidy/allowance or subsidised in-kind services), as summarised in Table 7.1.

Universal coverage within a single programme

Under this cluster, LTC coverage is provided through a single system, whether separate from health systems *(e.g.,* Nordic countries, social long-term care insurance), or part of health coverage *(e.g.,* Belgium). Systems with single universal LTC coverage provide publicly-funded *nursing and personal care* to all individuals assessed as eligible due to their care-dependency status. They may apply primarily to the old population *(e.g.,* Japan, Korea), or to all people with assessed care-need regardless of the age-group *(e.g.,* the Netherlands, Germany). Co-payments, user charges or up-front deductibles are required even in universal coverage systems. They are typically subject to income thresholds, with partial or full exemption from payments, or social-assistance mechanisms, for the poor, resulting, effectively, in a comprehensive collective coverage of LTC costs.

Table 7.1. **Public LTC coverage: A summary**

	Eligibility to coverage	Coverage programmes	Programme(s) name	Source of financing LTC	Target disabled population	Types of benefits provided	Public LTC spending, share of GDP (%)
Australia	Universal	Multiple programmes: Income-related benefits	Home and Community Care (HACC)	Tax: 60% federal, 40% local, state and territorial governments for HACC	Old people	In-kind, home and institutional care	0.8
			Residential care by ACATs (aged care assessment teams)	Tax-based			
Austria	Two cash benefit systems, one universal, one means-tested	Multiple programmes: Income-related benefits	Pflegegeld (universal cash system) 24-hour care benefit	Tax: In 2006, federal (EUR 1.62 billion) and Lander (EUR 301.5 million)	All Income criteria, Pflegegeld level 3	Cash, home and institutional care (in-kind benefits by Länders)	1.1
Belgium	Universal coverage within a single system (health-related and personal care)	Via the health system	Public health Insurance system (INAMI/RIZIV)	Social security contributions/payroll taxes (57%), general direct taxation (37%) and OOP (6%)	All	Cash and in-kind, home and institutional care	1.7
		Federal programme	Federal allowances for elderly/social welfare benefits	Direct general taxation	65+, low-income	Cash, need-tested and income-tested	
	Social care (domestic care and other support)	Flemish programme	Flemish care insurance	Mandatory yearly contributions	All	Cash, need-tested	
		Regional programmes	Home help assistance	General taxation and OOP (variable according to income)	At home	In-kind, home social care	
Canada	Set by each province	Mix of universal (for home care) and means-tested benefits (often for institutional care)	Varies by province	Provincial revenues from general taxes Federal Canada health transfers to provinces	All	In-kind, home and institutional care	1.2
Czech Republic	Mixed system	Parallel cash benefit schemes	Care allowance In-kind LTC services are divided across the social sector and universal health care system	Public budget from general taxation	All	Cash and in-kind, home and institutional care	0.2 (health) 1.2 (social)
Denmark	Universal coverage within a single system	Universal, tax-based		Block grants from federal government, local taxes, equalisation amounts from other local authorities	All	Cash and in-kind, home and institutional care	1.8
Estonia			Estonian Health Insurance Fund (EHIF) Health care Personal care services mainly provided by local governments	Welfare services for mental disabilities: State Nursing care services: Health insurance		Cash and in-kind, home and institutional care	
Finland	Universal coverage within a single system	Universal, tax-based		Government transfers to municipalities (31%), municipal and income tax (60%)	All	Cash and in-kind, home and institutional care	1.8

Table 7.1. **Public LTC coverage: A summary** *(cont.)*

	Eligibility to coverage	Coverage programmes	Programme(s) name	Source of financing LTC	Target disabled population	Types of benefits provided	Public LTC spending, share of GDP (%)
France	Mixed system	Income-related benefits	*Sécurité sociale* covers institutional and home care services (Ssaid) *Allocation personnalisée d'autonomie* (APA) *Prestation de compensation du handicap* (PHC)	Local and central taxes and social contributions APA: 70% local level funding	All Aged 60+, income-tested	Cash and in-kind, home and institutional care	1.7
Germany	Universal coverage within a single system	Public LTC insurance – Social insurance	Long-term care insurance	Tax, premiums, financing from Lander budgets	All	Cash and in-kind, home and institutional care	0.9
Greece	Mixed system	Mix of universal and means-tested (or no) benefits	Provision of social services by Ministry of Health and Social Solidarity and provision of care through Social Insurance Funds	Mixed: national budget, social security and private payments Housing allowance for the elderly: national budget	"Any old person"	Mainly in-kind, institutional care	0.3
Hungary	Mixed system		Health care under the National Health Insurance System	National Health Insurance Programme: Contributions Tax-based Social care: Central government, local government contributions and OOP	All	In-kind, home and institutional care for individuals needing more than 4 hours of care	0.3
Iceland						Institutional care	1.7
Ireland	Mixed system		Nursing Home Support Scheme	Tax-based	All/no standard	Cash and in-kind, home care	
Italy	Mixed system	Parallel universal scheme	Institutional care: *Residenze Sanitarie Assistenziali*, part of health system Care allowance: *Indennita di accompagnamento*		All	Cash and in-kind, home and institutional care	
Japan	Universal coverage within a single system	Public LTC insurance model – Social insurance	Long-term care insurance system	50% public contributions by those over 40, 50% governmental divisions (*of which:* 50% from national government, 25% from the prefectural government and 25% from the municipality)	Over 65, or 40-64 with age-related disease	In-kind, home and institutional care	1.4
Korea	Universal programme within a single system	Public LTC insurance model – Social insurance	National Health Insurance for the Elderly	Long-term care insurance fee, central and local government, budgets and out-of-pocket	Over 65 or under 65 suffering from geriatric diseases	Cash and in-kind, home and institutional care	0.3

Table 7.1. **Public LTC coverage: A summary** *(cont.)*

	Eligibility to coverage	Coverage programmes	Programme(s) name	Source of financing LTC	Target disabled population	Types of benefits provided	Public LTC spending, share of GDP (%)
Luxembourg	Universal long-term care insurance programme	Public LTC insurance model – Social insurance	Assurance Dependence, LTC programme part of healthcare insurance Gerontological homes	Individual contributions, State contribution and electricity tax Financed by the National Solidarity fund – EUR 7.6 million (2008)	All	Cash and in-kind, home and institutional care	1.4
Mexico	Mixed/Sub-national	Multiple programmes	Programme for older adults	Federal government (general taxes), contributions from employers and workers Seguro Popular – Federal and state governments, households	65+	In-kind, cash subsidies, institutional care	
Netherlands	Universal programme within a single system	Public LTC insurance model – Social insurance	Exceptional Medical Expenses Act (AWBZ)	Contributions and additional tax contributions	All	Cash and in-kind, home and institutional care	3.5
New Zealand	Mixed system	Mix of universal and means-tested (or no) benefits	Health funding authority in charge of LTC provision Residential care subsidy (RCS) pays the cost of contracted care	Tax-based, annual health care block grants from the District Health Boards		Mainly in-kind, home and institutional care	1.3
Norway	Universal programme within a single system	Universal, tax-based		National and local taxes	All	Cash and in-kind, home and institutional care	2
Poland	No separate system of LTC (2004)	Parallel universal scheme	Residential LTC by health care and social sector (Social Assistance System) National Health Fund (NFZ) Home care	Health services funded by a combination of general taxation and contributions to national health insurance schemes Fully provided and financed by local authority	Over 75 years, disabled persons	Cash and in-kind, home and institutional care	0.4
Portugal	Mixed		National network for long-term care Medium term and rehabilitation units	Health care: Ministry of Health, medium term and rehabilitation units-co-financed by Ministry of Labour and Social Solidarity (80%) and MoH (20%)	All	In-kind, institutional care	0.1
Slovak Republic			Municipalities and self governing regions provide social services including LTC	Cash benefits: state budget, social services: regional and municipal taxes	Age-related	Cash and in-kind, other: home and institutional care, government organises providers	0.2

Table 7.1. **Public LTC coverage: A summary** *(cont.)*

	Eligibility to coverage	Coverage programmes	Programme(s) name	Source of financing LTC	Target disabled population	Types of benefits provided	Public LTC spending, share of GDP (%)
Slovenia	Means-tested programme: No integral system for long-term care	Income-tested for in-kind benefits	Programme under health system and social security	Compulsory health insurance premiums Pension and social insurance contributions Tax revenue from Ministry of Labour, Family and Social Assistance Municipality tax for care for disabilities	Over 65, disabled chronically ill	Cash and in-kind, home and institutional care	0.8
Spain	Mixed system	Mix of universal and means-tested	National long-term care system	Tax-based through central government and regional taxes, Grants	All	Cash and in-kind	0.6
Sweden	Universal programme within a single system	Universal, tax-based		84% local municipal taxes, 11-12% national government grants	All	Cash and in-kind, vouchers for care, Home and institutional care vary across municipality	3.6
Switzerland	Mixed system	Mix of universal and means-tested (or no) benefits	Mandatory health insurance (LAMal), means-tested complementary cash benefits under Law on Disability Insurance (LAI), benefits under the Law on Old Age and Survivors' Insurance (AVS)	Compulsory health insurance premiums, cash benefits: State budget, private payments by the persons needing care	All	Cash and in-kind, institutional care, home care provided predominately by private organisations	0.8 (1.3 including disability and survivors benefits)
United Kingdom	Mixed – means-tested social care system, with universal benefits for disability	Means-tested, safety net	Adult social care	Central taxation – given as block grants, local taxation (council tax)	All aged over 18	Cash and in-kind, home and institutional care	0.96 (2002)
		Universal benefit	Disability living allowance(DLA)	Tax-based	Under 65, disabled		
		Universal benefit	Attendance allowance (AA)	Tax-based	Aged over 65, disabled		
United States[1]	Means-tested system	Means-tested safety net	Medicaid	Federal and state funds	Low-income	In-kind mainly, mandatory institutional benefits, optional state community benefits	0.6
	Social insurance for the elderly	Universal for seniors	Medicare	Part A: Payroll, income tax Part B: Medicare premiums and congress funds	Seniors	Post acute care in nursing homes	
	Voluntary insurance	Universal if employer opt in (opt out possible)	Community Living Assistance Services and Support CLASS (prospective)	Voluntary insurance	All	Cash benefits for home and institutional care	

1. Medicare is targeted towards those aged 65 and above or those people under 65 with certain disabilities. However, LTC or custodial care is not included in Medicare. Assistance for LTC may be sought, depending on eligibility from Medicaid, Programmes of All-inclusive Care for the Elderly (PACE) or in the future, the Community Living Assistance Services and Supports (CLASS) Programme; *www.medicare.gov/Publications/Pubs/pdf/10050.pdf*; *www.medicare.gov/Publications/Pubs/pdf/11396.pdf*; *www.pssru.ac.uk/pdf/rs040.pdf*.

Source: OECD compilation based on country replies to the OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

Three main sub-models can be distinguished: *i)* tax-based models *(e.g.,* Nordic countries); *ii)* public long-term care insurance models *(e.g.,* Germany, Japan, Korea, the Netherlands, and Luxembourg); *iii)* personal care and nursing care through the health system *(e.g.,* Belgium).

Tax-based models

Nordic countries are the most typical example. Norway, Sweden, Denmark and Finland provide universal, tax-funded long-term care services as an integral component of welfare and health-care services for the entire population. While the overall responsibility for the care of elderly and disabled rests with the state, a main feature of these countries is the large autonomy of local governments *(e.g.,* municipalities, counties, councils) in organising service provision and in financing care, including the right to levy taxes (Karlsoon and Iversen, 2010). The state typically contributes to financing by paying non-earmarked subsidies either to municipalities *(e.g.,* Finland) or to regional authorities *(e.g.,* Denmark), adjusted to the population structure and need. Public long-term care services are broad and comprehensive, resulting in a relatively large share of GDP spent on LTC – ranging from 2% in Denmark to 3.6% in Sweden. Beside personal-care support in institutions and at home, they can include for example help with domestic care (Denmark, Sweden), as well as the provision of sheltered housing, home adaptations, assisting devises and transport (OECD, 2008; Ministry of Health and Social Affairs of Sweden, 2007). Out-of-pocket payments for LTC account for relatively low shares, for example around 4% of revenues in Sweden, and the private contributions to cost are capped in Sweden and Norway.

Public long-term care insurance model

A second model of universal coverage consists of stand-alone, dedicated social insurance arrangements for long-term care services. A number of countries, which typically finance health care via social health insurance, belong to this group (Germany, Japan, Korea, the Netherlands, and Luxembourg; see Table 7.2). Similar to the Nordic countries' model, service coverage is generally comprehensive – not just in reaching the entire population needing care, but also with respect to the scope of the covered services. As for Nordic countries, users are required to contribute to the cost of care, with very different level of cost sharing across country (see Box 7.1). Board and lodging in nursing homes may be partially covered in some countries, for example in Japan. As a share of GDP, long-term care spending is above or around the OECD average of 1.5% for this group of countries, apart from Korea (0.3%) and, at the opposite end of the spectrum, the Netherlands (3.5%).

These countries' arrangements share three main features. First, there are *separate* funding channels for LTC and health insurance, although they follow the same social-insurance model. Second, participation in the scheme is *mandatory* for the whole or a large section (*i.e.* those aged 40 and over in Japan) of the population. Third, the scheme is predominantly financed through employment-based, *payroll contributions*, but senior people can also be asked to pay contributions *(e.g.,* all those above 40 years old in Japan; retired people out of their income in Germany) and a share of the cost is funded out of general taxation in most countries. There are some differences in the mix of financing sources, eligibility criteria, and benefit systems of these countries. For example, benefit values are fixed in Germany and were not consistently adjusted for inflation until the LTC reforms in 2008, which had led to a reduction in the purchasing power of LTC benefits until the stepwise increase in 2008. On the other hand, benefits statutory cover 90% of the cost

Table 7.2. **Universal long-term care insurance schemes in OECD countries**

	Year	Insurers/ purchasers	Financing sources	Contributions	Eligibility to benefits	Benefits	Providers
Germany	1995	Long-term care insurance funds	Payroll and income-related contributions (100%)	1.95% payroll tax (additional premium of 0.25% for those with no children Paid by all working-age and retired population Divided between workers and employers 11% of the population opts out of social insurance and is obliged to buy a private LTC plan with equivalent benefits to social LTCI	Based on a need-assessment regardless of age	In-kind or cash, at user's choice Fixed value, adjusted periodically	Providers on contract with the social long-term care insurance funds
Luxembourg	1999	National health fund (*Caisse nationale de santé*)	Taxation (about 45%) Contributions Special tax	Paid by working-age and retired population Contribution set at 1.4% of income	Disabled assessed as needing LTC, regardless of age	In-kind and/or cash, at user's choice	
Netherlands	1968	Regional insurers (private insurance companies)	Payroll and income-related contributions Means-tested co-payments	Contribution rate is based on income Paid by working-age and retired population (all citizens over 15 years old with a taxable income)	Disabled assessed as needing LTC, regardless of age	In-kind (institution, home care) Cash home (personal budgets)	
Japan	2000	Municipalities	Tax (45%) Contributions (45%) Cost sharing (10%)	Paid by over 40 year old population Insured individuals between 40-64 pay 30% of total LTC costs Income-related contributions for those aged over 65 years	Over 65 assessed as needing LTC Over 40 with certain types of diseases	In kind	Competing services providers (private companies, consumers' co-operatives, and NGO) certified by the government
Korea	2008	National health insurance (NHI) corporation	Tax (37%) Payroll contributions (52%) Cost sharing (11%)	Paid by working-age population through contributions to health insurance scheme 2011 NHI contributions set at 5.9% of wages, 6.55% of which goes towards LTC	Over 65 assessed as needing LTC Younger people with geriatric diseases	In-kind or cash	Competing services providers (private companies, NGO, etc.)

Note: Korea: "Long-term Care Insurance for the Elderly" (*Noinjanggiyoyangboheum*); Japan: Caregiving Insurance (*Kaigo Hoken*); Germany's *Pflegeversicherung* ("Care Insurance"); AWBZ (the Netherlands). All countries provide benefits for home and institutional care. Luxembourg and the Netherlands also include home adaptation and assistive devices.

Source: OECD compilation based on country replies to the OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

of care in Japan. In Japan, the scheme is targeted only to the elderly population, while all individuals, irrespective of their age, are entitled to LTC insurance benefits in Germany and the Netherlands (Rothgang, 2010; Schut and van den Berg, 2010; Campbell *et al.*, 2010; Mot, 2010). Korea was the last of this group to implement LTC insurance, in July 2008 (Kwon, 2008; Campbell *et al.*, 2009) (see also Table 7.2).

Personal care through the health system

A third model is based on the coverage of long-term care cost entirely through the health system. In this model, not only skilled nursing care, but also help with daily activities (dressing, eating, washing, etc.) are financed within the universal public health system. Long-term care is hence viewed as a health risk, and institutional arrangements reflect a "medical model" of care delivery (as opposed to a social model), with care services being primarily performed by professional nurses. Belgium is an example. Belgium's public health insurance system (INAMI/RIZIV) provides for universal coverage of LTC cost both at homes and in institutions. The reimbursement is subject to a personal contribution (*i.e., ticket modérateur*), with ceilings on out-of-pocket payments (MAF, *maximum à facturer*). To face the non-medical costs of LTC, allowances are granted to low-income elderly people with care needs. Moreover, the local social welfare centre (CPAS) can provide assistance for board and lodging in homes for the elderly or in nursing homes. At the regional level, the Flemish government implemented a compulsory dependence insurance scheme, financed through mandatory yearly contribution of EUR 40 (in 2010) a year from each person aged over 25 years, which provides complementary cash benefits. LTC spending as a share of GDP accounts for 2% in Belgium.

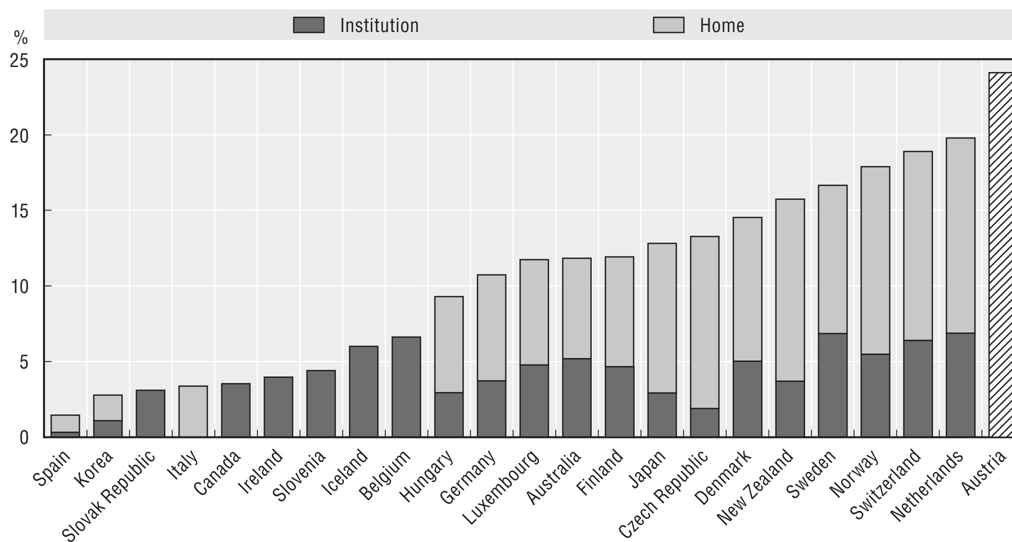
Assessing universal coverage within a single programme

Single-programme universal arrangements are good in ensuring wide access to LTC services. They are typically comprehensive in relation to both the share of the cost publicly reimbursed, the number of people using care at home and in institutions (Figure 7.1), and the spectrum of services covered in institutional and home settings. In some cases, coverage also includes the cost of support/domestic care, home adaptations and assistive devices *(e.g.,* some Nordic countries). These systems do not discriminate access based on income or assets of users (or that of their families), although these may be taken into account to determine individual cost sharing up to a ceiling *(e.g.,* Norway, Sweden, the Netherlands, see also Box 7.1 later in this chapter) and there are significant differences across countries in the extent of out-of-pocket cost borne by users – from 4% of total LTC cost in Sweden to a third of total LTC cost in Korea. Often, care provision by nurses or caregivers is regulated to ensure minimum standards for the care purchased through public funds *(e.g.,* Japan, Belgium). In addition, the separation between health and long-term care budgets in all these countries but Belgium, generally reduces utilisation of more expensive health care services and professionals *(e.g.,* hospital care, doctors) for long-term care needs, for example by making "social hospitalisation" of frail people with LTC needs more difficult.

While universal LTC coverage can be achieve through different financing models, there can be advantages in having "dedicated" financing channels for LTC as in the case of social LTC insurance in Germany, Japan, Korea, Luxembourg and the Netherlands. It can ensure a reliable and predictable source of revenue streams, relative to non-earmarked taxation; it can also create a sense of entitlement for people, raising their willingness to pay for such an entitlement.

Figure 7.1. **Users of LTC services vary significantly across the OECD**

Older recipients of long-term care services as a share of the over 65 population, 2008



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

Source: *OECD Health Data 2010.*

StatLink http://dx.doi.org/10.1787/888932401577

On the down-side, these systems generally cost a larger share of national income and domestic budgets than the OECD average – typically above the OECD average of 1.5% of GDP, up to 3.6% of GDP in Sweden, in line with the relatively larger share of people eligible to care supports, the range of services covered and the relatively higher reimbursement rates compared with other systems. While comprehensive single-programme systems may still have incentives or mechanisms to support family carers, most such carers provide less intensive care in these countries. The separation of health and long-term care budgets may jeopardise the continuum of care and lead to cost-shifting incentives between different providers and require efforts to ensure co-ordination. Dedicated financing has cons, too, including the potential rigidities it can introduce in the way expenditures are allocated.

Mixed systems

Under mixed systems, LTC coverage is provided through a mix of different universal programmes and benefits operating alongside, or a mix of universal and means-tested LTC entitlements. Many of the countries in this group do not have a comprehensive single-programme LTC system, rather have multiple LTC benefits, programmes, or entitlements, depending on target groups, specific LTC cost component or setting covered, and, in some cases, jurisdiction. Some countries have cash-benefit systems in lieu of, or in addition to, in-kind services.

It is difficult to give a proper account of the variety and complexity of institutional arrangements belonging to this group. Nevertheless, one possible way to group countries – in decreasing order of universality of the LTC benefits – is the following: *i)* parallel universal schemes; *ii)* income-related universal benefits or subsidy; *iii)* mix of universal and means-tested (or no) benefits.

Parallel universal schemes

Parallel universal schemes rely on different coexisting coverage schemes, each providing universal coverage for a different type of care. Typically, universal nursing care is financed through the health system, while universal personal care is through a separate scheme.

Scotland is an example. Since 2002, all the counties of the United Kingdom have supported free skilled nursing care (*i.e.,* the health component of LTC) for older people at the point of use. In addition, under the 2002 Scottish Health and Community Care Act, personal care (*i.e.,* ADL support) for older people, which is part of the social-care system, is free in both institutions and at home (Bell and Bowes, 2007; Bell *et al.*, 2007). Care is funded by the local authorities and is subject to an assessment of care needs, but it is irrespective of users' means. The system covers help with ADL, but it does not pay for accommodation costs in a nursing home, for which individuals are charged a fee.

Another example comes from some Southern and Eastern European Countries, which combine universal access to nursing homes (subject to available beds) or to skilled nursing care (often via the health systems), with universal, non income-related cash allowances to cover care cost, typically at home.

In Italy, specialised nursing homes for elderly and handicapped people *(e.g.,* the *Residenze sanitarie assistenziali*) are part of the health system or receive a subsidy out of the health budget, while responsibilities for home care are shared between the health and social system. About half of total LTC spending consists of a care allowance covering a fraction of the cost incurred by users ("*indennita' di accompagnamento*", amounting to EUR 472 a month in 2009), which is often used to pay a formal LTC worker or a family carer (IRCCS-INRCA, 2009).

In the Czech Republic, responsibilities for in-kind LTC services are divided across the social sector and the universal health care system, and between different levels of government. As part of the 2007 Act on Social Services, a monthly care need-related cash allowance is granted to all individuals needing care, ranging from EUR 79 per month for those in the lowest category (slight dependency) to EUR 471 per month for those in the highest category. In Poland, a non means-tested national nursing allowance and supplement is granted to disabled children and seniors, while home-help services are the responsibility of local governments. Despite universal entitlement to LTC-related benefits, there is still significant need covered by family carers.

Income-related universal benefits

A second sub-group of countries has *income-related universal benefits or subsidies (e.g.,* Ireland, Australia, Austria and France). In these countries, all those assessed as eligible on care-need grounds receive a public benefit, but the amount is adjusted to recipient's income and the adjustment can be very steep. There can also be additional benefits covered through the health systems *(e.g.,* nursing care in France) or by local governments *(e.g.,* in Austria and Australia).

Countries in this group have opted for a universal personal-care benefit but adjust the benefit amount to reflect the income of recipients. This approach works by progressively increasing the share of the cost paid for by the public system as the income of the recipient decreases. It is sometimes referred to as "tailored" or "progressive universalism" (Fernandez *et al.*, 2009) and it is not intended to cover the full – or nearly full – cost of personal care. In the case of France, the recipient is required to complement public funding with a personal

contribution, as a condition for receiving the public personal-care subsidy. Often, this *tailored benefit* applies to one care component *(e.g.,* home care; personal care), but different arrangements can apply for another components of the total LTC needed by the user. As in the previous group, this approach includes countries with both in-kind LTC services *(e.g.,* Australia), and cash allowances *(e.g.,* France).

Since the commencement of the *Nursing Homes Support Scheme, A Fair Deal of Ireland* in October 2009, all those with care needs are eligible to personal care in institutions, but everyone is required to contribute 80% of their assessable income and 5% of the value of any assets towards the cost of care (see also Box 7.1). In the case of long-term community services, eligibility is universal, although access is limited by resources and can result in targeting of services.

This is similar to the Australian approach. The majority of LTC cost (0.8% of GDP in 2009) is paid for by the government through consolidated, tax-based revenues (Ergan and Paulucci, 2010). Personal care is not free, however all individuals eligible to long-term care services through a care-need assessment process are entitled to a publicly funded subsidy. Recipients of residential and community aged-care services usually make a financial contribution to the cost of their personal care, whose amount is adjusted to user's income. In institutions, residents contribute to personal care cost via basic daily fees, income-tested fees, and fees for additional services, while the government subsidy accounts for about 70% (Productivity Commission, 2010).

Some European countries provide income-adjusted universal cash benefits or allowances to cover personal care cost. Austria has a mix of universal and income-related allowances, and in-kind benefits.[6] A universal cash allowance (*Pflegegeld*), co-financed through federal, Länder and municipality contributions, was introduced in 1993. It is provided regardless of income and assets, and its amount varies with the level of dependency, from EUR 154 to EUR 1 656 in 2010. Approximately 59% of those aged over 80 years and 9% of the 60-80 year old population receive Pflegegeld (Austrian Federal Ministry of Social Affairs and Consumer Protection, 2008). In 2007, a new income-tested grant for the most disabled recipients (so-called 24-hour care benefit) was implemented to complement the universal cash allowance. The two allowances do not cover the full cost of care and, for people unable to meet the remaining cost out of their pocket, public assistance organised by Länder comes into play. A key objective of Austrian LTC arrangements is to help individuals remain at home and live independent lives as long as possible. Another main goal is to formalise contractual arrangements between the care recipients and the caregiver, including (often undeclared) migrant carers. The law encourages care provided by family by not excluding family caregivers from entering in this kind of formal arrangement.

Another example is France. The health insurance programme (*Sécurité sociale*) pays for the health cost (*tarif de soins*) for all nursing-home stays (access is based on care need). In addition, the *Allocation personnalisée d'autonomie* (APA) is an income and need-adjusted cash benefit available to disabled people aged 60 years or older.[7] The monthly cash allowance varies according to the assessed level of dependence between EUR 530 and EUR 1 235 (April 2010), but depending on their income, beneficiaries are required to forgo a certain percentage of the assessed level of APA, up to a 90% reduction off the assessed floor. As a result, APA pays up to EUR 1 235 for high-need/low-income user, down to EUR 27 for higher-income users. For those living at home, APA provides support towards any expenses

incurred, in line with a personalised support plan identified by a socio-medical team. It can include support for both ADL and IADL services and, in some cases, the employment of a caregiver (except for their spouse or partner). For those living in a nursing home, APA offsets a portion of the personal-care cost while the remaining is paid by the resident (about 33% of the dependence costs on average; Drees, 2008). APA is administered by local departments but it is financed by a mix of local and central-government funding.

Mix of universal and means-tested (or no) benefits

The third sub-group includes countries which have a *mix of universal and means-tested (or no) benefits*. Generally, universal entitlement tends to apply to one or both of the following:

- health-related, *skilled nursing care* (either at home or in institutions) *(e.g.,* Switzerland); and
- nursing and personal care in *home-care settings (e.g.,* New Zealand; some Canadian provinces).

In addition, in countries with limited formal service delivery, universal benefits may apply only to certain services, for example to *institutional care* (subject to available places) as in Greece, or to *cash benefits* (relative to in-kind alternatives) as in Spain.

Switzerland provides universal in-kind nursing care (both at home and in institutions) through mandatory health insurance (LAMal), but there are also means-tested complementary cash benefits towards the cost of personal care within the legal framework of the Law on Invalidity Insurance (LAI) and the Law on Old-age and Survivors' Insurance (LAVS). They include so-called supplementary benefits for old-age and disability, granted to recipients affected by permanent or long-term incapacity. A significant share of personal-care cost remains a responsibility of the users, who pay themselves about 60% of total health-related LTC cost. However, if all cash benefits are considered, the share of personal-care cost which remains the responsibility of the user would amount to around 36%. Disability allowances for retired persons with mild disabilities living at home have been introduced in additional to the allowances for those with middle and heavy disabilities.

In New Zealand, people assessed as needing home-based personal care services are entitled to these services, although, after an income threshold, they need to pay a co-payment. Eligibility to care in institutions is based on both needs and ability to pay. The residential care subsidy (RCS) pays the costs of contracted care (including board and lodging costs) above a maximum income-related co-payment. Around 71% of residential care inhabitants received the RCS in 2008. Since 2005, the New Zealand Government has been phasing out asset tests for determining eligibility for institutional care. This is similar to a general movement in some Canadian provinces/territories to eliminate the use of asset-testing (but not income-testing) for targeting government support to residents living in long-term care facilities.

Most Canadian provinces provide nursing and personal care coverage without charges in home-care settings but have income tests for admission to nursing care facilities. All provinces provide case management *(e.g.,* care assessment and service co-ordination) and nursing care without charge in home-care settings, although some provinces impose service maxima on nursing care. Some provinces provide personal-care coverage *(e.g.,* bathing and grooming), but fees may be imposed for other services such domestic

care, meal preparation and shopping. As to institutional care, income testing is used in most provinces for admission, but there is a movement in many provinces to include public coverage for health-related services such as nursing and rehabilitation.

Another interesting case is Spain. Spain passed new legislation in 2006 introducing a tax-funded National Long-term Care System (Dependency Act, in force since 1 January 2007). The law guarantees a right to long-term care services to all those assessed to require care,[8] subject to an income and asset test. Entitlements to cash and in-kind services are slightly different, with cash allowances being universal, while not all individuals might receive in-kind services. Recipients are expected to pay one third of total costs of services. The system is intended to provide a "formal response" to societal and labour markets changes that are reducing the supply of family care in a context of ageing societies – and of growing need. It is expected to benefit 3% of the Spanish population in the short-term (a comparable percentage to that of some countries with fully universal benefits), and is to be phased in gradually until 2015 (Costa-Font and Garcia Gonzalez, 2007).

Finally, there are countries with less developed formal long-term care provision, which provide universal coverage for institutional care but no coverage for home care. The Greek long-term care system includes the direct provision of social services and care through health insurance funds. In theory, any old person, whether insured or uninsured, has access to long-term care where required by their disability status. There are no institutional discriminations or access restrictions, as long as people are legal residents of the country. On the other hand, there is limited formalised home-care provision in Greece, and no public funding for home care.

Assessing mixed systems

As for systems with single universal coverage, mixed systems generally do not cover long-term care cost in their entirety. Rather, income and, sometimes, assets of the care recipient can be taken into account to determine the subsidy level or the personal contribution to the cost of care (see Box 7.1). Several countries cap the benefit level *(e.g.,* France, Italy, Australia, Spain and the Czech Republic).

The level of the public subsidy relative to total LTC cost varies across the countries in this group. For example, in Spain users pay a third or the total LTC cost. In Australia, around 70% of residential care is covered by the Australian government subsidy, while 16% of the cost of the Community Aged Care Package (CACPs) is paid directly by users (Australia Government Productivity Commission, 2010). In France, APA private contributions represented about 20% of average APA entitlements for those receiving care at home and about 35% for those receiving care in an institution in 2008 (Dress, 2008). This cost is met by a number of different arrangements including funding from social assistance and other income-support mechanisms. In addition, the universal benefit or entitlement may refer to only one component of the care cost *(e.g.,* home care), but not to others *(e.g.,* care in institutions).

Mixed systems provide coverage for at least a share of LTC cost for all people needing care, and, therefore, offer a stable source of support for LTC dependent people. Generally, LTC benefits have been developed in recognition that long-term care can lead to catastrophic cost for users. Providing a universal entitlement is viewed as desirable both for equity reasons and for efficiency reasons – that is to offer insurance especially to those with high LTC need. The number of recipients as a share of the elderly population in this group varies from 1% in Poland to 10% in Switzerland, while *public* LTC spending as a share of GDP is below the OECD average of 1.5%, apart from France where it is above the average.

On the other hand, these systems can still leave a significant share of the cost to be paid out-of-pocket by users and their families. The lack of comprehensive coverage can be a disincentive to the growth of formal care supply in countries with less developed LTC delivery markets, with *de facto* reliance on family carers to shoulder high-intensity care. Where there is fragmentation – across different benefits or entitlements, across services governed by different programmes, across providers financed from different sources, across users entitled to different benefits depending, for example, on their age – there can be incentives for cost-shifting across providers and benefit systems, and it can be more difficult to quantify the overall support received by a user relative to the cost incurred. Some countries have set up mechanisms to facilitate co-ordination and help users navigate through the system, such as France.[9]

Means-tested safety net schemes

Under means-tested schemes, LTC coverage is provided through safety-net programmes. In these countries, income and/or asset tests are used to set thresholds for eligibility to publicly funded personal care. Only those falling below a set threshold are entitled to publicly funded LTC services or benefits, with care being prioritised to those with the highest care needs. This approach offers protection to those individuals otherwise unable to pay for the care themselves. The criteria for eligibility *(e.g.,* personal and/or family income and assets; availability or not of informal care), care-managers' flexibility in assessing needs, and thresholds for eligibility differ markedly and may or not overlap with prevailing social-assistance norms.

The United States belongs to this category. Medicaid – the public programme for the poor – is the chief public funder of long-term care services, paying for 40% of total LTC cost in 2010 (Kaiser Commission, 2010).[10] Medicaid is a social health-insurance programme funded by the federal and state governments, designed as a means-tested programme to assist people with limited income to pay for medical and long-term care expenses. States have mandatory benefits which must be offered, including institutional nursing-facility services, and home health-care services for individuals who are entitled to nursing facility services, but the majority of LTC services are at the discretion of the states, as are income and assets eligibility requirements. Means and asset testing is very strict. Commonly, in order for recipients to receive Medicaid coverage, participants will first have to exhaust personal resources. States may require Medicaid recipients to be responsible for a small co-payment. About 10 million people need long-term care in the United States, of which 3 millions are covered via Medicaid. LTC spending accounted for USD 115 billion in 2008 (Kaiser Commission, 2010), which accounted for around 0.8% of GDP.

England is often regarded as a means-tested system. Indeed, current policy discussion about reforming adult care coverage focuses around means-tested arrangements for personal care, although it is fair to say that there are also non means-tested benefits for severely disabled people in the United Kingdom. The Disability Living Allowance and Attendance Allowance are non-contributory, non means-tested and tax-free benefits, the former paid to severely disabled people who make a claim before age 65, the latter paid to those who claim from age 65. Social care is commissioned by local authorities, and is funded from a combination of central taxation, local taxation and user charges. Local authorities decide and set their own budget based on grants made from the central government, most of which are not earmarked. Access to nursing homes is both income- and asset-tested and users are required to deplete assets to be eligible for LTC nursing-

home coverage. Conversely, for home care, eligible users receive an income-tested benefit, which can be granted in the form of a personal budget. As already mentioned, the health component of LTC is also free at the point of use. In 2006-07, slightly over 4% of the elderly lived in an LTC institution (UK Department of Health, 2009). LTC spending was estimated to account for 1.5% of GDP is 2006 (Comas-Herrera *et al.*, 2010).

Coverage of personal-care cost in England has been subject to much discussion and reform proposal over the past few years. The previous Labour government proposed to provide free care at home for vulnerable elderly people. A White Paper released in April 2010 made proposals to extend the coverage of free care for people staying in residential care for more than two years (UK HM Government, 2010). The new (2010) government established the Commission on Funding of Care and Support, which is due to make its recommendations on reform to the adult social care system in July 2011 (Stone and Wood, 2010).

Assessing means-tested safety-net systems

Means-tested arrangements offer a safety net to those individuals that are otherwise unable to pay for the care themselves. Typically, coverage extends to support for daily living activities, but can also include board and lodging in nursing homes to the extent that people are required to deplete their resources before becoming eligible to public support. By targeting public funds to the poor, this approach can be effective at limiting costs, even though the cost per eligible user can be high. But it may also create inequities and incentives to use health care for LTC purposes, particularly where there are universal health-care services and targeted social-care services as in England. Means assessment can also be administratively expensive. These systems can result in unmet needs and leave families above the assets/income threshold vulnerable to high LTC expenditure (Fernandez *et al.*, 2009).

Safety nets face similar challenges to those confronting poverty programmes and social-assistance systems. For example, they can leave elderly and disabled people impoverishing to become eligible for care. Setting thresholds is hard, particularly as it always implies creating a group not poor enough to qualify for public funding, and yet not rich enough to pay for care costs. When people are required to sell their homes and use such proceeds before being eligible to public coverage, the system can be seen as unfair, particularly given older people attachment to their homes. If there are no uniform criteria for eligibly across different jurisdictions, this can also lead to confusion over eligibility for public funding and reduce transparency.

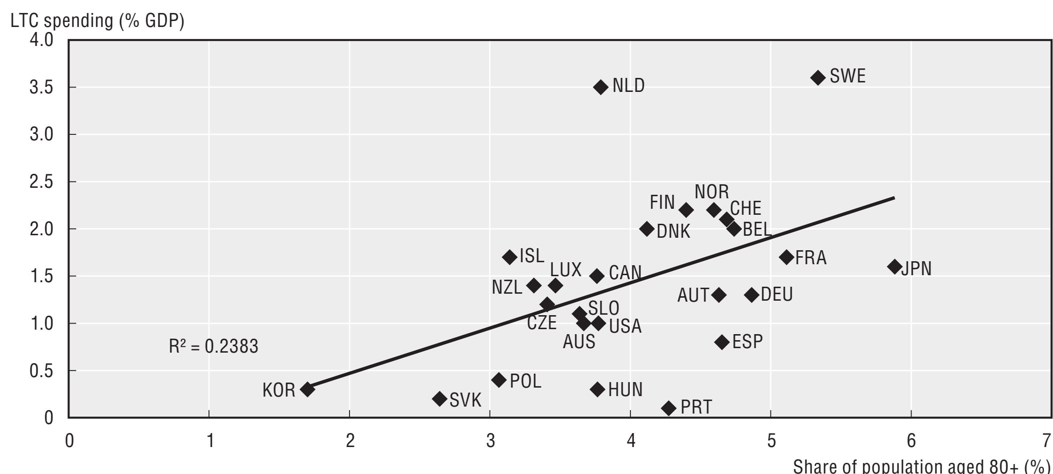
Given that benefit entitlements tend to reach a more limited number of individuals and households, there can be under-funding and under-investment in these programmes. Especially during times of fiscal restraint, they are more vulnerable to budget cuts or cash-constrains. Finally, in light of expected increase in demand for care, the adequacy of such an approach is called into question as many people in need of care are denied access.

7.3. Even within universal systems, the comprehensiveness of coverage can vary significantly

The important variation in the share of GDP that OECD countries devote to long-term care cannot be solely attributed to the fact that some countries are older than others. For instance, the Netherlands and Sweden allocate relatively more resources to LTC than the OECD average and more than could be expected given the share of the elderly population,

Figure 7.2. **Variation in LTC expenditure is not strongly correlated to the share of the population aged over 80**

Share of the population aged over 80 and percentage of GDP spent on LTC in OECD, in 2008 or nearest available year



Note: Data for Denmark and Switzerland refer to 2007; data for Portugal and the Slovak Republic refer to 2006; and data for Australia and Luxembourg refer to 2005. Data include both public and private LTC spending. Expenditure data for Austria, Belgium, Canada, Denmark, Hungary, Iceland, Norway, Portugal, Switzerland and the United States include only LTC nursing care, and therefore exclude social LTC spending.

Source: OECD Social and Demographic Database, 2010, and OECD Health Data 2010.

StatLink http://dx.doi.org/10.1787/888932401596

while Portugal and Hungary allocate less (Figure 7.2). One possible explanation is that the comprehensiveness of a LTC coverage system – that is the extent to which a system finances/protects against LTC need – differs across country.

Assessing the *comprehensiveness* of a LTC coverage system is all but easy. Universality of entitlements to care is but one aspect, which has been used to derive the typology of systems presented earlier. But not all universal LTC systems are comprehensive. For example a significant share of spending is still paid out-of-pocket by users. In Switzerland, nearly 60% of total LTC spending is privately financed (36% if including cash benefits granted under the Invalidity and Survivors' insurance). In Portugal out-of-pocket LTC financing accounts for 45% total LTC cost, while the corresponding figure for Germany and Spain is around 30% of total LTC cost (OECD, 2000) (Figure 7.3). In the United States, out-of-pocket spending represents 22% of LTC cost (Kaiser Commission, 2010).

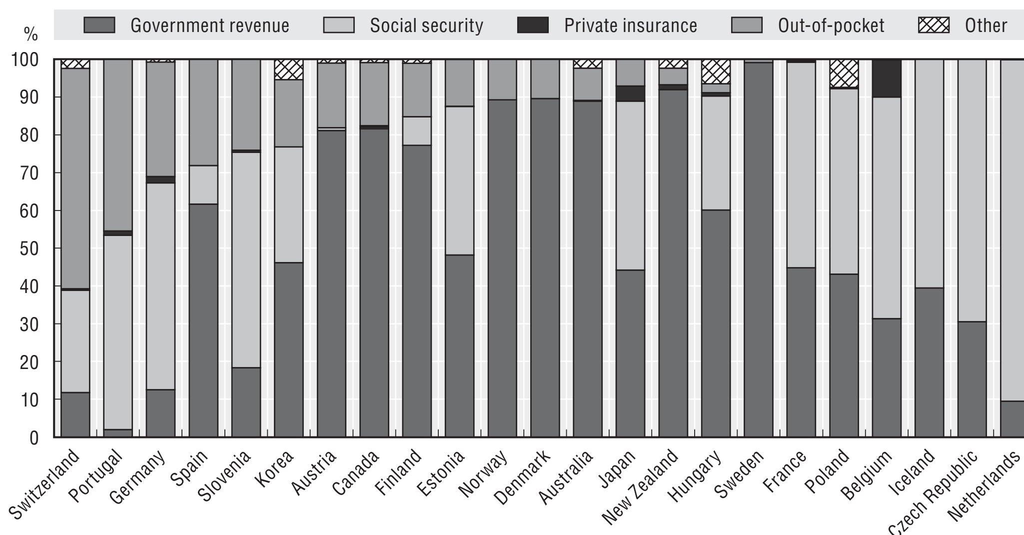
Eligibility rules – whether a system is universal or means-tested – are but one dimension to assess comprehensiveness of LTC coverage. In fact, three dimensions can be identified:

- *eligibility rules* – universal *versus* means-tested systems;
- the *basket of services* covered (breadth of coverage); and
- the extent of *private cost sharing* on public coverage (depth of coverage).

All countries have *eligibility rules* setting the care-dependency status and, in means-tested system, the income/assets levels triggering eligibility to public LTC support. Eligibility to care and the level of public support is determined on the basis of a care-need assessment based on physical and/or cognitive limitations (Table 7.3). Need assessment helps governments target care needs, and can follow more or less stringent rules depending on the country. While many of the functional capacities which are measured are similar, assessment systems and dependency levels on which eligibility is determined are not uniform across countries and, in

Figure 7.3. **Long-term care expenditures by sources of funding, 2007**

Countries ranked by decreasing share of out-of-pocket spending



Note: Data on out-of-pocket spending for some of the countries are underestimated. For example, in the Netherlands, cost sharing on long-term care services is estimated to account for 8% of the total LTC expenditure. The share of out-of-pocket spending for Switzerland is overestimated as cash benefits granted for care in care facilities are not considered.

Source: OECD Health System Accounts Database, 2010.

StatLink http://dx.doi.org/10.1787/888932401615

some cases, can vary across sub-national jurisdictions. For example, Germany provides public benefits to 10.5% of its seniors, whereas Japan provides public benefits to 13.5% of its population aged over 65 years (Campbell *et al.*, 2009). Health and/or social-care professionals are involved in the assessment process, although a medical doctor is involved in only a few countries, for example Belgium and France. For eligible people, the benefit amount is typically adjusted to need. An income and/or asset test may also be carried out to determine user cost sharing or the amount of the public subsidy (see below).

A number of countries – including the United States for Medicare and Medicaid, Canada for Chronic Care Funding (Ontario), parts of Switzerland, Iceland, Spain, Italy, and Finland – employ the International Resident Assessment Instrument (InterRAI) for assessing care needs and better target care support. InterRAI consists of a range of standardised assessment instruments that apply to different care settings such as residential care (RAI-LTCF), home care (RAI-HC), palliative care (RAI-PC) and mental health (RAI-MH). All InterRAI instruments include a comprehensive set of core-assessment items *(e.g.,* physical functions, locomotion, cognition, pain, relevant clinical complexity) that can be consistently used across care settings. To ensure consistency, each instrument is supported by a training and reference manual. The use of InterRAI can support efforts to ensure a continuum of care and better co-ordination through an integrated health information system. It can also play a complementary role in monitoring quality and care outcomes.

In terms of the second element – the *breadth of coverage* – LTC comprises multiple services (skilled nursing care, social work, personal care, medical equipment and technologies, therapies), delivered by different providers (nurses, low-skilled carers, allied health professionals) in a mix of settings (home, institutional, community care). While the

Table 7.3. **Long-term care need assessment process in selected OECD countries**

	Who can apply for care?	What is the assessment process?			Who is entitled to care?	
	Thresholds for eligibility to care	Assessment tool	Criteria and range	Assessor and process	Care categories assigned following assessment	Eligible users
Australia	Old people	For residential care: Aged Care Funding Instrument (ACFI)	12 care need questions Diagnostic information about mental and behavioural disorders and other medical conditions is also collected	Aged care homes	Three need categories in activities of daily living (ADLs), behaviour, and complex health care	
Belgium	All ages (assessment for cash allowance)	APA-THAB Guidelines used to guide doctors assessment	ADL and risk awareness	Examination by a federal-government service doctor	Points are allotted based in the assessment	Based on the number of points allocated
	All ages (assessment for nursing care)	Standardised assessment tool and scale (KATZ) for care in nursing homes or home care	Assessment of six capabilities on a four-scale range and assessment of cognitive status	Examination by the nurse of the patient (+ public control by doctor)	Four to five need categories (home care/institutional care)	
Czech Republic	All ages	Defined in the law for the whole country	A 36 ADL/IADL checklist divides people into four groups, according to the number of "disability" points. Children need fewer points in order to qualify	Medical examination and social worker assessment of 36 ADL/IADL limitations	Four levels	Level 1: More than 12 points Level 2: More than 18 points Level 3: More than 24 points Level 4: More than 30 points
France	People older than 60 years of age (for APA)	Standardised assessment tool (AGGIR – *Autonomie gérontologie groupes iso-ressources*)	ADL limitations Assessment of ten capabilities on a three-range scale	Socio-medical team carries the assessment Nationally standardised computer programme compiles the scores	Users assigned to six categories of care need	First four of six AGGIR categories APA benefits are based also on applicants income
	Younger disabled people (*Prestation de compensation du handicap*, PCH)	Standardised assessment tool (GEVA, *Guide d'évaluation des besoins de compensation des personnes handicapées*)	Personalised plan	GEVA does not aim at grouping individuals in broad care categories; the assessment is individualised		All those with an handicap
Germany	All ages	Estimation of specific time of care-assistance needed, based on a pre-defined scale of time required for each ADL	ADL limitations 20-25 minutes to wash entire body, 2-3 minutes for cutting food, 15-20 minutes for eating, and 4-6 minutes to take off clothing from entire body	Local councils responsible for determining care-allocation methods Medical assessment service of the person's sickness fund The assessor may deviate from the table, allowing for some flexibility	N.A.	If s/he needs a minimum of 46 minutes of ADL support (out of 90 minutes) per day

Table 7.3. **Long-term care need assessment process in selected OECD countries** *(cont.)*

	Who can apply for care?	What is the assessment process?			Who is entitled to care?	
	Thresholds for eligibility to care	Assessment tool	Criteria and range	Assessor and process	Care categories assigned following assessment	Eligible users
Japan	Citizens older than 65 years and aged 40-64 years with age-related illnesses (*e.g.* Parkinson's or Alzheimer's and terminal-stage cancer)	A national standardised tool based on a 74-item list is used for the assessment	Physical and mental status of the applicant	Applicants must contact their local municipality where the standardised questionnaire is administered Standardised computer programme assesses replies to questionnaire, complemented by doctor assessment Second stage review by an independent committee made up of local physicians, care managers and the applicant's doctor	Seven levels	The lowest two levels determines eligibility to preventive services The higher five levels eligible to care
Netherlands	All ages	Nationally standard tool created by the Ministry of Health	Psycho-geriatric or physical limitations Limitations assessed on a four-point scale	Independent governmental agency (Centre for Care Assessment, CIZ)	No specific categories; there are four steps to determine eligibly to care	Eligibility takes into account ADL limitations, alternative solutions (rehabilitation or home adaption), and ability of family caregivers to provide support
Sweden	All ages	No formalised measurement tool	N.A.	Professionals employed by the municipality carry out the assessment	No specific categories	Benefits are at the discretion of the assessor
United Kingdom	Older disabled people (social care)	Different tools are available, *e.g.* Resource Allocations Systems (RAS) and Single Assessment Processes (SAP)	National standard care categories based on dependency severity or risk (Fair Access to Care System, FACS)	Local council, the National Health Service (for health-related LTC) and, for working-age and younger people, the social security systems	Four levels of need	Set by local authorities
	Older disabled people (health care)	NHS checklist continuing care NHS decision support tool	11 areas of care Cognition, behaviour, communication, mobility, and continence	A health professional assesses health-care need based on the checklist	Four groups based on case severity	

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing; Ros *et al.* (2010).

typology presented in this chapter has focuses on variation in coverage for personal care, reimbursement arrangements can differ, for example, on the following:

- health/nursing care;
- domestic care, practical help, assistive devices;
- board and lodging costs.

Health/nursing care, requiring medical acts typically provided by nurses (*e.g.,* administering medication and changing dressings), is generally covered under public health-financing arrangements. However, coverage rules may depend on care settings and on which worker is providing the care. For example, coverage is through the health system when nursing care is received jointly with and as part of other medical care, whether in hospitals or at home. When nursing care is received in an LTC institution, coverage systems differ across country. Countries belonging to the "universal coverage within a single programme" group tend to lump this cost together with personal-care cost (but not Japan). Conversely, countries with safety net systems and some of those with mixed systems tend to have separate billing and reimbursement procedures for health-related and personal care-related cost (*e.g.,* France, Belgium, the Czech Republic, United Kingdom, the United States for post-acute care cost). In home settings, coverage is often via the health system when care is provided by a nurse, while it follows the same rules as personal-care coverage when care is provided by a lower-skilled LTC worker.

Domestic care, practical help, such as cleaning and cooking and help with so-called instrumental activities of daily living (IADL) is often not covered by public LTC systems, apart from countries with comprehensive LTC coverage (*e.g.,* some Nordic countries). However, in some countries these services can be included in care plans designed to provide – as a package – the most suitable services for users, for example in Austria, Belgium, or the United Kingdom for home care. Similarly, the provision of equipment, assistive devices and technology is included in home-care coverage packages in some OECD countries, such as Australia, Sweden, Canada, the Czech Republic, Japan[11] and Slovenia.

As to *board and lodging costs* for residents in LTC institutions, these are often not included in public LTC-coverage schemes, apart from low-income people eligible to targeted assistance. Public support towards board and lodging in nursing homes is therefore typically means-tested. Even in countries with very comprehensive universal LTC coverage, significant cost sharing can be required for this cost component. For example, in Norway, municipalities can ask up to 80% of resident income in user cost sharing.

OECD countries can be clustered into three main groups in respect to this component of the LTC cost, on a continuum moving from less to more comprehensive systems (Table 7.4). In safety-net programmes, as already mentioned, users need first to deplete their income and assets before being entitled to care, including coverage in nursing homes. Many OECD

Table 7.4. **Approaches to covering board and lodging cost (B&L) in nursing homes in OECD countries**

Public support for B&L only available for eligible poor		Means-related cost sharing for B&L cost	
B&L cost treated as other LTC cost, as part of safety-net LTC programmes	B&L cost treated separately from other LTC cost, under social assistance	Income-related	Income- and asset-tested
United Kingdom, United States (Medicaid), Slovenia	Germany, Belgium, France, Switzerland, Italy, Poland, Slovakia, Czech Republic, Spain, Portugal, Korea	Norway, Sweden, Netherlands, Finland, some Canadian provinces, New Zealand	Australia, some Canadian provinces, Ireland

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

countries – such as France, Belgium, Germany – consider board and lodging cost separately from personal and nursing care cost, requiring users (or their families) to pay for B&L themselves, unless they benefit from social assistance, targeted housing subsidies or other financial aid. Other countries include B&L as part of LTC coverage, but require income and, in some cases, asset-related contributions from users (*e.g.,* Netherlands, Nordic countries, Australia, New Zealand, Ireland). Last, in Japan, the cost of B&L is decided by contractual arrangements. There is a limit on the payment for low-income earners, making their share a flat fee, with the rest covered by the insurance benefit.

The third element of comprehensiveness – *cost sharing* – shows how deep is the protection of the public LTC scheme against long-term care cost. *All* public-coverage schemes across OECD countries require users to share part of the cost of the personal-care support they are entitled to. But countries differ markedly in method and extent.

Beside mains-tested systems, three main approaches can be identified (Box 7.1). A first one is to set (cap) the public contribution paid by the public system, leaving individuals

Box 7.1. **Cost sharing in OECD countries follow three main approaches**

Approach 1: Means-tested systems: Users have first to exhaust their means

Slovenia: For social care services, care recipients are required to cover the full costs. Exemption from payment is possible in exceptional financial circumstances and after a means test of household income. In such cases, the municipality will take responsibility for all charges.

United Kingdom: The national system of private contributions for residential care is means-tested such that an individual with over GBP 23 250 in savings are ineligible for public support with long-term care costs in a care home and must cover all care charges themselves. Individuals with less than GBP 23 250 are still expected to contribute to care costs but will receive some support from local authorities. Individuals with less than GBP 14 250 will have all their residential care costs paid for them by the state.

United States: Medicaid LTC services do not require user fees, but there are income and asset rules for eligiblity to Medicaid benefits.

Approach 2: Defined public contributions, cost sharing as residual

Australia: Institutional residents are asked to pay a basic daily fee towards accommodation costs and living expenses (*e.g.,* meals or heating and cooling). Maximum charges are regulated and set using a percentage of the basic single age pension (about 85% and equivalent to about AUD 14 000 a year). In addition, residents pay an additional fee for the care they receive, of up to about AUD 22 700 a year. The fee is income-tested such that residents with income less than about AUD 21 500 a year and assets less than AUD 37 500 do not have to pay it.

Austria: Those dependent on help with daily living activities are entitled to a needs-based universal cash benefit. The government can provide up to EUR 1 655 per month to the recipient. In 2007, a new income-tested benefit (so-called 24 hour care benefit) was implemented to complement the universal cash allowance.

France: In France, APA benefits are subject to national ceilings and the level of benefits is set to decrease as a proportion of income. Income includes a share of the imputed rent of non-financial income (*e.g.,* secondary residence) but does not include the imputed rent associated with a principal residence.

Box 7.1. **Cost sharing in OECD countries follow three main approaches** *(cont.)*

Germany: Cost sharing applies when the costs of LTC services go beyond the fixed public benefits. The family is obliged to help cover LTC costs that exceed statutory public benefits. For residential care, care recipients are liable for the costs of lodging and meals. In the event that care recipients are unable to cover LTC costs, social assistance may be available after an assessment of income, wealth and social circumstances.

Approach 3: Flat-rate cost sharing

Japan: User payments are set at 10% under of public LTC social insurance system and levied on all publically funded LTC services with the exception of LTC prevention services.

Korea: Under the national LTC insurance system, beneficiaries must pay 20% of total costs in institutional care and 15% of total cost for home-care services. Based on a means test on household income and assets, low-income recipients may pay half of the standard personal contribution rates. Social-assistance recipients are exempt from cost sharing.

Belgium: Private cost sharing for personal-care cost follows the same rules as for health insurance coverage. Payments for social care services received at home will vary according to eligibility for disability, and on income.

Approach 4: Income and/or assets-related benefits

Canada: In a number of provinces (British Columbia, Saskatchewan, Manitoba and Ontario), the level of co-payment for residential care services is set at different monthly rates according to one's income. In a number of provinces (Atlantic provinces) residents must pay the full cost of a nursing home, typically equivalent to board and lodging, unless their income is deemed not sufficient to pay for it.

Czech Republic: The level of cost sharing depends on the sector of provision of long-term care. In healthcare facilities, cost sharing consists only of the user charge for every day of hospitalisation (EUR 1.2 a day). In the social sector, the provider can charge up to 85% of the income (*e.g.* pension) of the client. There is no income testing or means testing to determine eligibility.

Finland: In home care, private contributions are set according to the amount of care needed and on the income of the care recipient and other household members, and cover about 15% of the total costs. In long-term institutional care, personal contributions are set at 85% of the recipient's net income. For institutions providing care to the elderly, user charges represent close to 20% of the total costs.

Hungary: Cost sharing is applicable to healthcare as well as chronic hospital treatment, social institutional care for the elderly and social support for IADL. Personal contributions are determined according to household income and the social situation of the care recipient. For institutional care, contributions cannot exceed 80% of a care recipient's total income and contributions for health-related services are fixed daily rates.

Ireland: In the case of institutional care, individuals contribute 80% of their assessable income and 5% of the value of any assets including land and property in excess of EUR 36 000 for an individual or EUR 72 000 for a couple. Assets include, for the first three years (also known as the "three year cap" deferral mechanism), the principal residence. For couples where one spouse continues to reside in the principal residence, the personal contribution of the spouse residing in the nursing home is determined according to half their combined income and assets.

Box 7.1. **Cost sharing in OECD countries follow three main approaches** *(cont.)*

Netherlands: LTC beneficiaries have to pay a fixed rate for each hour of care they receive, up to an income-dependent maximum amount. The minimum co-payment is set at about EUR 140 a month. The maximum amount varies according to the size of the household and to whether the disabled person is older than 65 years of age. As for those receiving care in an institution, two cost-sharing formulas are applicable. Under the low cost-sharing formula (during the first six months) private contribution equals to the lesser of EUR 1 700 or 12.5% of relevant income, up to EUR 9 000 a year. Under the high cost-sharing formula, private contributions can increase up to about EUR 24 000 (Mot, 2010).

New Zealand: Private contributions are determined by a means test, which evaluates income, capital savings and housing equity levels, with maximum annual amounts. A specific financial means test is applicable to persons over 65 years of age for residential care cost sharing.

Norway: Municipalities have the flexibility to set personal contributions consistent within a certain framework. Personal contributions are typically income-related, except for short-term stay in a nursing home, where contributions are set independently from one's income. For long-term stays in a nursing home, personal contributions cannot exceed 80% of a resident's income in excess of a given amount, while for home care, user charges are set so as to leave the recipient with a minimum income for extra expenses.

Poland: A recipient's income level will influence the amount of private contributions required but will not affect the recipient's eligibility for LTC services.

Slovak Republic: Each region has the flexibility to set private contributions which are applicable to all social services except for counselling, social rehabilitation and ergotheraphy. For individuals eligible for public LTC support (those who have less than EUR 39 833 in savings), cost sharing is determined by a means test, which typically considers income, assets and capital savings of the applicant and other household members.

Spain: Private contributions are determined by each autonomous region and differentiated according to care setting and type of service. The extent of cost sharing depends on an assessment of financial capacity which typically considers available capital, the estate of the beneficiary as well as household income. According to an individual's economic capacity, contributions for residential care range from 70 to 90% and 10 to 65% for home help.

Sweden: Municipalities can design cost-sharing structures flexibility, but consistently with some general principals established by the central government: fees should be fair, not exceed production cost and must leave users with a personal allowance (pocket money). As of 2003, central rules provide for maximum personal contribution amounts for both personal services and board and lodging as well as for minimum personal allowance amounts (pocket money). Maximum personal contribution amounts are set to about SEK 1 700 per month (about EUR 175) for personal services and about SEK 1 800 per month (about EUR 180) for board and lodging. Minimum personal expense allowances are set to about SEK 4 800 per month (EUR 490) for singles and SEK 4 050 (about EUR 415 per persons for cohabiting partners (Karlsson and Iversonm, 2010).

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing, and other information collected by the OECD Secretariat.

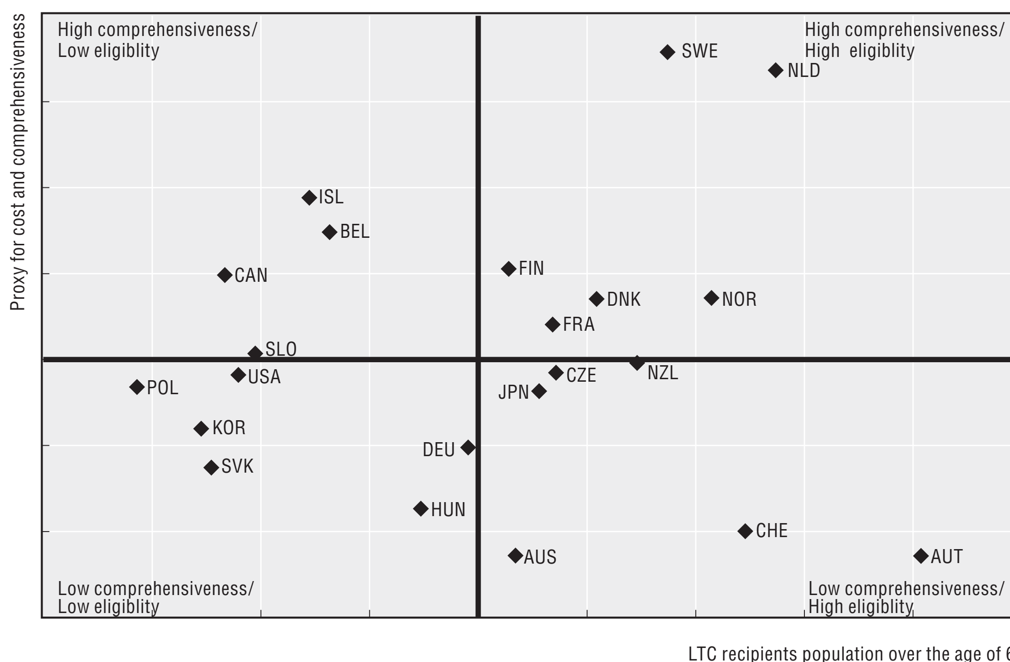
responsible for paying the cost difference between the set public amount and the actual cost of LTC services *(e.g.,* Germany, Czech Republic, France, Italy, Austria). In Germany's LTC insurance one third of all funding is out-of-pocket and several LTC users are on social assurance. Flat cost sharing, where cost sharing is a given percentage of LTC cost, is applied in Belgium, Korea (20% in institutions, 15% at home), and Japan (10% co-payments), with upper ceilings on the user contributions in Belgium and Japan, but not in Korea. Last, private LTC cost sharing can be set according to disposable income and, in some cases, assets of the LTC user, with very diverse approaches regarding maximum amounts taken into consideration to calculate user cost sharing, the income/asset components taken into account, and the proportion of income/assets that cost sharing represent. For example, in Sweden, co-pays are income-relayed with a cap for home help services of EUR 180 per month, while in Ireland (from 2010) individuals contribute 80% of their assessable income and 5% of the value of any assets to nursing-home cost, and in the Netherlands, 9% of AWBZ expenditure is financed from income-related co-payments (with ceiling of EUR 1 800 per month).

As already said, it is difficult to draw a general assessment of systems' comprehensiveness. Despite limits to underreporting of private expenditure data on long-term care, the figures presented in Figure 7.3 gives a broad idea of the extent of private cost sharing for publicly covered long-term care services (depth of coverage), but it provides no indication on the difference in the range of services covered (breadth of services). Another way to look at the issue is shown in Figure 7.4, which represents:

- on the horizontal axis, the probability of an individual aged 65 years old to use LTC, measured as each country' distance from the average share of LTC recipients in the over 65 population;

Figure 7.4. **Comprehensiveness of public LTC coverage across the OECD, 2008**

Share of LTC recipients in the over 65 population (X axis) and LTC spending in GDP (Y axis)



Note: Each country point shows the distance from the average share of LTC recipients in the over 65 population (in X axis) and the distance from the average share of LTC spending in GDP (in Y axis), across the OECD. Spending data are based on both public and private LTC spending. For Austria, Belgium, Canada, Denmark, Hungary, Iceland, Norway, Portugal, Switzerland and the United States, spending data are based on LTC nursing care only.

Source: *OECD Health Data 2010.*

StatLink http://dx.doi.org/10.1787/888932401634

- on the vertical axis, LTC spending relative to GDP, measured as each country' distance from the OECD average, controlling for both the share of the population aged over 65 years using LTC, and for the share of a country's population aged over 65 years.

The horizontal axis can be considered an indication of system eligibility, while the position in the vertical axis can be regarded as an indication of the breadth and the depth of coverage. The position on the vertical axis also reflects differences in the relative high or low cost (unit cost and prices) of care in a country, as well as differences in the relative shares of the population aged under 65 using LTC.

7.4. Different approaches but similar directions: Universalism and choice-based models

The analysis of public LTC financing in OECD countries shows the complexity of existing arrangements. Coverage for long-term care does not follow pure models in many OECD countries. LTC-coverage schemes are the outcome of heterogeneous policy objectives, philosophies and institutional frameworks. Despite this mind-boggling diversity, LTC coverage schemes across the OECD are evolving in some common directions.

Coverage models reflect diverse motivations and institutional settings

OECD countries are at different stages of developing formal LTC delivery, partly because of ageing structures, partly because attitudes towards family responsibilities for caring are not the same, as well as the size of the economy. For example, there is relatively little formal-care supply and use in some low-income OECD countries *(e.g.,* Mexico, Turkey), in central European countries, and in countries with strong family-care tradition *(e.g.,* Mediterranean countries). This affects the development of LTC financing mechanisms (and *vice-versa*), and reflects in LTC spending figures.

Perhaps more than in the case of health care, there is considerable diversity in societies' norms regarding the appropriate balance between individual and collective responsibility for financing the cost of caring for elderly and disabled people. For example, Nordic countries have relatively broad and comprehensive systems with high reliance on public spending. Coverage of LTC can be seen within the context of an encompassing welfare system where the state – rather than the family – has the responsibility for making long-term care services available on a universal basis (Karlsson and Iversen, 2010). But in other countries the issue of LTC coverage is somewhat a "late comer" in welfare-state discussion. A consequence is that not all OECD countries have set up dedicated entitlements[12] for long-term care. This can explain the fragmentation across benefits, programmes, and funding sources for long-term care in some countries. A few OECD countries do not yet regard long-term care as a risk in and on its own. Others, which do, might have limited fiscal margins to play with, especially when "money is tight" as in the aftermath of the recent economic downturn.

There can also be other motivations behind the creation of similar LTC-coverage schemes. In Germany, the set up of LTC insurance in 1995 was partly motivated by limitations of social assistance for covering LTC users – such as the stigma on beneficiaries and growing cost for municipalities (Arntz and Thomsen, 2010). Informal care by family and friends continues to be regarded as an important complement. Indeed, users can choose between receiving benefits in-kind or cash, which can compensate a family carer in Germany. Conversely, a desire not to trap women into caring roles was behind the

establishment of the Japanese LTC system and the choice to provide only in-kind benefits (services) (Campbell and Ikegami, 2000; Campbell *et al.*, 2009). Avoiding expensive, so-called social-hospitalisation of the elderly needing long-term care was another important goal for the creation of a stand-alone LTC insurance system in both Japan and Korea (Kwon, 2008). Expanding coverage to certain services can be a way to stimulate service providers to enter the market, or encourage particular settings. For example, one way to promote home care has been to push for more comprehensive/universal care provided at home *(e.g.,* Canada).

LTC coverage policies are not drawn on white canvas (Ikegami, 2010). Choice of financing sources and systems draws on the existing administrative structure. All countries with social long-term care insurance use similar social-insurance arrangements for health care, and similarly in the case of tax-based LTC coverage models. Different views regarding the nature of long-term care – as being a health or social risk – led countries to set up coverage arrangements that may in part overlap with health coverage, but the health-social boundaries are not uniform across the OECD. For example, nearly all LTC services are regarded as a component of the health system in Belgium, where a majority of care is delivered by nurses. Other OECD countries – such as Australia – regard personal care as entirely within the social sector. In many eastern European countries, support for LTC is largely perceived as a family responsibility, and public coverage approaches are characterised by fragmentation, mirroring the division between the health and social care sectors (Österle, 2010).

Finally, existing institutional arrangements are also reflected in the division of responsibilities among central and local authorities. Typically, local authorities have large autonomy in implementing programmes, assessing need, and delivering services, and often, have co-funding responsibilities. This governance structure has its logic and advantages. It enables services to be organised and delivered close to where the need is, and tailored to communities. It enables flexibility in spending decisions and allows sub-national government units to determine policy trade-offs. On the other hand, where there are no cost-sharing and equalisation arrangements across lower levels of governments, it can create inequities in the treatment of similar needs across different localities.

LTC systems are evolving towards common directions

Despite the diversity of approaches, looking back over time, long-term care systems in OECD countries are evolving in some common directions. The level of public coverage of long-term care cost is increasing in low-coverage or strict-targeting countries, although there is also greater targeting of public funding in the most comprehensive LTC systems. A desire for greater choice and consumer direction underpins recent reforms in a number of countries. LTC expenditure as a share of GDP is growing, and is projected to grow at a higher rate than other fast-growing areas of government, such as health care.[13]

At one end of the spectrum, some means-tested, safety-net approaches have been called into question, mostly on grounds of fairness and growing need. The use of asset testing for accessing a nursing home is being phased out in New Zealand, while Ireland introduced in 2009 a system of "tailored universalism" for coverage of institutional care. In England, despite universal disability benefits, means-tested social care leaves many people above the income eligibility threshold vulnerable to catastrophic LTC spending. A 2010 commission on long-term care will consider new ideas for reforming the LTC funding system, including a voluntary insurance scheme to protect the assets of those going into residential care and partnership schemes with an individual contribution matched by the

public system (Wanless, 2006). The United States is introducing a voluntary publicly-managed LTC insurance programme as part of the new health-care legislation (so-called, Community Living Assistance Services and Supports, CLASS Act).

At the opposite end of the spectrum, in comprehensive universal coverage countries, the range of services eligible for coverage has been subject to scrutiny and increased targeting to those on most severe needs. Sweden has increased targeting of public services to the most sick and disabled (OECD, 2005). France has – at least in the medium-term – set aside discussion of creating a new social-security LTC pillar and is considering, among others, steeper targeting of APA. In the Netherlands, there have been proposals to re-introduce asset tests (Bureau Beleidsonderzoek, 2010). In Austria, the minimum amount of hours of care needed by those with milder disabilities to qualify for the universal cash benefit has been recently raised. In Japan, elderly assessed with the lowest care needs have been moved to a prevention scheme.

These trends result in a certain convergence in the "breadth" of eligible services covered and the "depth" of public coverage across countries. Ultimately, in a context of limited public funding, there can be trade-offs between providing broad eligibility and directing additional resources to those who need it the most, such as those with higher care needs or lower income. This is further examined in Chapter 9.

It is important to note that universal coverage for some share of the LTC cost does not mean that access to care is always provided in a prompt way. Even in universal benefit systems, eligibility can be targeted to those with the highest care needs, relative to those with milder care needs. There can be deviations from the universal model due to shortages of providers in semi-urban and rural areas and of specialised institutions (*e.g.* nursing homes, institutions of rehabilitation). If LTC programmes are funded through fixed budgets or if budgets are constrained *(e.g.,* in lower-income OECD countries), coverage is limited to the services that can be funded, even when there is entitlement to some universal LTC benefit. Waiting lists – especially for access to nursing homes – are a way to match service supply with available resources. This means that there can be de-facto targeting of care based on (implicit or explicit) access and prioritisation rules.

Consumer choice and flexibility is another major goal of modern LTC systems. There is growing demand for better tailored and more responsive care. Within both universal and safety-net systems, several OECD countries have opted for providing LTC benefits in the form of cash entitlements or personal budgets in order to support family care and enhance autonomous choice for users and sometimes countries provide for both in-kind and in-cash benefits leaving users with the choice *(e.g.,* Netherlands, Germany, Eastern European countries, Italy, England) (Da Roit *et al.*, 2007; Glendinning, 2009). In some cases, the provision of a cash benefit is the sole care-coverage entitlement. While some central and eastern European OECD countries are far away from implementing an LTC system with extended coverage for nursing and personal care cost, Hungary, Slovakia, and the Czech Republic have set up cash-for-care schemes which can be used to compensate family carers and pay for a share of LTC cost (Österle, 2010). In Italy, use of the cash-for-care allowance, initially set up to provide income-replacement to disabled people unable to work, has grown to 4% of the population in 2004 (between 6 and 22% of the elderly, depending on the region), and is today the main and most significant source of financial support for elderly in need of long-term care (IRCCS-INRCA, 2009).

These direct payments bring more choice over alternative providers (including, in some cases between formal and informal carers) and can strengthen the role of households in the care-management process (Lundsgaard, 2005). Yet, it can be more difficult to exert control over the way cash benefits are utilised. If the value of benefits is not adjusted for cost inflation, it leads to a real loss in purchasing value of the benefit, exposing recipients to higher out-of-pocket expenses.

Maintaining cost growth within financially and fiscally sustainable limits[14] will be a key goal for the future. As the available pool of informal carers is likely to shrink, much in line with the overall working-age populations, there will be pressure to increase formal provision of LTC in OECD countries. Population ageing is pushing up public LTC expenditure, probably at faster rates than the growth in government revenues. Demands for better quality and responsive care systems are likely to continue. Although some goals of an LTC system such as broad access and ensuring equity can be achieved by expanding the comprehensiveness of coverage arrangements, these can rapidly lead to higher costs, and may have unintended negative impacts on the supply of (already shrinking) family carers. If costs grow more rapidly than the economy, this means that governments will either need to give up on spending in other areas or raise contributions/taxes to pay for higher LTC cost. Alternatively, and especially in the current economic and fiscal environment, governments will need to consider ways to ensure value from LTC spending. This means that private collective financing arrangements could have a role in complementing public coverage, at least in some countries. This also means that reforms in the delivery of long-term care services may need to consider improvements in productivity. These issues will be further discussed in the next chapters.

7.5. Conclusions

The fact that the cost of LTC can be high and an individual's need for LTC is uncertain, indicate the need for a LTC coverage mechanism, such as LTC insurance. LTC coverage pools risks and ensures protection against potentially catastrophic LTC costs. Although LTC involves a complex mix of services, several countries have similar LTC coverage approaches.

In ten OECD countries, LTC coverage is universal within a single programme while, at the opposite side of the spectrum, the United States and England use means-tested schemes. LTC coverage may also be provided through a mix of different universal programmes and benefits operating alongside, or a mix of universal and means-tested entitlements.

Assessing the comprehensiveness of a LTC coverage system is not easy. Several dimensions need to be taken into consideration, the first of which are the eligibility rules. The second dimension is the breadth of coverage, since LTC comprises multiple services, delivered by different providers in a mix of settings. The third dimension is cost sharing, showing the level of protection of the public LTC scheme against LTC costs.

OECD countries are at different stages of developing formal LTC delivery, due to ageing structures, attitudes towards family responsibilities for caring and the size of the economy. Nevertheless, countries are evolving in some common directions. Some means-tested approaches have been called into question, while, in universal systems, the range of services covered has also been subject to scrutiny. Consumer choice and flexibility have become a major goal of modern LTC systems. In the future, maintaining cost growth within financially sustainable limits will be a key goal.

Notes

1. In the past decade, the health component of total long-term care has increased, in per capita terms, at an annual average of over 7% in real terms across 22 OECD countries, compared to an average real per capita health spending growth of slightly over 4%.
2. The source of the information included in this section is the OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing and other articles indicated in text. Country descriptions of LTC systems across the OECD are available at: *www.oecd.org/health/longtermcare*.
3. The classification presented here is not the only possible taxonomy of LTC coverage. For example, Kraus *et al.* (2010) classify 21 European LTC systems according to system characteristics, summarised in the dimensions of organisational depth and financial generosity.
4. The term universal means that all those needing LTC because of their dependency status would receive it, including higher-income groups, although individuals may still be required to pay for a share of the cost.
5. Means-testing refers to assessment of the financial "means" (income and assets) of a person to determine whether the person is eligible for LTC benefits.
6. Cash benefits made up 0.7% of GDP, out of the total expenditure on LTC in 2006 of EUR 3.3 billion, or 1.1% of GDP (BMSK, 2008). In-kind services can be bought, using the *Pflegegeld* to cover costs. According to local Länder arrangements, the beneficiary may opt for benefits in kind if they are better suited for care needs. In-kind nursing home-care benefits provided by Länder often require income and asset-related co-payments, depending on care needs.
7. In 2007, close to 1.1 million individuals received a total EUR 4.5 billion (about 0.25 of GDP) in APA benefits. About 40% of APA beneficiaries were living in institutions.
8. The system is implemented incrementally starting with provisions for those with the severest (degree III) disability from January 2007, with the aim of covering those with milder disabilities by the end of 2014.
9. This is the role of the *Caisse nationale de solidarité pour l'autonomie* in France.
10. Medicare pays for some post-acute care, accounting for 24% of spending. Private LTC insurance pays for 9%.
11. Although there can be differences across municipalities.
12. Such as obligations to provide LTC coverage written into specific laws or Acts (Merlis, 2004).
13. Under basic demographic scenarios, health spending (excluding long-term care) is expected to growth by just over 50% between 200 and 2050, while long-term care spending is expected to grow by 150% (OECD, 2001; and OECD, 2006).
14. See definitions in Chapter 9.

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