World Health Organization
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BETTER POLICIES FOR BETTER LIVES

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Foreword

The Member States of the World Health Organization are obligated to strengthen their financing systems to ensure that all people have access to essential services and are protected against financial hardship in paying for these services. While payment methods have received a great deal of attention among policymakers and practitioners, less attention has been paid to price setting and how it can also contribute to broader system objectives.

This study focuses on financing for long-term care (LTC). LTC involves a range of services including medical and nursing care, personal care services, assistance services and social services that help people live independently or in residential settings when they can no longer carry out routine activities on their own. Governments invest in LTC to provide access to care that older persons need, ensure financial protection against high out-of-pocket spending, and provide a social safety net for those unable to pay for required services.

The objectives of this study are to describe experiences in financing and price setting and how pricing has been used to attain better coverage, quality, financial protection, and outcomes in LTC. Policy choices are critical in how health and social services for older people are delivered, and how the prices of these services are set or negotiated. These choices include the means of defining eligibility for public benefits, the use of means-testing, and the definition of the benefits package. In this context, pricing is not only about covering the costs of service delivery. Pricing is also an important policy tool that provides the right incentives to ensure that budgetary goals are met, to promote quality, to increase equity, and to foster coordination and integration with health services.

This report focuses on high-income countries that are several decades ahead of low- and middle-income countries in investing in formal LTC. Formal LTC has been organized and financed in these settings because of the demand for health and social services appropriate to the needs of older persons and reduced availability of informal caregivers, particularly with reductions in birth rates and greater participation by women in the labour market. As such, experiences in these countries may inform the policy options for other settings. The continued evolution of policies and practices may help other countries that are considering their policy options and how to align LTC with overarching system goals, including access to needed services and financial protection. The importance of reducing pressure on the acute care hospital system may be particularly important where resources are scarce.

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The World Health Organization (WHO) and the Organisation for Economic Co-operation and Development (OECD) have been collaborating since 2014 to study pricing policies. The research was guided by Sarah L. Barber from WHO and Luca Lorenzoni from OECD, who established the scope and framework for the analysis in consultation with global and regional experts. Recognizing that no single model is applicable to all settings, the study aimed to generate best practices and identify areas for future research, particularly in low- and middle-income settings.

The authors of this report are Sarah L Barber, World Health Organization Centre for Health Development, Kobe, Japan; Kees van Gool, Sarah Wise and Michael Woods, Centre for Health Economics Research and Evaluation, University of Technology, Sydney, Australia; Zeynep Or and Anne Penneau, Institut de recherche et documentation en économie de la santé, Paris, France; Ricarda Milstein, Hamburg Center for Health Economics, University of Hamburg, Hamburg, Germany; Naoki Ikegami, Keio University, Tokyo, Japan; Soonman Kwon, School of Public Health, Seoul National University, Seoul, Republic of Korea; Pieter Bakx, Erik Schut and Bram Wouterse, Erasmus School of Health Policy and Management, Erasmus University, Rotterdam, the Netherlands; Manuel Flores, Research Institute for Evaluation and Public Policies, Universitat Internacional de Catalunya, Barcelona, Spain; and, Luca Lorenzoni, Organisation for Economic Co-operation and Development, Paris, France.

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Executive summary

Governments invest in long-term care (LTC) to provide universal access to care that older persons need, ensure financial protection against high out-of-pocket spending, and provide a social safety net for those unable to pay for services. LTC involves a range of services including medical and nursing care, personal care, assistance and social services that help people live independently or in residential settings when they can no longer carry out routine activities on their own. The diversity of health and social care needs results in a wide scope of providers and institutions offering a range of services.

Policy choices are critical in how health and social services for older people are delivered, and how the prices of these services are set or negotiated. These choices include the means of defining eligibility for public benefits, the use of means-testing, and the definition of the benefits package. In this context, pricing is not only about covering the costs of service delivery. Pricing is also an important policy tool that provides the right incentives to ensure that budgetary goals are met, to promote quality, to increase equity, and to foster coordination and integration with health services.

Case studies were carried out in Australia, France, Germany, Japan, the Republic of Korea, the Netherlands, Spain, Sweden, and the United States of America (USA) to examine the organization, financing and price setting for LTC services, and to review experiences in the use of pricing to achieve policy objectives. Most of these countries take a universal approach to LTC coverage with the overall goals of access to required services and financial protection. In the USA, publicly funded LTC operates as a social safety net with targeted eligibility for persons with a low income and high level of need.

Patterns of expenditures on LTC are largely based on supply side factors such as the availability of formal care rather than demand or need. Many countries manage LTC funds separately from general health funding by, for example, creating separate funding streams for LTC (e.g. Australia, France, Germany, Japan, the Republic of Korea, the Netherlands and Spain). Among these countries, Germany, Japan, the Republic of Korea and the Netherlands have dedicated LTC insurance programs.

In recognition of the heterogeneity in health, functional and social care needs across the age spectrum, needs assessments are applied in all countries. Eligibility for care and the level of entitlements are typically established through a graded dependency assessment. Monitoring and evaluation of needs assessments are not routinely done to inform whether unmet needs result from the different ways of defining eligibility. In addition, most of the countries in this study apply means-testing to determine the level of government subsidies or user co-payments. In some settings, individual co-payments for needed care are significant.

The fragmented nature of LTC organization and funding is reflected in differences in mechanisms used to set prices for services, both between and within countries. Prices for LTC services in the countries described in this paper are mostly set unilaterally by the purchaser or through collective negotiations between purchasers and providers. These methods have the potential to reduce price discrimination in LTC services and promote affordability for the public payer in comparison with a system where prices are entirely determined through market-based mechanisms. However, such advantages may be offset where there are differences in the level of administration and local authorities set prices depending on the availability of resources. For example, subnational governments in France, Spain and Sweden play an important role in price setting by the public payer for LTC personal and social care services for older persons, resulting in substantial price variation within country that does not necessarily reflect differences in the costs of production or local wages. For residential care, most countries differentiate prices among care services (such as nursing) from living services (such as meals and accommodation).

Price adjustments and add-on payments are made in several countries to promote equity in access and resource allocation. Such adjustments are done mainly to address variations in the cost of providing care by geographical location or by older persons' characteristics. Pricing and payment systems have important consequences for ensuring optimal resource allocation (allocative efficiency), particularly given the need for a high level of coordination between health and social services, and the more substantial financial risk associated with the provision of institutional care versus home care. For example, home care may be managed at the municipal level to adapt care plans to local and individual circumstances. At the same time, institutional care may be managed by the national government given that the national level may be better able to bear the substantial financial risk of this type of care. This has implications for the way price setting and regulations could be used to optimize resource allocation between those settings.

Few countries take into account differences in quality in their pricing and payment systems because of the lack of data, heterogeneity in relevant outcomes, and difficulty in measuring and monitoring quality in LTC - particularly given the range of settings where LTC services are provided from institutions to home care. Most of the countries in this study release information publicly about the quality and prices of services to promote trust and transparency. However, evidence is lacking about the impact of price and quality transparency on choice of provider and the incentives for efficiency and quality improvement.

The following lessons learned may be applicable to other countries.

- **Public investments in formal LTC systems are important because of population ageing and declines in the availability of family caregivers, many of whom are women.** At the individual level, it is impossible to plan for how much money is needed to pay for LTC. Providing older persons with services that support their ongoing health and social needs can help maintain their functional independence and quality of life. It may also reduce demand for more expensive hospital care. Adequate pricing of LTC contributes greatly to ensuring an appropriate allocation of the public budget and thus to achieve this goal.
- **The overall objectives of a given LTC system will have an influence on how care is organized and financed in that system.** The level of financial protection and LTC coverage for service needs depends on the stringency of eligibility criteria, how financing arrangements are set, and the pricing of services.
- **A separate funding stream may help ensure that LTC funding is not diverted to other purposes**, promotes transparency in management, and enables policies specific to the LTC sector to be implemented when they may not be applicable for health services (for example, eligibility testing). However, the separation of funding for LTC and health care may pose problems in coordination across health and social care.
- **Funding to LTC should be linked with need and the care provided.** Objective needs assessments to determine eligibility and benefits have been used to link prices and payments with health and social care needs. Transparent needs assessment mechanisms ensure that people understand their right to care and can access the care that they need.
- **Where cost control is the primary objective and eligibility criteria are stringent, unmet needs may emerge.** Therefore, needs assessment systems should be monitored to ensure that they enable access to needed care. Similarly, systems of user charges should be formally evaluated as to whether their application results in reduced utilization and unmet need.
- **Funding to LTC should be based on a secure reliable source that reduces any regional inequities in resources available.** Policy initiatives are important to reduce fragmentation of services and financing arrangements, and encourage coordination among different services and across different levels of government (i.e. municipal, regional and national).

- **Price adjustments and add-on payments could be used more broadly to foster equity in provider payment.** Such policy uses are particularly important to address variations in the costs of providing care by geographical location or by older persons' characteristics.
- **Quality measurement in LTC is an important area requiring further policy development, which can be linked to price levels and payment mechanisms.** Evaluation of the impact of publicly released information about quality and prices could usefully inform efforts to improve relevant outcomes.

1
Justification for the study

Governments invest in health and social long-term care (LTC) to provide universal access to care for older persons, ensure financial protection, and provide a social safety net for those unable to pay for needed care. LTC includes medical or nursing care, personal care services, assistance services and social care services. This study focuses on LTC to meet the health and social needs of older persons.

Profound shifts in population ageing and fertility decline require changes in how countries organize and pay for the care of older people. In many countries, families and communities deliver most LTC. However, as populations age, countries face reductions in the supply of informal caregivers and seek alternatives in managing chronic and social needs. Where the provision of social care (personal and assistive services) is not formalized, there is greater pressure on the health system to meet these needs. Governments have therefore invested in LTC to ensure access to needed services, protection against high out-of-pocket spending, as well as to reduce the pressure on health systems and hospital services.

1.1 The scope of LTC

LTC involves a range of services including medical and nursing care, personal care services, assistance services and social services that help people live either independently or in residential settings when they can no longer carry out routine activities on their own. LTC services are considered part of the health or the social care system (Barber, Ong and Han 2020). Typically, LTC includes four main components: medical or nursing care, personal care services, assistance services and social care services (OECD, Eurostat and WHO 2011):

Medical and/or nursing care includes the management of symptoms involving medical and nursing care services, and emotional support to older people and their family members. Such care may include preventive services, chronic disease management; rehabilitation; care to maintain functionality; and care when functionality can no longer be fully maintained or rehabilitated. It may also include palliative and end-of-life care.

Personal care services are provided in response to limitations in self-care primarily due to frailty, disability and/or illness. These services provide help with activities of daily living (ADL) such as eating, bathing, washing, dressing, toileting, and getting in and out of bed. Most residential care as well as some day-care and home-based services will include personal care services.

Assistance services enable a person to live independently in their homes. They aid with tasks of household management (i.e. instrumental (I)ADL), such as shopping, laundry, vacuuming, cooking and performing housework, managing finances, using the telephone, etc.

Social care services involve community activities and occupational support given on a continuing or recurrent basis to individuals, such as activities whose primary purpose is social and leisure. These services are typically provided by household members, friends, community members, or social welfare and community service organizations.

1.2 The drivers of LTC demand

Profound demographic shifts will require changes in how countries organize and pay for the care of older people. In high-income countries, almost one in ten persons will be 85 years or older by 2100 (UN DESA 2020a). Even relatively young nations will experience a substantial growth in older populations in the coming decades. By 2050, 71% of people 65 years and older will be in middle-income countries (UN DESA 2020a). Fertility declines among women are occurring in every region of the world (UN DESA 2020b). This implies fewer children to care for older members of their household.

Across OECD countries, about three in five caregivers over 50 years of age are women (OECD 2019). The availability of a spouse to provide informal care is associated with lower public expenditure for LTC, and this effect is larger than the effect of the presence of children (Yoo et al. 2004). However, the impact on informal caregivers' health and employment through foregone wages and other opportunity costs can be significant.

One category of LTC is assistance with routine IADL, such as cooking, cleaning, washing, and taking medications. Individuals informally supply much of this kind of LTC to older members of the household and people within their community, and this support enables individuals to live in their own communities and function well. In many countries, the burden of LTC is often on the household members and the community. Older persons may reside with their families and children who provide care, and the government role is limited. However, with economic and demographic changes, declines occur in the supply of informal caregivers, and the extended family, household, and community do not provide the same level of personal and nursing care.

Having a large share of the population at older ages does not necessarily result in higher levels of disability. Populations may be healthy as they age, or they may face higher levels of chronic diseases or disability over time requiring more complex services. Rechel, Jagger and McKee (2020) consider three possible scenarios: an expansion of morbidity in which people spend more years living in poor health as life expectancy increases; compression of morbidity in which longer life expectancy is accompanied by fewer years of disability; and dynamic equilibrium with an increased prevalence of chronic diseases offset by a reduction in their severity. Each of these scenarios has implications for economies, public finance and health and LTC spending.

Moreover, different scenarios can apply to separate population groups even within a given country. For example, in Australia and across OECD European countries (OECD 2017), evidence nationally suggests that a person's lifetime spent in ill health remains relatively constant. However, for those in the lowest socioeconomic areas, there is an expansion of morbidity with a greater proportion of life spent in ill health (AIHW 2020). Indeed, the share of the population requiring LTC is likely to be higher in low-income countries, which is related not to ageing but to the prevalence of chronic conditions in early life that contribute to disability in later life (WHO 2007).

1.3 Why governments should invest in LTC

Public LTC spending is projected to increase gradually over time. According to projections for countries in the European Union, public LTC spending is estimated to increase from 1.6% to 2.2% of GDP between 2016 and 2040 (European Commission, Economic Policy Committee 2018). In Australia, national government expenditure on aged care services accounts for 0.9% of GDP in 2014-15 and is projected to rise to at least 1.7% of GDP by 2054-55 (Commonwealth of Australia 2015). These increases are attributable to population ageing, a decline in informal family caregivers, increased availability and costs of formal LTC, and growing household wealth.

A primary reason that governments have invested in LTC is to reduce health expenditures through substitution. Where no family members are available to provide care, or medical attention is needed, people may be admitted to hospitals or other health institutions. In many settings, governments developed formal LTC programs to substitute hospital care with other less costly services that could better meet the needs of older persons (Costa-Font, Jimenez-Martin and Vilaplana 2018). Similarly, to reduce length of stay among older persons in acute care hospitals, governments have established alternative institutional or community care solutions. In some settings, however, not enough funding for the level of need is provided, and prices may vary at subnational level. Government intervention can foster fair prices to improve equity in access.

Even with the expanded role of government in LTC, family members continue to provide personal and assistance care. With increasing demand to deliver appropriate services to older persons and reduce the pressure on hospital systems, there is a shift toward formal caregiving financed in part or fully by the government. As a result, an increasing proportion of LTC is covered by public financing schemes in high-income countries, in contrast with low- and middle-income countries where needs are also increasing.

LTC markets, like health care markets, face the problems of adverse selection and moral hazard, which leaves a role for the government. Adverse selection occurs because people who have some certainty of using private LTC insurance (LTCI) are the main buyers; moral hazard occurs when there is an additional utilization of LTC services due to the presence of insurance (Konetzka et al. 2019). In addition, many people do not believe that they will need LTC in the future, underestimate the cost, or believe that costs are covered by health insurance programs (Brown and Finkelstein 2011; Norton 2016; Zhou-Richter, Browne and Grundl, 2010). Indeed, while some people never need LTC, others may require intensive support or institutional care, which may exceed their available income or wealth. Using data from the USA, it was estimated that men and women 50 years of age have a 50% and 65% chance, respectively, of needing residential care (Hurd, Michaud and Rohwedder 2013). Given the potentially catastrophic and uncertain costs, pooling risks make the costs more predictable.

Where strong public LTC programs exists, there is weak demand for duplicative private coverage. Other reasons for low demand of private LTCI include perceptions of risk by younger persons of working age and limited ability to estimate LTC dependency (Costa-Font and Courbage 2015; Fernandez et al. 2009). Premiums are usually paid entirely by individuals, not partially or wholly by employers as is the case of health insurance, and those who enroll must continue to pay premiums until they need LTC. Because of these factors, private LTCI markets remain relatively small (Fang 2016) and do not represent a major source of funding for LTC. In the USA, the decline in the private LTC insurance market is also the result of pricing and market instability. Insurers have dramatically increased premiums for policies, both new and in-force, and this has led to much lower demand. Also, the total number of insurers actively selling in the market has dramatically contracted (U.S. Department of Treasury 2020). However, in some countries (i.e. France, USA), individuals do purchase private voluntary insurance to complement or substitute public programs.

1.4 Why price setting is important

Prices are a key component of provider payment systems that create economic signals and incentives and influence the behavior of people that provide the services, those that pay for them, and those people that use them. From a societal perspective, the price is the amount that must be paid to elicit the supply and quality of services that society wishes to have and is willing to pay for. Countries have aligned pricing policies with the broader goals of ensuring financial protection, equitable distribution of resources according to health needs, promotion of quality and public health objectives as well as controlling the growth in health care and LTC expenditures and increase efficiency. Price regulations may help to achieve these

objectives, as it promotes price transparency, setting price ceilings on commercial health plans, and instructing providers on conditions of billing within the legislative framework for the LTC sector. Through price regulation, the government may also set the maximum financial contribution paid by individuals to purchase services.

Price setting and regulation is a key component of strategic purchasing. It is linked with revenue raising, given that ultimately the prices must be in line with the available resources. There are also associations with pooling, e.g. price setting and regulations can be used to harmonize payment methods and rates across different schemes or pools. Price adjustments and add-on payments can be used when prices are set unilaterally or negotiated collectively to ensure that specific services or care for populations in need, particularly where there are additional costs of providing care or it is considered unprofitable. In this manner, pricing can be an important tool in allocating resources to meet public health goals

In the context of LTC, pricing is challenging because of the wide range of providers and institutions established to respond to diverse health and social care needs. Subnational governments in several countries finance and deliver personal and social care, and thus play important roles in price setting for LTC for older persons. Measuring quality in LTC is a long-standing challenge given the diversity of providers and institutions involved in care provision and the heterogeneity in relevant outcomes, which poses difficulties for integrating quality measures into pricing and payment systems.

2
Organization and financing of LTC

LTC is delivered in a variety of contexts, from residential and other institutions to the home and community. In many OECD countries, residential facilities have traditionally been the focus of formal LTC systems. However, residential facilities operate at relatively high cost, face problems with maintaining quality, and there is an increased demand for home-based care. As such, families, governments, and purchasers have sought alternatives to residential facilities that meet the specific health or social needs of older persons at reasonable cost and quality.

This section focuses on the organization and financing of LTC based on the findings from case studies carried out in Australia, France, Germany, Japan, the Republic of Korea, the Netherlands, Spain, Sweden and the United States of America (USA) in 2020. LTC systems can be classified into several approaches and by the level of public and private funding, benefits packages and institutional mechanisms for implementation including pricing and payment systems (Applebaum, Bardo and Robbins 2013; Colombo et al. 2011; Wong 2013). These approaches determine to a large extent the way in which countries fund and determine eligibility for LTC.

2.1 Settings for LTC provision

LTC can be delivered through institutions and facilities, or at home and in the community. Some countries have created facilities according to the level of nursing care required, including residential nursing facilities, residential facilities, and short-term nursing and rehabilitation facilities.

Residential nursing facilities address the needs for people who may require intensive nursing care and assisted living[1]. There are also specialized care units in nursing homes to meet specific patient needs, such as care for people with cognitive decline. Within skilled nursing facilities, care is generally provided for an extended period to individuals requiring ongoing nursing care by licensed nurses that provide nursing and part of personal care.

Residential facilities have also been established for individuals who are no longer able to live or function on their own optimally or safely, but who do not require a high level of medical care and supervision. These facilities also seek to sustain and foster residents' independence for as long as possible. Depending on the facility, they may also provide other types of social support, such as assistance with day-to-day living tasks and assistance toward independent living.

Short-term nursing and rehabilitation facilities, unlike acute hospitals, play a role in inpatient rehabilitation outside hospital settings for older persons and others. Most dedicated rehabilitation facilities provide step-down services, in which older persons can regain strength following a hospital stay and

1 In the USA, assisted living is better categorized as a residential facility rather than a nursing facility.

before they return home. Some facilities also offer step-up services, which aim to provide services that prevent hospital admissions. Typically staffed by skilled professionals, including medical professionals, nurses, and mental health and social workers, rehabilitation facilities offer physical and occupational therapy, with the aim to prevent admission or re-admission to acute care hospitals. As an example, in Spain, skilled nursing facilities offer intermediate socio-health care to patients that are transitioning from an episode of acute hospitalization to their homes or residence.

Home- and community-based rehabilitation services are also offered in some settings. The care model can include health issues; however, rehabilitation facilities primarily focus on promoting independent functioning rather than addressing health problems.

Hospitals provide inpatient long-term nursing and rehabilitative services in some settings to persons requiring convalescence as well as to facilities specializing in the LTC of persons diagnosed with learning difficulties, physical disabilities, chronic illnesses, cognitive impairment, or mental health problems. Subacute care facilities may also be established as step-down facilities after hospital discharge.

In France, LTC departments in hospitals function like a residential nursing facility in a hospital setting, where they attend to the needs of people who require high level of medical attention and support (all age groups). However, the policy in the past two decades has been to shift older people to dedicated residential care facilities outside hospitals. In Australia, public hospitals are the largest providers of end-of-life care. In Japan, 24% of non-psychiatric hospital beds are LTC beds[2]. In Spain, LTC beds represent 9% of total beds in government facilities, which typically offer palliative care either for chronic patients or patients with cancer. In contrast, in the Netherlands, hospitals do not play a major role in LTC provision.

Home care. Shifting LTC provision from institutions towards home-based care has been the focus of LTC policies in developed nations (OECD and European Commission 2013). This trend has been driven by both patient demand and the high cost of LTC institutional care that can fall on both older persons and government. Such care substitutes for LTC provided in institutions and can also enable quicker discharge for hospital inpatients. In addition to medical care, lower-level clinical care, principally provided by nurses (and some allied health), comprises the majority of LTC at home and addresses chronic care needs.

For people with higher care needs in rural and remote areas, particularly those who require a higher level of medical supervision, appropriate and cost-effective home care may be possible with suitable technology and referral systems. Indeed,

2 LTC beds are beds in hospitals – excluding psychiatric beds, infectious disease beds and tuberculosis beds – and medical clinics mainly used for patients requiring LTC.

in the Netherlands, home care is no less expensive in comparison with nursing home care for frail older persons (Bakx et al. 2020). However, it may enable individuals to receive care at home that meets their needs and preferences at a similar cost to institutional care.

2.2 Organization and financing of LTC

Most countries in the study, except for the USA, provide universal access to LTC benefits with the overall objectives of equitable access based on health needs. Personal evaluations of health and functional ability determine eligibility and the level of benefits. The use of both formal and informal care providers is common. Service packages tend to be comprehensive, including a range of home-based and institutional care, personal, assistive and social care. As such, public expenditures on LTC in these countries tends to be relatively high (except for Spain), and patient contributions are modest, primarily covering board and accommodation in institutional care. However, social care services may not be fully covered or adjusted by income where recipients pay a share of the cost through co-payments, savings, or private insurance.

Table 1. The organization of long-term care (LTC) by country and institution

Institution/ program/ financing scheme	Types of services covered	Eligibility	Administration level	Number of users (million)	% of total population
Australia					
Commonwealth Home Support Program (CHSP)	Entry-level home support services mainly covering assistive service, some personal care, and limited clinical care. Services are available on an ongoing or short-term basis and may include day and residential respite services.	Guideline age is adults 65 years and over, 50 and over for Aboriginal and Torres Strait Islander people	National	0.84	3.3
Home care package program (HCP)	A structured, comprehensive package of assistive, personal care and clinical care tailored to meet the needs of older people living at home with more complex needs than the CHSP can support.	Guideline age is adults 65 and over, 50 and over for Aboriginal and Torres Strait Islander people	National	0.14	0.56
Residential care	Residential aged care facilities provide daily living, personal and clinical care and accommodation for those with higher care needs who are no longer able to live at home.	Guideline age is adults 65 and over, 50 and over for Aboriginal and Torres Strait Islander people	National	0.22	0.88

Institution/ program/ financing scheme	Types of services covered	Eligibility	Administration level	Number of users (million)	% of total population
Short-Term Restorative Care Program	Early intervention to reverse or slow functional decline in older people including assistive, personal, clinical and rehabilitative services. The focus of the program is to promote older peoples' independence and to prevent or delay their admission into residential care.	Guideline age is adults 65 and over, 50 years and over for Aboriginal and Torres Strait Islander people.	National	There were 809 people in this program in total in 2019-20	<.01
Transition care Program	Short-term, goal-oriented and therapy-focused services to older people in their own home or residential facility following a hospital stay. It is provided as a package of care that may include physiotherapy, occupational therapy, social work, nursing care and personal care.	Guideline age is adults 65 and over, 50 and over for Aboriginal and Torres Strait Islander people	National	There were 24775 people in this program in total in 2019-20	<.01
France					
Social Health Insurance (SHI)	Skilled nursing facility (SSR) (medical, assistance, personal); residential nursing homes (EHPAD) (medical, nursing); LTC services at home (medical, nursing) (SSIAD); palliative (acute care hospital; at home; mobile teams)	Universal	Central	Total population	100
Allocation personnalisée d'autonomie, APA ("Personal autonomy allowance") (Local authorities and Caisse nationale de solidarité pour l'autonomie)	Residential nursing homes (personal care), day care in residential homes (medical, nursing); LTC services at home	Adults 60 years and older with mid-to high dependency (the first four levels on the national dependency score (GIR))	Local / regional	1.3	1.9
Social allocations for elderly	Allocations in residential nursing homes (accommodation),	Adults 60 years and older, everyone is eligible for tax benefits	Local	0.12	0.2
Tax benefits	LTC services at home; self-employed domestic help	Universal	Central	n.a.	n.a

Institution/ program/ financing scheme	Types of services covered	Eligibility	Administration level	Number of users (million)	% of total population
Germany					
Social Health Insurance (SHI)	Inpatient/hospital care, outpatient care, palliative care, home-based intensive care (medical)	Universal. Mandatory insurance	Federal, state (Länder), individual	73	87.7
Private Health Insurance (PHI)	Inpatient/hospital care, outpatient care, palliative care, home-based intensive care (medical)	Annual gross income > 64.350 per annum, civil servants, self-employed	Federal, state (Länder), individual	8.73	10.5
Mandatory Social Long-term care insurance (LTCI) (statutory)	Home-based care, residential care, day care	Anyone eligible. Needs assessment necessary to receive benefits	Federal, state (Länder), county	4.0	4.8
Mandatory Private Long-term care insurance (LTCI)	Home-based care, residential care, day care	Anyone eligible. Needs assessment necessary to receive benefits	Federal, state (Länder) and county	0.23	0.3
Japan					
Social Health Insurance (SHI)	Hospital care (medical, personal); home-based care (medical);palliative care (medical, personal)	Universal	Central	125 (medical insurance applicants, 2018)	98.6
Long-term care insurance (LTCI)	Nursing facilities (medical, assistance, personal care); residential facilities (assistance, personal); home-based care (assistance, personal), palliative care (assistance)	Adults 65 years and older and those 40-65 years old with age-related conditions	Prefecture, municipal	6.1 (2016)	4.8
Republic of Korea					
Social Health Insurance (SHI)	Hospital care (medical); long-term care hospitals (medical); palliative care (medical, assistance, personal)	Universal	Central	Total population	100
Long-term care Insurance (LTCI)	Nursing facilities (assistance, personal care); residential facilities (assistance and personal); home-based care (medical, assistance, personal)	Universal but more strict for persons <65 years	Central	Total population	100

Institution/ program/ financing scheme	Types of services covered	Eligibility	Administration level	Number of users (million)	% of total population
The Netherlands					
Social LTC insurance	Nursing facilities (medical, assistance, personal); palliative care (medical, assistance, personal) based on eligibility	Universal	Central/ Regional	197 530 people (2019)	1.4
Social health insurance	Home-based care (medical, personal); palliative care (medical, assistance, personal)	Universal	Health insurers	477 200 people 65 + (2019)	13.5% of the population 65 years and over
Social support act	Home-based (assistance); social care in the community	Universal	Municipal	789 750 people 60 + (2019) (540 870 people 75+)	17.9% of the population 60+ (34.7% of those 75+)
Spain					
National LTC system	In kind (prevention, tele-assistance, home care, day/ night centres, residential care), cash (services purchase, informal care, personal assistance)	Anyone eligible	State (auto-nomous communities), municipal	1.12 (December 2019)	2.4
National Health System	Health services (includes hospital care and palliative care)	Universal	State (auto-nomous communi-ties)	Total population	100
Sweden					
Municipal programs	Institutional care, home care, in kind, cash	Anyone eligible	Municipal	236360 users of home health care (65+); 88 044 residential care home residents (65 +) (2018)	2.3 (home health) and 0.9 (residential care)
United States					
Medicaid	Nursing care; residential care settings; home and community-based services	Low-income individuals	State	4.7 million users of LTSS (5.5% of total Medicaid enrollees) (FY 2018)	1.4
Medicare	Skilled nursing facilities	People 65 years and older	Federal	1.6 million (FY 2018)	0.5
Medicare	Home health care	People 65 years and older	Federal	3.4 million (FY 2017)	1.0

Note: In Japan, individuals such as public assistance recipients who do not subscribe to medical insurance are covered by the public assistance system.

Sources: Authors.

Germany, Japan, the Republic of Korea and the Netherlands have established LTCI systems to provide care and determine benefits (Table 1). Compulsory LTCI has been established in Germany, Japan and the Republic of Korea. The Netherlands uses a mix of compulsory LTC and health insurance. Social LTCI pays for care in nursing homes, social health insurance (SHI) pays for nursing and personal care provided at home, and the Social Support Act makes municipalities responsible for organizing and financing assistive and social support for the elderly living in the community.

LTC benefits are financed through taxes in Australia, Spain and Sweden. In France, LTC is funded from SHI and local taxes collected by sub-national government entities (*departments)*.

In contrast, in the USA, LTC operates as a social safety net targeted to people without the ability to pay for needed services; thus, coverage is more limited (Weiner et al. 2020). Public LTC is funded by general tax revenue (national and local) and eligibility and co-payments are based on needs assessments and means-testing. In such a system, the overall objective is poverty alleviation and protection of vulnerable groups. Eligibility for public funding is subject to means-testing and only granted after a person depletes his/her own financial resources and has a high level of disability.

In the USA, LTC is provided as a safety net, and eligibility for benefits is based on income and assets. Some analysts include Medicare as another major public payer of LTC for adults 65 years and older (Colello 2018). Medicare provides universal access to health care for acute medical care, outpatient visits and skilled nursing facilities. While the inclusion of Medicare as a public payer of LTC is debatable, this report, consistent with the approach used by the U.S. Congressional Budget Office, includes Medicare post-acute services (skilled nursing and home health services) as a component of LTC spending. In 1997, the Program of All-Inclusive Care for the Elderly (PACE) was established as a permanent Medicare and Medicaid benefit to help nursing home eligible seniors avoid institutional care by providing them with a mix of coordinated acute and LTC services in the community (MACPAC 2019). PACE is not, however, not universally available. Voluntary private health insurance complements the public programs.

The level of administration varies by country and program. Under Japan's LTCI scheme, municipalities act as the insurers and are responsible for setting municipal budgets as well as premium levels for beneficiaries. In Australia, Germany and the Republic of Korea, the funding of services providing care and support for older persons is primarily the responsibility of the national government; therefore, provision is essentially uniform across the country. In Spain, the regulation of LTC is primarily the responsibility of the national government, whereas the funding comes from a mixture of national and – for a large part - subnational sources.

In France, the government created a new (fifth) branch of social security for LTC funding in August 2020. LTC spending was previously part of the SHI budget and financed by National Objective for Health Insurance Spending. At present, it is covered by a new branch, called "autonomy", which is managed by the National Solidarity Fund for Autonomy. It receives a share of income tax funding from generalized social contribution to finance LTC services that was previously covered by health insurance. Sweden is an example of tax funded LTC services, which are organized and financed by local governments. Municipalities decide on their own tax rates and are responsible for providing "eldercare" services. These activities are also funded to some extent by government grants.

2.3 LTC spending

Total spending on LTC (including both the health and social care components[3],[4]) accounted for 1.5% of GDP on average across OECD countries in 2018 (Figure 1). At 3.9% of GDP, the Netherlands ranks as the highest spender followed by Sweden (3.4%). Both countries offer universal LTC. In those countries, expenditure on LTC was around double the OECD average. As noted in Table 2, out-of-pocket payments as a share of total expenditures on LTC are the lowest in the Netherlands, Sweden and Japan (8% or less).

At the other end of the scale, the Republic of Korea and Spain allocated 1% of their GDP to the delivery of LTC services. Notably, out-of-pocket expenditure as a share of LTC expenditure is highest in the Republic of Korea (31.5%) and relatively low in Spain (16.2%) (Table 2).

On a per capita basis, there is a large variation in spending, with the Netherlands spending US$ 2142 (in purchasing power parities, PPP) per person in 2018, six times the amount spent by Spain (Figure 1). This variation reflects differences in the population structure, the level of LTC investment, and the stage of development of formal LTC systems as opposed to informal arrangements provided by family members or friends.

3 Following the System of Health Accounts (SHA) framework (OECD, Eurostat and WHO 2011), LTC (health) consists of medical and nursing care and personal care services, whereas LTC (social) includes assistance services. Note that social care services are outside the SHA accounting boundaries.

4 From an expenditure tracking perspective (OECD, Eurostat and WHO 2011), LTC services are categorized according to several criteria. Dependent persons must require LTC services on a continued and recurrent basis for an extended period and suffer from chronic conditions with functional or cognitive limitations over an extended time. Moreover, the service is related to LTC dependency status. For example, medical treatment of a common cold will most likely not be related to LTC dependency and would not be classified as LTC. For the purposes of financial reporting, the OECD excludes informal care, because value is based on a transaction in which a service is financially remunerated. However, care allowances to beneficiaries or caregivers are included, as these payments are taken as a proxy for a paid transaction

Table 2. Long-term care (LTC) financing, 2018

Country	Source of funding	Public spending on LTC (% of GDP)	Total spending on LTC (% GDP)	Out-of-pocket spending on LTC (% of total spending on LTC)
Australia	Tax, user payments	Not available	1.4	22.3
France	Tax	1.9	2.4	24.8
Germany	LTCI contributions, taxes, co-payments/out-of-pocket payments	1.5	2.1	23.0
Japan	50% premiums (people >40 years); 50% public (half from central, 25% each from prefectural and municipal governments)	1.8	2.0	8.0
Republic of Korea	LTCI contribution (main), taxes, and copayment.	0.7	1.0	31.5
The Netherlands	Insurance premiums, general taxation, co-payments	3.7	3.9	6.7
Spain	Tax, regional grants	0.8	0.9	16.2
Sweden	84% municipal taxes; 12% national grants	3.2	3.4	6.9
United States	Medicaid: general revenue, state general funds, health care provider taxes levied by the state. Medicare: general revenues, payroll taxes and beneficiary premiums.	Not available	1.6	Not available

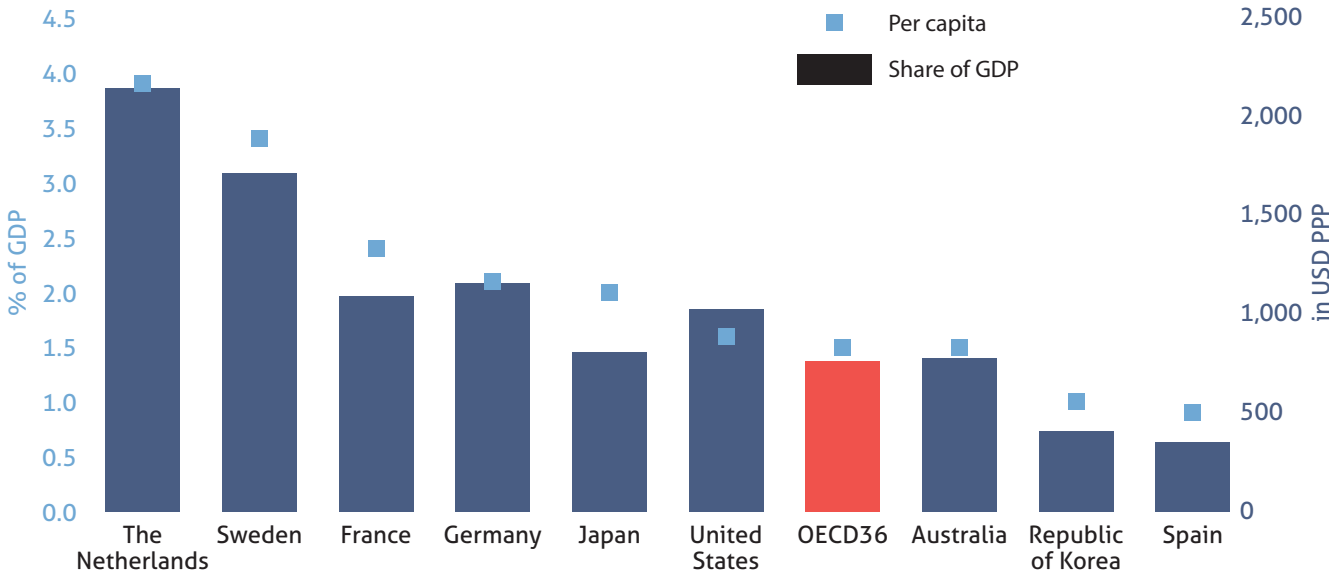
Source: OECD Health Statistics (2021).

Notes: For Australia, figures are estimated from the Aged care snapshot and the Eight report on the funding and financing of the aged care industry (Australian Government). The share of OOP is the proportion of total expenditure that is consumer contributions to the residential, home care and home support programs.

In Australia, accommodation in residential care is paid as a refundable deposit

For the United States, figures are from the National Health Spending Accounts (CMS)
LTCI: Long-term health insurance

Figure 1. Total LTC expenditure (health and social components) as a share of GDP and per capita, selected countries, 2018

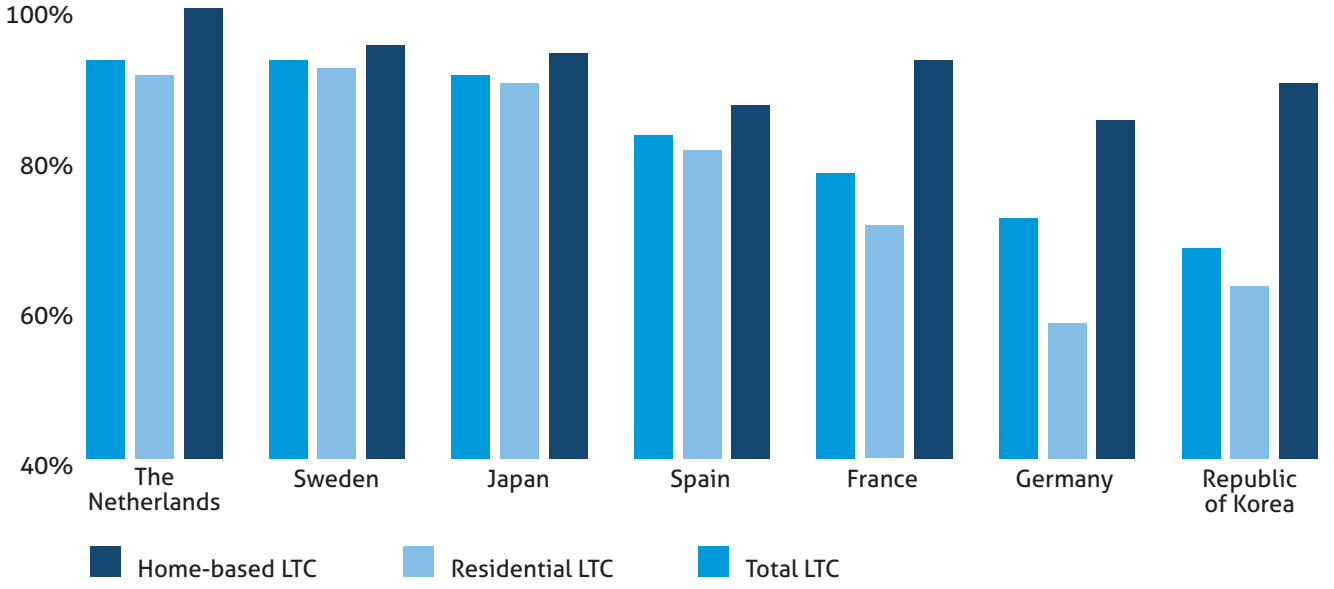


Notes: Germany, Japan and the Republic of Korea do not report social spending.

Source: adapted from OECD (2020).

In countries covered in this study, the costs for the two main modes of provision for LTC – residential care and care provided at home - are covered to a great extent by either a government program or through compulsory insurance (mainly social insurance), with residential care covered less by government or compulsory insurance than home care (Figure 2).

Figure 2. Share of spending for different LTC services financed through public schemes, selected countries, 2018 (or nearest year)



Notes: Germany, Japan and the Republic of Korea do not report social spending.

Source: adapted from OECD (2020).

3 Determining eligibility for public benefits

LTC typically comprises a package of services to individuals with an increased level of dependency on a continued or recurrent basis and over an extended period. The greater the dependency level, the more comprehensive the set of services included in the package. A continuum of care can be tracked from more intensive medical or nursing services through personal care services to assistive services and social care.

Given that the dependency level is a determinant of benefits, needs assessments are applied to restrict or enable access to public benefits and determine the level of services for which beneficiaries are eligible. Needs assessments recognize the heterogeneity in health needs across the spectrum of older persons and identify health needs that trigger government entitlements and services. Some LTC programs also take account financial means, including income and assets, to determine the level of support that they receive.

3.1. Needs assessments

In all the countries studied, needs assessments are conducted to identify eligibility by evaluating health and functional status. Such assessments are administered regardless of whether the LTC approach is universal or functioning as a social safety net; however, the latter programs tend to have stricter needs eligibility criteria because cost control is one objective of the programs. In selected countries, needs assessments are also used to determine whether benefits should be covered under the health insurance or LTCI programs.

In each of the case studies, eligibility is established based on level of complexity of the health condition, physical functioning and medical needs (Table 3). For example, in France, the care package in nursing homes is calculated based on the iso-weighted care group (GPMS) scores, which generate 238 condition-profiles corresponding with the average care needs and dependency level of people living in the facility. The average level of resources required for the 238 profiles was defined by specialists and reported as points per cost item. This instrument uses ten variables measuring physical and mental capacities and seven variables for domestic and social activities (i.e. cooking, household tasks and mobility). For people living at home, medical and social care services are provided and paid for separately.

Eligibility is established through a dependency threshold to identify those persons with care needs. Once need is established, these systems also identify the level of need typically through a graded dependency assessment. In the example of France, the dependency level is determined on the basis of 10 variables concerning physical and mental activity and seven variables related to domestic and social activity, with category 1 being the most dependent and requiring higher levels of care. Similarly, in Germany, evaluations of patient need are based on physical, medical, cognitive and

psychological assessments, and the ability to live independently. These assessments are graded on a scale from 0 to 100, which is divided into five stages of need. The level of benefits received thus depends on the level of need.

Table 3 indicates substantial variation and details in the needs assessments. Clearly defined eligibility criteria can result in greater transparency in resource allocation and ensure that people understand their right to care. In this case, resource allocations are linked to health and social care needs. Governments commonly adjust the price and payment level based on the level of complexity of the health condition, physical functioning, medical needs, and financial means. More detailed and strict criteria may be better for controlling expenditures; however, it is unclear whether there is also an impact on unmet needs, and systematic monitoring and evaluation of needs assessment systems and criteria are lacking.

Table 3. Needs assessments to determine eligibility and funding

Country	Individual needs assessments
Australia	An independent comprehensive assessment is conducted for access to govenrment-subsidised home care, residential care and short-term re-ablement and respite programs. Assessments are conducted in the older person's home environment or in hospital; they test physical and psychological functioning, their physical environment and availability of social support. If the older person is deemed to require residential care, their service provider will conduct a further assessment to determine the level of government subsidy using the Aged Care Funding Instrument. It is based on 12 areas including ADLs; behavioral and cognitive ability; and complex care needs.
France	Personal autonomy allowance (APA) eligibility is defined by the national dependency score (GIR) based on 10 variables of physical and mental activity and seven variables of domestic and social activities of living. Only mid-to high dependency persons are eligible (the first four levels of GIR). Assessment is made by departmental teams. For home-based services, the allocation amount is calculated by multidisciplinary teams of local authorities based on GIR score and the "care plan" that they define. APA amount in nursing homes is calculated according to the average GIR score (GMP) of the facility and the value or price of the GIR point fixed by the local council (Conseil départemental).
Germany	Individuals take a uniform needs-based assessment test, which assigns them to one out of five potential "care stages" (Pflegegrade) ranging from 1 – "little impairment of independence" to 5 – "hardship". The stages define the amount of benefits the individual receives. The assessment is based on six elements: mobility; behaviour and psychological issues; cognitive and communication skills; self-care; coping and dealing independently with illness and treatment-related demands and stresses; planning day-to-day living and maintaining social contact. For people in the statutory LTCI, this assessment is carried out by the Medical Service of the German SHI providers (Medizinischer Dienst der Krankenversicherung). For people in the private LTCI, it's carried out by its counterpart, called MEDICPROOF.
Japan	Based on questions on functional status and mental function. Based on responses, applicants are qualified as either ineligible or assigned to one of the seven levels of eligibility. The final decision is taken by an expert committee.
Republic of Korea	Six levels based on functional status and mental function (grades 1-5 plus cognitive assistant grade) in LTCI

Country	Individual needs assessments
The Netherlands	Social LTC insurance: For nursing homes, independent needs assessment are based on functional limitations requiring permanent supervision or 24-hour access to LTC. For peronal care and nursing, needs assessment by providers are based on functional limitations. For home care assistance, needs assessment by municipalities are based on functional limitations. Moreover, the applicant needs to be ineligible for a nursing home admission. Municipalities may set rules about limiting eligibility for assistance when informal care is available
Spain	Eligibility depends on an assessment of the degree of dependency, evaluated on the basis of the Scale of Dependency. The scale measures limitations with various (I)ADLs. Each single activity receives a specific weight and a coefficient indicating the required level of support and supervision. The final assessment is expressed as a numerical score, from 0 to 100. Individuals with a score below 25 are not entitled to any service or financial benefits from the SAAD. There are three degrees of dependency: Degree I (Moderate Dependency, 25-49 points), Degree II (Severe Dependency, 50-74 points), and Degree III (High dependency, 75-100 points). Responsibility for assessing the degree of dependency and benefit entitlement lies with the regions (ACs).
United States: Medicaid	Functional eligibility for Medicaid-covered LTSS is determined using functional assessment tools. Depending on the state, the entity responsible for conducting the Medicaid eligibility functional assessment may be the state or local health department, an area agency on aging, an aging and disability resource center, or a contracted vendor
	Home health care eligibility determined by several criteria including: being homebound; a physician must certify a patient's eligibility for home health care. For skilled nursing facilities, a preceding hospital stay is required

Sources: BOE (2011), CIZ (2019), Department of Health, Government of Australia (2020), MACPAC (2019), Medicare Payment Advisory Commission (2021), MEDICPROOF (2021), Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen e.V. (MDS), GKV-Spitzenverband (2021), Ministerio de Sanidad, Política Social e Igualdad (2011), Ministry of Health, the Netherlands (2021a, 2021b), Ministry of Health, Republic of France (2021), NHIS (2020).

The entity conducting the assessment may be the service provider (e.g. to assess care needs to determine the level of funding service providers are paid for residential care in Australia), a multidisciplinary team of local authorities (e.g. personal and assistance care in France), the Medical Service of the German SHI providers, an investigator of the municipal government (e.g. Japan), a national government agency (e.g. nursing homes care in the Netherlands and the Long-term Care Bureau of National Health Insurance Services (NHIS) in the Republic of Korea), the regional or local social or health department (Spain), the state or local health department, an area agency on ageing, an ageing and disability resource center, or a contracted vendor (e.g. Medicaid in the USA).

3.2. Means-testing

In countries that offer LTC as a social safety net, means-testing is applied to identify whether people are eligible for benefits based on income and/or assets. This applies to the USA Medicaid program, where federal criteria identify low-income individuals receiving Supplemental Security Income as eligible. Means tested systems may result in significant unmet needs and be perceived as unfair in penalizing those with savings or provide incentives to deplete their assets (Fernandez et al. 2009).

In countries that provide universal access to care based on needs, means testing is used to estimate the users' contribution to the cost of care. In Australia, residents make a means-tested contribution to the cost of their care, and this amount is deducted from the level of subsidy paid by the government. Residents pay a set rate for their basic daily services (set at 85% of the single age pension) as well as fees for any additional services that facilities may offer at market prices. For home care, an income tested care fee is applied as a reduction to the home care subsidy paid by government, with annual and lifetime caps to the out-of-pocket costs paid by individuals.

In France, the amount of the personal allowance for autonomy (*Allocation personnalisée d'autonomie* - APA) paid by the local government to meet personal care and assistance needs at home or in residential facilities is adjusted based on the income of the recipient. The full amount of the allowance is paid to individuals with a monthly income below US$ 968, whereas only 10% of the allowance is paid to beneficiaries with a monthly income of US$ 3567 and above.

3.3. Out-of-pocket costs

People are usually expected to make some contribution towards the cost of their care from their own resources. These out-of-pocket costs could represent a given percentage of LTC costs, and link to the level of needs or the user's financial means. Monthly or annual ceilings for out-of-pocket costs may be set.

Most countries set levels of co-payments dependent on income, while some, including Australia, France, Spain and the USA, also consider a person's assets when determining co-payments or eligibility, particularly for food and accommodation in residential care (Cravo Oliveira Hashiguchi and Llena-Nozal 2020). The countries in the study also use very diverse approaches regarding the maximum amounts taken into consideration to calculate user cost sharing, the income/asset components taken into account, and the proportion of income/assets that the cost sharing represents.

In the Republic of Korea, cost sharing represents 15% of the total payment of home-based care services, but it represents 20% of facility-based payment. In Japan, 90% of beneficiaries of LTC services pay a 10% cost sharing, whereas the remaining 10% pay from 20% to 30%. Japan places a cap on the monthly amount paid, which is combined with health care services on an annual basis. In contrast, in the Republic of Korea, there is no cap, but exemptions for low-income persons. In the Netherlands, cost sharing for social assistance is €19 (US$ 22.60) per month (in 2021), and personal care and nursing provided at home are fully paid by SHI.

In Sweden, recipients' cost-sharing represents a small part of the total costs. A ceiling is set annually by the government,

representing the maximum amount that a recipient can be charged. This ceiling is set without means-testing in principle, but it may be reduced if the recipient's monthly income is below the minimum cost of living (the "reserve amount") as annually defined by the government. The reserve amount is the minimum amount to cover daily costs, rent and long-term additional costs due to individual needs. Within these rules, each municipality will determine their own schedule of cost-sharing for recipients.

In Germany, the nationally defined benefits schedule is paid directly to providers of residential care. It covers part, but not all, of the negotiated price. People in need of care are invoiced for those parts of the receipt that exceed the defined coverage of the care insurance, the costs for accommodation and meals and a contribution to investment costs. The amount that an individual has to pay depends on the total cost of their care.

In the Netherlands, in 2020, income- and wealth-related copayments were a maximum of €2419 (US$ 2763) per month for residential care or €881 (US$ 1006) per month for substitute care provided outside of a nursing home. In Spain, household contributions are determined by each autonomous region and differentiated according to the 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. Beneficiaries are expected to use no more than 90% of their income.

Under the USA Medicaid program, beneficiaries receiving LTC services in an institution or in the community qualifying through certain eligibility groups are required to apply their income exceeding specified amounts toward the cost of their care[5]. Within federal guidelines, a beneficiary may retain a certain amount of income for personal use based on the services one receives (Colello 2017).

5 These rules are commonly referred to as the post-eligibility treatment of income (PETI) rules.

4
Approaches to setting prices

Any payment method has several dimensions: the base upon which prices are defined and set; the process by which the price level is determined; and the price level per unit of payment (Reinhardt 2006, 2011, 2012). The process by which prices are determined can be grouped into three main approaches, including individual negotiations between providers and purchasers, collective negotiations between associations of providers and purchasers, and unilateral decision by purchasers. A comparison of the three approaches is discussed elsewhere (Barber, Lorenzoni and Ong 2019; Barber, Lorenzoni and Roubal 2020).

Price setting refers to an administrative process or negotiation upon which prices are determined and the unit for payment (e.g. health professional visit, a day of care in a nursing facility, or a hospital admission) is established. These processes can be grouped into three main methods (Reinhardt 2012): individual negotiations between providers and purchasers, collective negotiations between associations of providers and purchasers, and unilateral decisions by purchasers. We examine each in the context of the country case studies.

4.1. Base for payment

The type of service, for the most part, is the base for payment for pricing home-based care across most countries studied (Table 4). The exception is the Home Care Package program in Australia, which uses a package of care; the APA in France, which uses an hour of home care and support services; a global budget for intensive home care in Germany; and a visit as the base for payment in the Republic of Korea.

As for residential care, a day of care is the most used base for payment across countries in this study. In a few cases, where skilled nursing facility care is funded by SHI, a global budget is used to pay providers. Most countries differentiate prices between care services (such as nursing) from living services (such as meals and accommodations).

In France, SHI funds the medical care package in residential nursing homes based on iso-weighted care groups classification, whereas Medicare in the USA uses the Home Health Resource groups to set the base for payment.

Table 4. Base for payment

Country	Institution/ program/ financing scheme	Line item budget	Global budget	Fee for service	Per diem	Patient classification systems (e.g. Diagnosis Related Group or Resource Utilisation Groups)	Bundled episode	Capitation, other
Australia	Residential care				Personal, clinical, and social care, accommodation and hotel services			
	Home care package program (HCP)							Personal and clinical care for complex care needs
	Commonwealth Home Support Program (CHSP)			Home support				
France	Social Health Insurance (SHI)	Residential nursing homes (medical care)	Skilled nursing facilities	Self-employed nurses		GME in Skilled nursing (post-acute) facilities (750 groups). GMPs in Residential facilities (250 need groups). Hospital at Home: DRG-based		Home nursing services: capitation
	Personal Autonomy Allowance (APA)	Residential nursing homes (personal care)			Day care in residential nursing homes			Home care and support services: hourly rates
	Social aid & tax benefits	Accommodation in nursing homes; home help services		Non-medical residential care				
	Private			Self-employed domestic help				
Germany	SHI/Private Health Insurance (PHI)			Outpatient palliative care	Hospice	Inpatient palliative care		

Country	Institution/ program/ financing scheme	Line item budget	Global budget	Fee for service	Per diem	Patient classification systems (e.g. Diagnosis Related Group or Resource Utilisation Groups)	Bundled episode	Capitation, other
	SHI/PHI, Social/ private Long-term care insurance (LTCI)		Intensive home care					
	Social/private LTCI			Home care	Care substitutes for informal care givers.			Care allowances to beneficiaries: per capita. Home care help (Haushaltshilfe): per hour.
	Social/private LTCI				Residential care			
Japan	Social Health Insurance (SHI)			Basic principle for all services				
	Long-term care insurance (LTCI)			All services				
Republic of Korea	Social Health Insurance (SHI)				Palliative care	Long-term care hospitals		
	Long-term care insurance (LTCI)				Nursing (assistance, personal); Residential (assistance, personal)			Home-based care: pay per visit
The Netherlands	Social LTC insurance		Nursing facilities (medical, assistance, personal) including palliative care (medical, assistance, personal)		Nursing facilities (medical, assistance, personal) including palliative care (medical, assistance, personal)			

Country	Institution/ program/ financing scheme	Line item budget	Global budget	Fee for service	Per diem	Patient classification systems (e.g. Diagnosis Related Group or Resource Utilisation Groups)	Bundled episode	Capitation, other
	Social health insurance		Home-based care (medical and personal) including palliative care (medical and personal)	Home-based care (medical and personal) including palliative care (medical and personal)				
	Social support act			Home-based (assistance); social care in the community				
Spain	National long-term care (LTC) System			Home care	Day/night centres, residential care			
	National Health System		Hospital care		Palliative care			
Sweden	Municipal programs			Home care	Institutional care			
	Medicaid			Home care	Nursing facilities			
	Medicare				Skilled nursing facilities	Home care: Home Health Resource groups		

Notes:
DRGs: Diagnosis Related Groups
GME: Groupes médicoéconomiques en soins de suite et de réadaptation
GMPs: Groupe iso-ressource (GIR) moyen pondéré

Sources: Authors

4.2. Unilateral price setting

The first method of setting prices is unilateral administrative price setting by a regulator. When prices are administered, a form of yardstick competition rewards a given firm depending on its standing vis-a-vis an exogenous benchmarking independent of the costs incurred by each provider (Shleifer 1985).

In France, prices are set unilaterally based on the average level of resources required to provide medical and nursing services for the 238 profiles of care established in the health needs assessments. This allows the measurement of the case mix in a comparable way across facilities and to have a cost scale. The price per point (on the cost scale) is fixed at the national level by a Ministerial decree. The prices for social residences are regulated and fixed unilaterally by local authorities.

In the Republic of Korea, there is a formal price negotiation process for LTCI as in the case of collective price negotiation between the provider association and the national health insurance system for health care services. An LTC committee plays a key role in the pricing of LTC. It discusses and finalizes decisions about various aspects of LTCI, such as premiums, benefits, and pricing for providers. It consists of 21 members with the Vice Minister of Health and Welfare as the Chair: seven from payers (employer associations, labour unions, civic groups), seven from providers (associations of LTC facilities and home-care providers, medical association, nurse association), and seven representing public interests (ministries of health, finance, insurance program, and four experts).

In Japan, not only the fee (price), but also the volume of each service is controlled by setting strict conditions of billing in the Fee Schedule. The Fee Schedule is revised every three years in LTCI. The prime minister first decides the global revision rate which respectively sets a de facto global budget for LTCI expenditures. Next, the fees and conditions of billing are revised on an item-by-item basis within the budget following negotiations with provider organizations. Some fees are increased; others are lowered. Conditions of billing are relaxed in some; tightened in others. The impact of revising each item on the global budget is calculated from the national claims database.

Under the USA Medicaid program, prices are usually set unilaterally at the state level following guidelines established at the national level. The base for payment ranges from a day of stay for nursing facilities to a unit of service for home-based care. Starting in 2019, the Medicare program applies per diem case-mix adjusted payments for nursing homes using the Patient-Driven Payment Model (PDPM). Five case-mix adjusted components are used: Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Non-Therapy Ancillary (NTA), and nursing. Each resident is classified into one group for each of the five components, mainly based on the

primary diagnosis clinical category, and function and cognitive levels. A resident may be assigned to one of 16 PT groups, 16 OT groups, 12 SLP groups, 6 NTA groups, and 25 nursing groups. Each component has its own associated case-mix index and per diem rate. Additionally, the PDPM applies per diem payment adjustments to three components (PT, OT, and NTA) to account for variations in resource use. The adjusted PT, OT, and NTA per diem rates are then added together with the unadjusted SLP, nursing component rates and the non-case-mix component to determine the full per diem rate for a given resident.

Table 5. Ways in which prices are negotiated

Country	Institution/ program/ financing scheme	Individual negotiations	Collective negotiations	Unilateral administrative	Other
Australia	Residential care			Level of subsidy individuals receive set by the federal government	Set by the market
	Home care package program (HCP)			Level of subsidy individuals receive set by the federal government	Set by the market
	Commonwealth Home Support Program (CHSP)			Level of subsidy individuals receive set by the federal government	Set by the market
France	Social Health Insurance (SHI)		Self-employed nurses	Residential nursing homes (medical care); palliative care ; skilled nursing facilities; Home nursing services	
	Allocation personnalisée d'autonomie, APA ("Personal autonomy allowance") (Local authorities and Caisse nationale de solidarité pour l'autonomie)	Free negotiations for Home care and support services (in 77% of local authorities) and day care (in 43% of local authorities)		Residential nursing homes (personal care); Social Aid; self-employed domestic help; Home care and support services (in 23% of local authorities); day care (49% of local authorities)	Reference prices used for self-employed domestic help
	Social aid, tax benefits, central government			Accommodation in nursing homes (at local level)	
	Private				Market based: accommodation fees in residential nursing home + home help
Germany	Social LTC insurance	Home care	Home care		
	Social LTC insurance	Residential care	Residential care		
Japan	Social Health Insurance (SHI)		Hospital care (personal); home-based care (medical);palliative care (medical, personal)	All fee decisions made by Minister of Health	
	Long-term care insurance (LTCI)			Nursing facilities (medica, assistance, personal care); residential facilities (assistance, personal); home-based care (assistance, personal)l palliative care (assistance)	

Country	Institution/ program/ financing scheme	Individual negotiations	Collective negotiations	Unilateral administrative	Other
Republic of Korea	Social Health Insurance (SHI)		Long-term care hospitals (medical); palliative care (medical, assistance, personal)		
	National Health Insurance for the Elderly (LTCI)			Nursing facilities (assistance, personal care); residential facilities (assistance, personal); home-based care (medical, assistance, personal)	
The Netherlands	Social LTC insurance	Nursing facilities (medical, assistance, personal); palliative care (medical, assistance, personal) based on eligibility			Room for negotiations limited by regulation
	Social health insurance	Home-based care (medical, personal); palliative care (medical, assistance, personal)			Room for negotiations limited by regulation
	Social support act	Home-based (assistance); social care in the community			Room for negotiations limited by regulation
Spain	National LTC System			In kind (prevention, tele-assistance, home care, day/night centres, residential care), cash (services purchase, informal care, personal assistance)	
	National Health System			Health services (includes palliative care)	
Sweden	Municipal programs			Institutional care, home care	
United States	Medicaid			home care; nursing facilities	Managed care: competitive bidding
	Medicare			home health care; skilled nursing facilities	Managed care: competitive bidding

Sources: Authors.

4.3. Collective negotiations

Under collective negotiations, a national purchasing agency or an association of purchasers (i.e. health insurers) negotiate with associations of hospitals or health providers.

In France, fees for services provided by self-employed nurses are negotiated between the SHI and the representatives of self-employed nurses. The prices are defined for three types of basic nursing activities: "medical nursing", which refers to activities such as wound management, injections and swabs; "nursing care", which refers to ADL (e.g. hygiene and surveillance); and "nursing approaches" to prepare an individual nursing care plan.

In Germany, beneficiaries can choose to receive services from any provider registered with LTCI funds at the state level. Providers of home and residential care come from the public, not-for-profit and private sectors. Individual providers or provider associations negotiate the fees they are paid for the services with LTCI funds and social welfare authorities. Although these fees are negotiated on a local level – in order to offer flexibility to meet local needs – they are governed by state- and national-level contractual frameworks. Following the principle of subsidiarity, Germany has sought to develop a stable and competitive provider market by creating a national regulatory framework to coexist alongside market principles.

In the Netherlands, the Dutch Health Care Authority sets maximum prices for legally defined types of activities for home-based nursing and personal care – that is personal care, nursing care, specialized nursing care and advice, instruction and counseling - based on calculated average costs per activity. Health insurers and providers negotiate the prices for these activities, which may not exceed the regulated maximum prices. However, instead of paying regulated maximum prices or negotiating lower prices for legally defined types of activities, providers and insurers may also opt for negotiating a single integrated price for a bundle of agreed-upon activities. In practice, this has become the standard way of price setting. The Health Care Authority also sets maximum prices for `care packages' in nursing home care based on researching the actual costs across of these packages across providers. These care packages do not describe the exact type and hours of care required; instead, the integrated (per diem) price for a care package should cover all the care needed for a certain health profile. Regional purchasing offices negotiate prices with providers, which must be below the regulated maximum price.

4.4. Individual negotiation

Under individual negotiations, prices are agreed upon through negotiations between an individual purchaser and a provider of services. In the context of LTC, this may include personal services provided to older persons at home, for example, that result in market prices in which the government plays mainly a regulatory role. In Australia, all home care is publicly funded (with a small means tested contribution), and this funding is paid to the purchaser who negotiates care services with one or more regulated providers. Prices are market-based, but the level of government-subsidy paid to individuals is set unilaterally.

Individual negotiation for prices is typically associated with private health insurance in the USA. Despite the strong case for risk pooling, there are few private insurance options for LTC. Private insurance for LTC remains a niche product covering only a small proportion of total LTC costs. Given that the role of private health insurance in covering LTC services for older persons is quite limited, individual negotiations of prices between purchasers and providers is also limited.

In Germany, nursing care charges are negotiated individually between the nursing home, welfare organizations and LTC funds, whose enrolees contribute at least 5% of the nursing home's nursing days. During these negotiations, nursing homes explain any increase in fees. In the Netherlands, health insurers and providers negotiate a single integrated price for an agreed-upon bundle of home-based nursing and personal care activities. In this case, a contract between the provider and insurer is required. Integrated prices are typically set per hour, although an increasing number of providers and insurers switched to monthly prices.

In France, prices for self-employed domestic help are freely fixed on the market respecting the French labour code (e.g. minimum wage, social security contributions). To be included in the "care plan" of the APA (a cash-for-care scheme for personal care), self-employed workers need to be accredited by a regional labour and employment agency.

It is worth noting that in some countries, such as France, Spain and Sweden, subnational governments play a key role in setting prices for LTC services at home. In France, local authorities fix an APA reference price for self-employed domestic help for the amount reimbursed from APA to people employing self-employed domestic aid; however, the actual prices can be much higher. In Spain, the reference prices for self-employed help are much lower than those in the public LTC system (*Sistema para la Autonomía y Atención a la Dependencia*, SAAD), ranging from €8-13/hour (US$ 9-15), because local authorities support the deployment of SAAD in which they can control the care standards.

4.5. Bidding or tendering

Another mechanism to set prices is through bidding or tender processes, mainly used to price managed care plans' service packages to Medicaid enrolees in the USA and social assistance in the Netherlands. The original goal of contracting with private managed care plans was to harness their ability to use care-coordination tools to offer high-quality care, while providing enhanced benefits for beneficiaries and saving money for taxpayers.

In the USA, states can select state-established and administered capitation rates (e.g. fixed offer), competitive bid capitation rates, or a hybrid model (e.g. range and soliciting bids). After developing an actuarially-sound administratively set payment "benchmark", which loosely reflects the level of spending for an "average risk" enrolee, states provide interested plans with a data book of information needed to develop rate bids. The state selects plans based on the bids and accompanying technical proposals.

To help ensure participation, many states require minimum provider rates in their contracts with managed care organizations that may be tied to fee-for-service rates (Kaiser Family Foundation 2020a). Furthermore, over three-quarters of capitated Managed Long-term Services and Supports (MLTSS) states have network adequacy standards for home and community-based services providers, with time and distance as the most common (Kaiser Family Foundation 2020b).

5
Maintaining a balanced budget, adjustments to prices, and incentives for quality

Price setting may result in different prices set or negotiated with different providers. These price differences may not only reflect supply and demand (and monopsony/monopoly pricing) but other factors as well, including expenditure control, promoting quality, providing public health goods and attaining other public health goals.

5.1. Maintaining a balanced budget

Prices are influenced by the budget envelope. In some settings, overall growth in spending is constrained by macro-economic metrics, e.g. economic growth rates, expected payroll increases, inflation rates, increases in utilization, and population growth and ageing (Reinhardt 2012).

Prices have been used to respect the overall budget and redistribute resources for LTC among various providers. In Australia, the national government applies planning and supply limits to maintain control over the LTC budget. The supply of home support is controlled by capping annual funding grants to providers. The annual budgetary determination of the amount of grants available to service providers is based on a broad assessment of need and the government's fiscal capacity. For home care and residential aged care (as well as the short-term care programs), the national government manages the planning of and expenditure on services by specifying a national target provision ratio. The 'aged care provision ratio' is the number of subsidized aged care places for every 1000 people aged 70 years and over and is an estimate of consumer demand. The government also exercises control over the size of the home care market through demand-side queuing. Older persons who have had an assessment and are eligible for a home care package are placed on a national prioritization queue for their package level according to the date of approval and their priority level. The size of the residential aged care market is controlled through supply-side capping of the number of places allocated to providers through a periodic competitive allocation round. The number of places released in each allocation round is determined by the target aged care provision ratio and the level government funding expected in the forward estimates, demographic projections, current levels of service provision (i.e. number of operational places, occupancy levels), and newly allocated places from previous rounds that are not yet operational. The median waiting times for future residents from the time of their assessment by an aged care team to accessing a residential aged care place in 2018-19 was 152 days, though many older people assessed as eligible for residential aged care choose not to enter a facility when offered a place (Australian Government, Productivity Commission 2020).

In France, skilled nursing facilities and residential nursing homes are funded by annual prospective global budgets adjusted to consider the volume and case-mix of the patients

treated, while home care nursing services are funded only on the basis of volume without considering patient severity.

In the Netherlands, the national government sets a macro budget for all care financed through social LTCI for the coming year based using forecasting accounting for changes in wages, prices, demographics, and policies. The macro budget is then divided across the regional purchasing offices. The allocation of funds across regions is currently based on past trends. The regional purchasing office responsible for the procurement of care within their region comply with the lump-sum regional budget set by the government. This implies that regional purchasing offices must adjust prices and/or volume of the contracted care to fit the regional budget restrictions.

5.2. Price adjustments and add-ons payments

Price adjustments and add-on payments are common when prices are set unilaterally or negotiated collectively to ensure that specific services or care for populations in need, particularly where there are additional costs of providing care or it is considered unprofitable. In this manner, pricing can be an important tool in allocating resources to meet public health goals (Table 6).

Prices can be adjusted for geographical location, the degree of dependency of beneficiaries and the type and length of the home care service to recognize the legitimate and unavoidable cost differences among providers. In Australia, the Netherlands, and the USA, geographic price adjustments are made for facilities in rural areas. In Japan, the base rates differ across geographic area: supplemental payments made to metropolitan Tokyo are up to 11.4%, reflecting the higher wage levels there.

Outlier payments are made for additional care needs including veteran status and oxygen and enteral feeding (Australia), palliative care (Australia, France), short and long stays (France), and specific conditions such as dementia (Australia) or Huntington's disease (the Netherlands). In the Republic of Korea, co-payment ceilings depending on income levels are used to reimburse specific co-payment amounts if a patient stays for a long time in an LTC hospital.

Supplemental support is provided to ensure services in indigenous communities in Australia. In Japan, the fees and conditions of billing have been revised to align with policy goals for access and quality. For example, bonus payments for home care agencies are given to employ more experienced workers.

In the Netherlands, an additional payout to compensate providers of nursing home care or substitute round-the-clock home care in relatively expensive regions can be made if the regional budgets are not sufficient (for instance, because of high turnover in personnel in urban regions).

Table 6. Price adjustments and add-on payments

Country	Geographic adjustments	Outlier payments	Public health goods
Australia	Supplement for rurality / remoteness	Supplements paid for specific health needs, e.g., dementia, enteral feeding, oxygen therapy, and palliative care (residential care only)	The National Aboriginal and Torres Strait Islander Flexible Aged Care Program supports culturally appropriate residential and home care services to older Indigenous Australians on Country (ancestral land), close to family, community and language, mainly in remote areas. The Multi-Purpose Service (MPS) Program supports sustainable health and aged care services in sparsely populated communities. The national government's grant for aged care places is 'pooled' with state government funding for hospital and community health services.
France	Not applicable.	For palliative care in acute hospitals, prices are adjusted for very short (<4 days) and long (>12 days) stays.	SHI prices in nursing homes are adjusted for having their own, integrated, primary care services (GP and pharmacies)
Germany - residential care	Variation in gross salary for LTC staff. Different requirements across states (Länder) for providers, such as staffing regulation. Adjustments are subject to negotiations.	Not applicable.	Not applicable.
Republic of Korea	Not applicable.	Specific amounts of co-payment over a set ceiling reimbursed if a patient stays for a long time at a LTC hospital	Not applicable.
The Netherlands	Nursing homes in relatively expensive regions receive an additional markup on the per diem tariff	Nursing homes receive markups on the per-diem tariff for additional care for patients with specific diseases, such as Huntington's, or additional services like transport	Not applicable.
United States: Medicare	Skilled nursing facilities (urban versus rural; wage component); home health care (wage component)	Not applicable.	Not applicable.

5.3. Payment mechanisms and other incentives for quality

Quality in LTC is particularly difficult to measure and monitor, given the diversity of providers and institutions involved in care provision. A few countries, however, do take quality into account in their pricing and payment systems. A few examples are noted here.

In the Netherlands, additional funding for quality improvements of nursing homes based on lump-sum funding is distributed across care providers. The regional purchasing offices distribute these funds across providers based on mandatory quality plans.

To assure quality of care in the LTC sector, the Korean NHIS implemented a quality evaluation system in 2009. The number of quality indicators varies by type of service provider, and indicators are grouped into five domains, namely management of institutions, environment and safety, guarantee of rights of beneficiaries, process, and outcome. Evaluation scores are disseminated through an official LTCI website, and high-performing institutions have received 1%–2% additional payments (Jeon and Kwon 2017).

Sweden has made use of financial incentives for better performance, and there have been occasions since 2010 when governments in connection with the transfers from the state to the municipalities have included performance targets based on outcome results for the care of older persons. The *Ädelreformen* reform, the Law on System Choice in the Public Sector, and the use of conditional budget transfers have created an environment where providers' performance is encouraged through incentives for providers to compete, for users to choose across providers, and for municipalities to deliver value and quality.

Publishing information about prices and quality is one means to help beneficiaries make informed choices and has the potential to reduce price variation and promote quality. Provider prices for residential and home-based services are published by the government or an associated independent institution in all countries in this study, with the exception of Germany, where providers must publish their price schedule on their websites. However, there is little evidence about the associations between the publication of prices and quality of outcomes for choice, price variation, and quality (Cornell et al. 2019).

As for quality of care, periodic quality assessments are made publicly available in Australia, Germany and the Republic of Korea. In the Netherlands, nursing home and home care providers (offering personal care and nursing only) are required to report information online about patient-reported metrics. Sweden and the USA publish online comparative quality indicators to facilitate patient choice of providers at the local level.

Table 7 shows the type of information on prices and quality that is available in the countries in this study.

Table 7. Public release of information about price and quality

Country	Published prices	Published information on quality
Australia	Providers must publish a schedule of prices for services.	Quality report and non-compliance notices are publicly available.
France	Skilled nursing facilities and hospital at home prices are published by ATIH on is website. Residential nursing homes and social residence prices are published on government website (since 2016)	Not available
Germany	Prices of home care providers are published by each provider on their respective home pages. Prices of residencial care homes are published by each residencial provider on their respective home pages. Additionally, prices are made available by social LTCI funds on four internet plaforms.	Annual, structured assessment of home and residencial care providers. They are made publicly available by providers at a visible location (e.g., entrance), and by social LTCI funds on four internet plaforms.
Japan	National government sets prices and conditions of billing for all items covered by social health insurance and LTCI	Reporting of quality limited to voluntary decision of each hospital
Republic of Korea	Price schedule of SHI and LTCI	Periodic quality assessment
Netherlands	Maximum tariffs for nursing home care and for home care (personal care and nursing only) are published by the Nederlandse Zorgautoriteit (Dutch Healthcare Authority). Some municipalities choose to report the prices for assistance on their website. Health insurers are required to put the payouts for nursing and personal care provided by uncontracted providers on their website	Providers of nursing home care and home care (personal care and nursing only) are required to report information on patient-reported experience measures online.
Spain	Average prices in Spain and its regions (ACs) of public LTC services, as well as reference prices for subsidized private day centres and residential care centres.	Not available
Sweden	Not available	Sweden publishes the Open Comparisons report annually showing providers' quality of care to the elderly based on 28 quality indicators along with grading of their performance. A relative comparison between municipalities is provided using a traffic light system. Quality of care to the elderly indicators are also avaialble online (kolada.se).
United States: Medicaid	Fees by provider are usually posted on to Medicaid webpages at State level	Not available
United States: Medicare	Fee schedules are reported in the annual Federal regulations and notices	For people with Medicare or their caregivers who want to choose a Medicare provider (such as nursing homes and home health care), the Care Compare tool provides a single source search and compare experience, that lets the user make more informed decisions - also based on quality of care - about where to get services

Sources: Aged Care Quality and Safety Commission (2020), ATIH (2021), CNSA (2021), AOK (2021), BKK Dachverband e.V. (2021), KNAPPSCHAFT (2021), Verband der Ersatzkassen e.V. (2021), Ministry of Health, Labour and Welfare, Japan (2021), Ministry of Health and Welfare, Republic of Korea (2021a, 2021b, 2021c), Nederlandse Zorgautorieit (2020a, 2020b), Zorginstituut Nederland (2018, 2019), IMERSO (2020), National Board of Health and Welfare (Socialstyrelsen) (2021), US National Archives (2021a, 2021b).

6
Comparing prices across countries

Countries in this study gathered prices for several standard services provided either at home or in a facility, including medical or nursing care, personal care and assistance services.

Table 8 reports the mean price for these services using an hour as the unit of measurement for home-based services and a week of stay in a facility for institutional-based care. Prices are expressed in US dollars using period-average 2019 exchange rates. Of note for Australia, government funding is set for a package of services (home care and residential care) and any additional services are market-based. In residential care, additional services are a small proportion of the total price; therefore, most care is priced at the assessed level of the government subsidy.

The price for an hour of care at home varies between US$ 45.60 and 65.30 for medical or nursing care, from US$ 16.30 to 65.30 for personal care and from US$ 16.30 to 62.20 for assistance services. A week of medical or nursing care in a residential setting is paid between US$ 257.50 and 730.60, whereas a week of personal care is paid from US$ 43.60 to 444.00 and a week of assistance services from US$ 33.70 to 465.00. Some countries reported that a unique price is used for different types of services provided during a week of care in a residential setting, and that that price varies between US$ 1071 and 2994.

The likely explanations for the variation in reported prices include differences in wages, the intensity of the service provided, and the qualification of the staff that provide the service. Furthermore, prices for residential-based services may not cover the same cost items across reporting countries.

Table 8. Mean price by type of care provided (in US$)

	Home care per hour of care			Facility-based care per week of care		
Country	**Personal care services**	**Medical or nursing care**	**Assistance services**	**Personal care services**	**Medical or nursing care**	**Assistance services**
France	22	47.8	13	43.6 /160.1 (low dependency/ high dependency)	257.5	465.7
Germany	Not available	Not available	Not available	318.6	412.4 / 730.6	Not available
Republic of Korea	18.6 / 62.2	45.6	18.6 / 62.2	337.7 / 415.4	376.8 / 458 (LTC hospitals)	337.7 / 415.4
The Netherlands	65.3	65.3	30.2	One tariff including all services: 1915.6	Not available	Not available
Spain	14.6	Not available	14.6	396.7	396.7	396.7
United States: Medicaid	22 (16/28)	Not available	21 (16 / 28)	Not available	Not available	Not available
United States: Medicaid nursing home	Not available	Not available	Not available	one tariff including all services: 1715 (1071/ 2905)	Not available	Not available
United States: Medicare Skilled Nursing Facilities	Not available	Not available	Not available	one tariff including all services: 2994.9	Not available	Not available
United States: Medicare home health care	69.1	152.6	Not available	Not available	Not available	Not available

Note: figures reported in this table are indicative. They should not be directly compared across countries as prices may cover different types of costs.

Sources: Berenschot (2019); Nederlandse Zorgautorieit (2019); Statistics Netherlands (2020); Authors' estimates.

7
Lessons learned for other settings

OECD countries are several decades ahead of low- and middle-income countries in investing in formal LTC. Formal LTC has been organized and financed because of the demand for health and social services appropriate to the needs of older persons and reduced availability of informal caregivers, particularly with reductions in birth rates and greater participation by women in the labour market. As such, experiences in these countries may inform the policy options for other settings. The continued evolution of policies and practices may help other countries that are considering their policy options and how to align LTC with overarching system goals, including access to needed services and financial protection. The importance of reducing pressure on the acute care hospital system may be particularly important where resources are scarce.

The study found that formal LTC was established with several aims, including ensuring access to needed care, providing financial protection, and offering a social safety net for older persons. The overall goals affect approaches in how LTC is organized and financed. Most countries in this study take a universal approach to LTC provision. Under a universal approach, the overall objectives are access to needed services and financial protection for beneficiaries, and these objectives may be reflected in eligibility criteria, financing and pricing systems. In settings where LTC operates as a social safety net, cost control may be reflected in the policies for eligibility criteria, means-testing, and reimbursement.

Most countries in this study have established dedicated LTC funding streams to meet the needs of older adults, whereas in Sweden and the USA, the health and social care needs of older persons are identified, delivered and financed within existing programs and institutions. The diversity of health and social care needs results in a wide range of providers, institutions and funding streams, and this can result in fragmentation.

Prices for health and social services for LTC tend to be set unilaterally or through collective negotiation, but this may not reduce price variation. In principle, both collective negotiations and unilateral price setting could have several key advantages, including reducing or eliminating price discrimination and promoting affordability. However, this relies on the level of administration, where subnational governments play an important role in price setting for personal and social care, substantial price variation within a country may result.

Allocative efficiency is a key element with implications for the incentives and financial risks faced by payers and providers. For example, the financial risks related to the provision of nursing home care can be more substantial than the risk for the provision of home care. This also has implications for the outcomes of the negotiations, not only in terms of prices and volumes but also quality of life for older persons who need care and their relatives and other informal caregivers.

The following lessons learned may be applicable to other settings.

Public investments in formal LTC are important as changes in demographics occur including population ageing and declines in the availability of family caregivers, many of whom are women. At the individual level, it is impossible to plan for how much money is needed to pay for LTC. Where the provision of social care (personal and assistance services) is not formalized, there is greater pressure on the health systems and acute care hospitals to meet these needs. This implies that underinvestment or inappropriate payments for LTC could be costly to the health sector. Low- and middle-income countries face increasing pressures to respond to chronic disease care and disability. The demand for LTC may be greater in settings where health investments in early life were relatively low, such as low-income settings.

Funding to LTC should be based on a secure reliable source that reduces any regional inequities in resources. A separate funding stream may help ensure that LTC funding is not diverted to other purposes, promotes transparency in management, and enables policies specific to the LTC sector to be implemented. However, the separation of funding for LTC and health care may pose problems in coordinating health and social care and reducing fiscal flexibility in meeting changing societal priorities.

Funding to LTC should be linked with need and the care provided. Objective needs assessments to determine eligibility and benefits increase equity in service provision, promote transparency, and ensure that people understand their right to care. Needs assessments should be systematically monitored and evaluated to determine whether they are enabling needed care.

Policy initiatives are needed to ensure the optimal allocation across services and coordination among different services and provision at different levels of government (i.e. municipal, regional and national). LTC is closely connected with other health and social services, particularly at the local level, and can lead to differences in prices and funding. Subnational governments in several countries play an important role in price setting for LTC for older persons, in particular, personal and social care, resulting in substantial price variation within a country.

Price adjustments and add-on payments can also be used to foster equity in access and fairness in payment to providers. Although experience is still limited, some efforts have been made to implement price adjustments and add-on payments to foster equity in access. Such payments can reduce price variations across regions and compensate for the additional costs of providing care by geographic variations and by variations in users' characteristics. Estimating the actual costs of care provision can usefully inform prices and reimbursement levels and assist to identify where price adjustments are needed.

Objective needs assessments to determine eligibility and benefits can increase equity in service provision, promote transparency, and ensure that people understand their right to care. All settings in the study implement needs assessments with defined criteria to determine eligibility and the level of benefits in recognition of the heterogeneity in health needs across the spectrum of older persons. In some settings, particularly where LTC operates as a social safety net, the eligibility criteria may be more detailed to identify those with a high level of disability, because cost control is a primary objective of these systems. Where cost control is a major driver, unmet need should be taken into consideration and monitored to ensure that people receive the care they need. Similarly, user charges for needed care should be carefully considered and formally evaluated as to whether their application results in reduced utilization and unmet need.

Quality measurement in LTC is an important area for further policy action. Quality in LTC is particularly difficult to measure and monitor, given the diversity of providers and care settings from institutions to home care and the heterogeneity in relevant outcomes. Few countries take quality measurements into account in their pricing and payment systems. However, some initiatives are being undertaken. Most of the countries studied release publicly information about quality and prices to promote trust and transparency. Given that the impact of these efforts is unclear, evaluating the impact of publicly released information about quality and prices could usefully inform efforts to improve relevant outcomes.

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Case studies

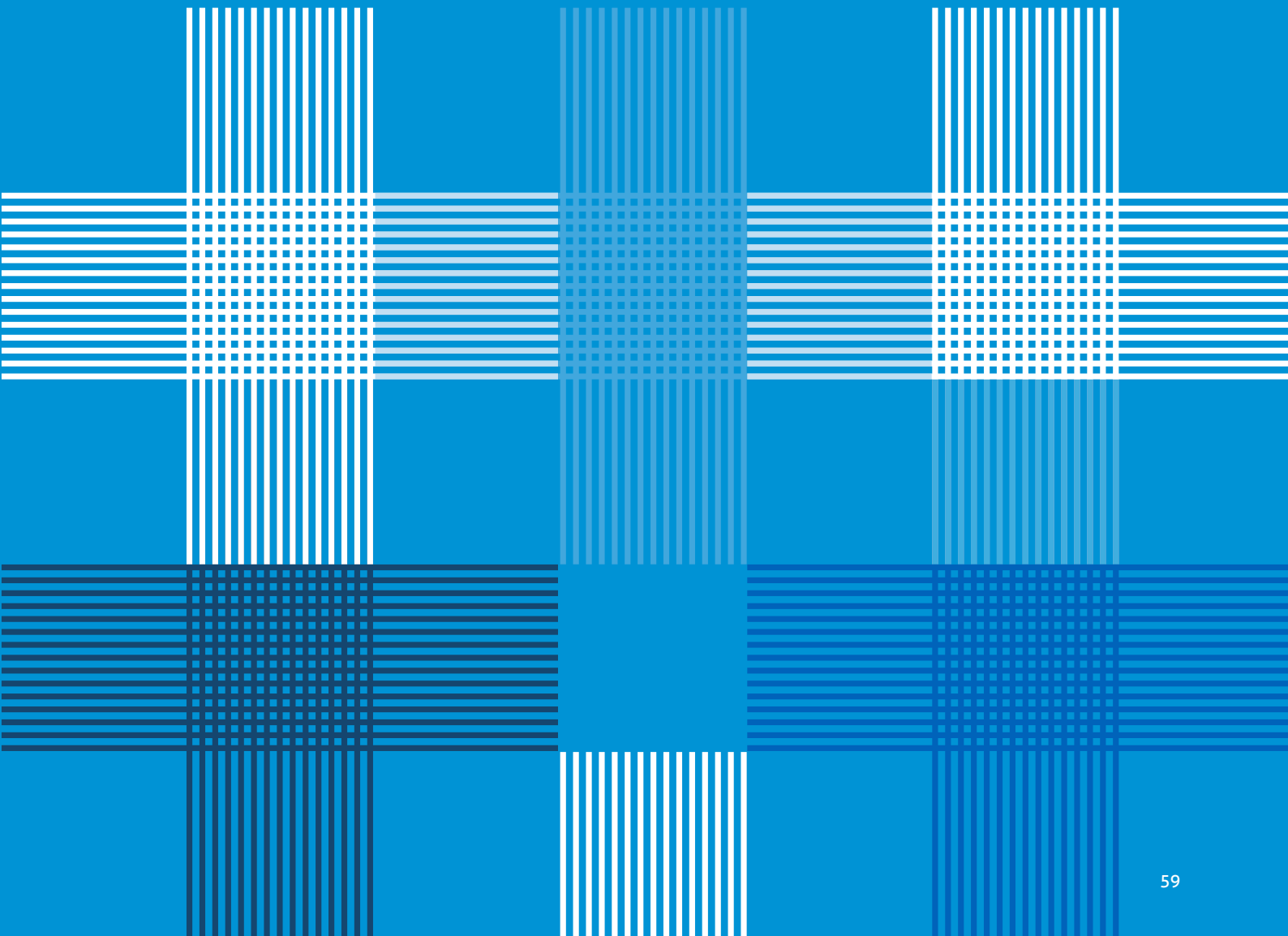
Case study

Australia

Sarah Wise, Michael Woods and Kees van Gool

University of Technology Sydney

Sydney, Australia



Abstract

The guiding principles of the Australian aged care system are consumer choice and control within a market-based system, but with government oversight of quality, price setting and safety nets. Publicly subsidized aged care services are funded through a mix of government subsidies (the largest share) and consumer contributions, priced using a combination of cost-based and market-based mechanisms, and delivered by not-for-profit, for-profit and government providers. While most consumers are satisfied with the quality of the services they receive, the sector is struggling meet rising demand especially in the staffing models required to provide continuity of care for an older, more clinically complex population. Moreover, the system is difficult to navigate for consumers and places a high administrative costs on providers. This case study describes how the Australian government has grappled with the design of policy and pricing mechanisms, and proposals for fiscally sustainable solutions to long-term care that are in line older people's wishes.

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Introduction

In this case study, we describe and provide commentary on the Australian approach to the residential and long-term care of older persons. As in other OECD countries, the demand for aged care services in Australia is expected to increase as the population becomes older, frailer and experiences higher rates of dementia. Below replacement fertility levels combined with increasing life expectancy means the proportion of people aged 65 years and over is projected to increase over the next 50 years, from 15% in 2017 to 23% in 2066. Over the same period, the proportion of people aged 85 years and over is projected to increase from 2.0% to 4.4% (ABS 2018). In 2019, an estimated 387 800 Australians had dementia, nearly half of whom were aged 85 years and over. This number is anticipated to grow to around 900 000 by 2050 (Department of Health 2019a).

The guiding principles of the Australian aged care system are consumer choice and control within a market-based system, but with government oversight of quality, price setting and safety nets. Publicly subsidized aged care services (the 'aged care system') are funded through a mix of government subsidies (the largest share) and consumer contributions, priced using a combination of cost-based and market-based mechanisms, and delivered by not-for-profit, for-profit and government providers. A government-funded assessment process determines eligibility for these services and the level of contribution to be paid by consumers. In 2018–19, over 1.3 million people received some form of aged care service, around 5% of the population (Department of Health 2019a).

The funding and regulation of aged care services are primarily the responsibility of the national (Australian) government, therefore, provision varies little between states. The national government funds services from its general tax revenue with expenditure in 2019-20[1] budgeted at A$ 21.6 billion (4.3 percent of its general government sector expenses). This expenditure currently represents 1.08% of Australian GDP and is projected to increase to 1.7% of GDP by 2055 (The Commonwealth of Australia 2019).

The present case study is arranged into six sections:

- **Interface between health and aged care services** differentiates the health and social care services provided under the healthcare and aged care systems. It then briefly describes the specific provisions for older people in Australia's universal healthcare system.
- **Aged care services in Australia** describes the key government programs designed to deliver aged care services at home and in residential facilities.

1 In Australia, the financial year runs over the 12 months from 1 July to 30 June.

- **Structure of payments and pricing for aged care services** describes the payment and pricing arrangements for the mainstream programs of home care, home support and residential care.
- **Consumers and providers of aged care** describes the processes for consumer access and eligibility, provider approval and quality standards, the characteristics of purchasers and providers, and the planning and control of supply.
- **Challenges for the Australia aged care system** discusses the key challenges for Australian policymakers and service providers, along with proposals for reform.
- **Lessons from the Australian aged care system** identifies lessons from the Australian experience that have broader applicability to other countries.

1 Interface between health and aged care services

Aged care programs are managed by the national Department of Health, but are administratively and functionally separate from general health services. Aligned with the OECD's definitions of the health and social care aspects of long-term care (OECD 2018), the health care activities provided under the Australian aged care system may be classified as:

- Personal care (e.g. assistance with personal hygiene, dressing, feeding, taking medication)
- Clinical care (e.g. nursing and allied health services)

Social care activities within aged care provision may be classified as:

- Basic daily living services (e.g. meals, housekeeping, home maintenance and modifications, laundry and social activities)
- Accommodation (for residential aged care only)

Older people in Australia have the same access to Medicare, Australia's system of universal health coverage, as the general population (Barber, Lorenzoni and Ong 2019). The Transition Care and Short-Term Restorative Care Programs under the aged care system aim to manage older people's short-term health and care needs following an episode of injury or poor health and are described later. In this section, we briefly describe how the Australian healthcare system manages older people in hospital care, primary care and end-of-life care.

1.1 Older people and hospital care

Public hospitals are managed by the government of each state or territory to provide patients with comprehensive inpatient and emergency care. Under Medicare, all citizens have access to free public hospital care, and no distinction is made on the basis of age. Formerly, the national government allocated a fixed budget to state governments to contribute to the cost of public hospital services. These budgets were based on the size of each state's population, with need-based adjustments including increased funding for states with an older population. With the advent of activity-based hospital funding (ABF) in 2011, the national government contribution became explicitly tied to the number of hospitalizations. Older people are greater users of hospital services, therefore, funding is now directly linked to the demands of an ageing population. People aged 65 and over comprise 15% of the population but account for 42% of hospital separations and 49% of patient days (AIHW 2018). Under ABF, hospitals in an older demographic catchment area receive funding that reflects higher activity levels. Earlier versions of Australia's diagnosis related groups (AR-DRGs), the basis of ABF payments, used age-based adjustments to the price of many hospital episodes. The patient's age (typically those over 65 years) attracted increased funding. With each new edition, the age-adjusted AR-DRGs have given way to classifications that adjust for complexity and co-morbidity.

Limited availability of residential aged care places or appropriate support at home in some areas can impact hospitals through extended lengths of stay for older patients. The Productivity Commission's Report of Government Services shows that, on average, around 1% of all available bed-days are accounted for by patients who cannot be discharged due to a shortage of aged care support, a rate even higher in rural and remote regions and in lower socio-economic areas (Steering Committee for the Review of Government Services 2020).

1.2 Older people and primary care

Primary care (and other out-of-hospital medical care) is mainly funded by the national government through Medicare on a fee-for-service basis with some co-payments. Patients pay the service provider directly and claim back a rebate for services listed on the Medicare Benefit Schedule (MBS)[2] from the government. Doctors' fees are not regulated in Australia, and the MBS rebate is often less than the fee charged by providers resulting in a co-payment for patients. That said, 83% of general practice (GP) visits are charged at the same price as the rebate and therefore do not attract a co-payment. Co-payments for specialist medical services are much higher. Primary care patients in Australia also make co-payments under the Pharmaceutical Benefits Scheme (PBS), which subsidizes medicines for Medicare-eligible patients. Under the PBS, patients contribute up to a maximum fixed amount per script. The government pays the remaining cost of the medication that

2 See http://www.mbsonline.gov.au

is above the fixed co-payment. Prices for medications listed on the PBS are negotiated between the national government and pharmaceutical companies following a rigorous health technology assessment process including cost-effectiveness analysis.

Most older patients are eligible for a Commonwealth Seniors Health Card. These and other concession card holders are entitled to: (i) a substantially reduced co-payment for prescribed medications listed on the PBS; (ii) an incentive paid to GPs to provide consultations with zero co-payments; and (iii) a lower threshold to reach the PBS and Medicare safety nets. To qualify for either safety net, patients have to incur a specified amount of out-of-pocket costs. Once they qualify, the patient is entitled to additional benefits that will reduce their co-payments for the remainder of the calendar year (see Table 1). The national government spends around A$ 9.6 billion on concession card entitlements, with the majority (A$ 8.8 billion) on the prescriptions entitlement. This accounts for around 80% of total national government expenditure on prescription medications.

Table 1
Entitlements for concession card holders and the general population in AUD (as of January 2020)

	Concession card holders	General population
Prescriptions		
PBS listed medication co-payment	$6.60 per script	$41 per script
PBS safety net threshold amount	$316.80	$1486.80
PBS listed co-payment once qualified for safety net	$0 per script	$6.60 per script
Medical Care		
Incentive payment for GP consultations to charge no co-payment to concession card holders	$6.40 per consultation in metropolitan areas $9.60 per consultation in selected rural and regional areas	No incentive
Medicare safety net threshold amount for out of hospital services	$692.20	$2169.20
Co-payments for those who reach Medicare threshold	Up to 80% of all co-payments covered for the remainder of the calendar year	Up to 80% of all co-payments covered for the remainder of the calendar year

As for hospital care, older patients are greater users of the primary care system. Those aged 65 and over account for 29% of GP consultations but account for only 15% of the population. They make more than twice as many claims for GP consultations per annum (10 per person) compared to those under 65 (4.4 per person)(AIHW 2018). In recent years, the national government has sought to encourage doctors to provide services aligned to the changing needs of the ageing population, particularly for those with complex and chronic health problems. There have also been significant problems in

delivering primary care in aged care facilities for residents unable to attend a GP practice. New items have been added to the MBS to encourage doctors to deliver more complex, multidisciplinary care and assessments for elderly patients, and to deliver services in residential facilities (including telehealth and medication reviews). However, many of these items do not offer sufficient financial incentives to substantially increase access for older people in residential care. For example, only around three in ten patients living in residential aged care facilities claimed a medication review that included a GP.

In recognition of the limitations of Australia's fee-for-service system, for complex, long-term care, the national government allocated A$ 448 million in the 2018-19 Budget to a new scheme that will provide additional GP funding in the form of blended payments to encourage older patients to enroll with a GP practice. From 1 July 2020, patients aged 70 years and over will be eligible to enroll with a single, accredited general practice. The aim of the program is to increase continuity of care, which has been associated with improved health outcomes and reduced spending.

1.3 End-of-life care

Public hospitals continue to be the largest providers of end-of-life care in Australia, in specialist hospices, hospital wards and through community health services. While there is increasing provision for end-of-life care to support people to stay at home until their death, Australia has the second lowest proportion of home deaths compared to institutional deaths (in hospital or residential aged care facility) in the OECD (Broad et al. 2013). There is significant unmet need for end-of-life care at home. Surveys consistently show that 60-70% of Australians would prefer to die at home, but only 14% currently do so (Swerissen and Duckett 2014). There is little research on the capacity of aged care services provided at home to support end-of-life care, but the pattern of service usage suggests that many enter residential facilities as their care needs increase. Of the 25 700 people who exited a home care package in 2017-18, the majority (56%) entered a residential aged care facility, while 30% died while still receiving care at home (7710 people) (AIHW 2019c). Palliative nursing and personal care are recognized in the funding instrument that determines the government subsidy for aged care residents. However, there have been challenges in accessing specialist palliative care services in the residential setting, and many age care residents are transferred to hospital when they are near death. The 2018-19 Budget included A$ 57.2 million over six years for the Comprehensive Palliative Care in Aged Care Measure, a cost-sharing arrangement with state and territory governments intended to improve palliative and end-of-life care for older people living in residential aged care, to enable people to die where they want and be supported by increased aged care services.

2
Aged care services in Australia

This section describes the key government programs designed to deliver aged care services at home and in residential facilities across a broad continuum of care. Special programs to meet the challenges of delivering services for older people living in remote and rural Australia are described in *Box 1*. There are three mainstream aged care programs: the Commonwealth Home Support Program (CHSP) to promote continued independent living; the Home Care Packages Program (HCP) for those with more complex needs; and residential aged care for those no longer able to live in their own home. There are also three programs designed for short-term care: respite care for older people and their carers to take a break (administered through the mainstream programs); transitional care for those who have been recently hospitalized; and restorative care to provide early intervention to reverse or slow functional decline in older people.

Recent Australian government policy has aimed to increase the funding and utilization of home care services to allow older people to live at home as long as possible, or 'age in place'. Remaining at home is the preferred option for the vast majority of older Australians. In 2017–18, 71% of Australians aged 65 and over lived at home without accessing government-subsidized aged care services, 22% accessed some form of support or care at home, while just 7% lived in a residential aged care facility (AIHW 2019a). The average age for accessing aged care services at home is 80 years, while the average age on entry to permanent residential aged care is 82.3 years for men and 84.6 years for women (Department of Health 2019a). Community preferences to remain at home as long as possible are aligned with government interests in fiscal sustainability since the provision of aged care at home requires less public funding than residential aged care (Productivity Commission 2015). Table 2 gives the total government and consumer expenditure for each of the three mainstream programs. It shows that residential aged care accounts for 74% of government expenditure on aged care services, but only 20% of consumers, reflecting the higher care needs and resource-intensity of providing care in a residential setting. The current policy goal is to increase the provision of more complex care at home through the HCP to delay or prevent admission into residential care. Table 2 also illustrates that while consumer contributions are an important element in the aged care funding in Australia, government subsidies account for 77% of expenditure.

Table 2
Australian Government and consumer expenditure by aged care service type (2017-18)

		Expenditure (AUD)	% government expenditure within program	% program of total government aged care expenditure	% consumers in program
Home Support (CHSP)	Government Consumer	$2.4b $219m	92%	14%	70%
Home Care (HCP)	Government Consumer	$2b $122m	94%	12%	10%
Residential	Government Consumer	$12.2b $4.5b*	73%	74%	20%
TOTAL	**Government** **Consumer**	**$16.6b** **$4.8b**	**77%**	**100%**	**100%†**

Source: ACFA (2019)
*Excludes consumer contributions towards their accommodation paid as a refundable accommodation deposit. Includes consumer accommodation contributions paid as a daily accommodation payment.
† Total number of consumers in the three programs = 1 206 100.

The following provides a description of the main features of the three mainstream programs of home support, home care and residential care followed by the three programs for short-term care: respite, transitional and restorative care.

2.1 Home support

The CHSP provides entry-level home support services to help older people and their carers to live independently at home. The CHSP is underpinned by a wellness approach which aims to build each person's strengths, capacity and goals to promote their independence, mobility and autonomy. The program also aims to prevent or delay the need for a home care package or entry into residential aged care (Department of Health 2018). The CHSP provides funding as a grant to approved providers, and consumers may be asked to contribute to the cost of services.

Services under the CHSP may include daily living services (e.g. housekeeping, home modifications, subsidized transport and meal delivery), personal care (e.g. help with personal hygiene and grooming), and some clinical care services (e.g. basic nursing care, occupational therapy). Services are available on an ongoing or short-term basis and include day and residential respite services so that informal carers may take a break (see *Support for carers and respite care*). As an entry-level, lower cost service, the CHSP provides subsidized support for 70% of aged care consumers but accounts for just 14% of government expenditure (Table 2).

2.2 Home care

The HCP subsidizes a more structured, comprehensive package of daily living, personal care and clinical care tailored to meet the needs of older people living at home with more complex needs than the CHSP can support. The HCP operates under the principle of consumer directed care that encourages older people to be involved in determining how their care budget is spent. Providers must work in partnership with consumers to identify their goals and needs, which form the basis of a care plan. There are four package levels depending on individuals' assessed needs: basic care needs (Level 1); low level care needs (Level 2); intermediate care needs (Level 3); and high care needs (Level 4). Consumers may pay a basic daily fee as well as an income-tested contribution to their care.

The *Increasing Choice in Home Care* reforms introduced in 2017 aimed to increase consumer control by assigning budgets to individual consumers rather than providers, and making them portable between providers. Prior to 2017 providers were allocated 'funded places' through a competitive process, and they retained any unspent funds if a consumer left a service, which created a disincentive for consumers to change providers. Unspent funds now move with the consumer to a new provider or returned to the government if the consumer leaves the HCP. The reforms also stimulated the market in HCP provision by removing supply-side limits, and applying demand-side controls instead. This was achieved by allowing all interested providers who could meet the aged care standards to become an approved provider (see *Provider approval and quality standards*) to enter the market, not just those who had previously been allocated 'funded places'. However, the size of the HCP market is controlled by the government by limiting the annual release of HCP packages to consumers. Even after an individual has been assessed as eligible for a new package, there can be a considerable wait to reach the top of the national prioritization queue for their funds to be released (see *Planning and control of supply*).

2.3 Residential aged care

Residential aged care facilities provide daily living, personal and clinical care and accommodation for those with higher care needs who are no longer able to live at home. Historically, residential aged care places were designated as 'high care' or 'low care' according to residents' level of clinical and daily living dependency, and many facilities specialized in providing one or the other. This distinction was removed in 2014 with the introduction of an 'ageing in place' approach and residential aged care facilities now provide services across the spectrum of care needs. However, as support for home-based services has increased, those who enter residential aged care are older, frailer and more dependent than in the past. As of 30 June 2019, just over half of all residential aged care residents had a diagnosis of dementia (Department of Health 2019a). Few residents would now be classified as 'low care', which has

implications for the nursing skill mix in aged care facilities (see Staffing adequacy).

Residential aged care funding is based on a complex system of government subsidies and consumer contributions that vary according to the older person's care needs and ability to pay, as well as government programs for capital infrastructure. All residential aged care facilities must include the following services in accordance with residents' needs and agreed care plans:

- hotel-like services (e.g. bedding, furniture, toiletries, cleaning, meals)
- personal care (e.g. showering, dressing, assisting with toileting)
- clinical care (e.g. wound management, administering medication, nursing services)
- social care (e.g. recreational activities, emotional support) (see p44 of Department of Health (2019a)).

2.4 Support for carers and respite care

As an increasing number of older people continue to live in their own home, carer support and respite care have become increasingly important for the family members and friends who support them. In 2018 there were 2.65 million carers of older people and people with a disability in Australia, representing 10.8% of all Australians (ABS 2019a). The majority of primary carers (79.1%) reside in the same household as the person for whom they provide the most care (ABS 2019a). There are several government-funded services that provide information and support directly to carers[3]. In recognition of their reduced ability to work, means-tested income support (as a carer payment or allowance) is also available to carers of older people who are ill, frail or disabled. Once the carer reaches age-pension age (currently 66 years) they must choose between continuing to receive carer income support or switch to the age pension (Department of Human Services 2019).

Government-subsidized respite care within the aged care system is available to give informal carers a break from their caring role on an occasional or ongoing basis. Access is through the eligibility of the older person in receipt of care and is available in a range of settings. The CHSP supports flexible respite services at home or in a centre, while HCP recipients may use their package to purchase respite services. Residential respite in approved residential aged care facilities is also available on a planned or emergency basis for up to 63 days per year (more with approval). Some older people also use respite care as an opportunity to "try before you buy" prior to entering a residential aged care facility.

3 See for example https://www.carergateway.gov.au/.

In 2018–19, 51 039 people received respite services through the CHSP, and there were 83 455 admissions for respite care in a residential facility (Department of Health 2019a). The availability of beds for respite care is at the discretion of providers. Despite increasing use of respite services, many older people and their carers report problems in accessing appropriate services (Royal Commission 2019a). A review of respite services conducted by the Aged Care Financing Authority recommended a greater focus on the choice and supply of respite services, especially for older people with special needs, such as those with dementia, and from culturally and linguistically diverse backgrounds. It also recommended that there be 'funding neutrality' between permanent and respite care in aged care facilities. Currently, the respite care consumer does not pay for accommodation, and care funding is not on the same basis as for permanent care, creating a disincentive for providers to make beds available for respite care (ACFA 2018).

2.5 Transition care

The Transition Care Program provides short-term, goal-oriented and therapy-focused services to older people in their own home or residential facility following a hospital stay. Care is provided for 12 weeks, with an extension of up to 6 weeks available subject to a needs assessment. In 2018–19, the average length of an episode of transition care was 53.2 days (Department of Health 2019a). The aim of the program is to improve an older person's independence and functioning and to delay their entry into residential aged care (if they are living at home). It is provided as a package of care services that may include physiotherapy, occupational therapy, social work, nursing care and personal care. Transition Care is funded by the national government and managed by the state and territory governments who determine the service models that best suit local and individuals' care needs. All state and territory governments have arrangements with external providers to deliver transition care. As of 30 June 2019, there were 4060 funded transition care places. During 2018–19, a total of 24 432 people received transition care (Department of Health 2019a).

2.6 Short-term restorative care

The Short-Term Restorative Care Program offers a similar package of services to Transition Care but is available only to older people living in their own home and not on a home care package, and not necessarily following a hospital stay. The program provides early intervention to reverse or slow functional decline in older people. Functional decline is defined as a person having difficulty in performing day-to-day activities such as bathing, dressing and mobility and are slowing down mentally, physically or both. The focus of the program is to promote older peoples' independence and to prevent or delay their admission into residential care. Unlike

Transition Care, the federal government commissions providers directly to provide restorative care. The program provides services for older people for up to 8 weeks, and they may access up to two episodes of restorative care in a 12-month period. During 2018–19, 2543 people received care under the Short-Term Restorative Care program (Department of Health 2019a).

3 Consumers and providers of aged care

This section provides an overview of the consumers and providers in Australia's aged care system: how consumers access government-subsidized aged care services, and the process, quality standards and prudential requirements that providers must satisfy to deliver those services and to manage government subsidies. It then describes the purchaser and provider relationships in each of the three mainstream programs and the ownership profile of the approved providers. The section concludes by explaining the mechanisms for the planning and control of the supply of aged care services.

3.1 Consumer access and eligibility

Access to aged care services in Australia is determined by need rather than age. There is no legislated minimum age for receiving subsidized aged care services, but it is generally considered a service for older people aged from 65 years (50 years for Indigenous Australians). A broader age range is used for Indigenous Australians because of their greater need for care at a younger age due to poorer health status and lower life expectancy compared to non-Indigenous Australians (Royal Commission 2019b). Among those aged 65–74, Indigenous Australians are 3.1 times as likely to use home support, 7.1 times more likely use home care, and 2.1 times more likely to use residential aged care than non-Indigenous Australians (AIHW 2019b). Non-Indigenous Australians may also be deemed eligible for subsidized aged care services under 65 years if, for example, they have early onset dementia, multiple sclerosis or other conditions requiring specialized care not covered under the National Disability Insurance Scheme.

Every older person must undergo a free standardized assessment to receive a publicly subsidized aged care services. Older people can access the open market for a range of care and support services without an eligibility assessment if they are willing to pay the full cost of the services. The Department of Health's 'My Aged Care' website[4] and contact centre is the entry point to the aged care system. To receive an assessment, an older person (or their carer or health service provider acting on their behalf) must register with My Aged Care. Assessment is a two-stage process. The first is a simple eligibility check completed online or over the phone to establish if, and what

4 https://www.myagedcare.gov.au/

type of aged care service the older person may require. The second is a more in-depth, face-to-face assessment to establish the older persons' health status, functionality within the home environment, and any existing supports they have. Face-to-face assessments usually take place in a person's home or in a hospital if they have been admitted for inpatient care and are likely to be discharged soon. There are currently two types of face-to-face assessments, one for home support (CHSP) and the other for home care (HCP), residential care and short-term care. Both assessments are funded by the national government but are conducted by assessors employed by state and territory governments or not-for-profit organizations who are independent from aged care providers.

If the My Aged Care eligibility check establishes the older person only requires entry-level home support (CHSP), the face-to-face assessment is conducted by a Regional Assessment Service (RAS). If the assessor deems the older person is eligible for one or more home support services, consumers receive a separate referral code for each of those services. Eligible consumers may take each of these referral codes to a range of providers who view the client's record and decide whether they have funding, skills and workforce capacity to deliver the required services. Consumers must often wait for services or receive only some of the services for which they are eligible. Around 54% of CHSP consumers receive one type of service, 41% receive between two and four types of service, and 5% access five or more types of services (ACFA 2019).

Assessments for home care (HCP), residential care and short-term care (i.e. respite, transitional and restorative care) are performed by an Aged Care Assessment Team (ACAT). The ACAT usually includes a nurse plus another healthcare professional (e.g. occupational therapist or social worker). The assessment criteria are specified in the *Approval of Care Recipients Principles 2014*[5], and provide a comprehensive picture of an older person's physical, medical, social and psychological needs and preferences. The ACAT makes a recommendation for the type (home support, home care or residential) and level of support the older person requires and a priority level for receiving care. The eligible person is then placed on the waiting list for home care or referred to a service for home support or residential care (See *Planning and control of supply*).

3.2 Provider approval and quality standards

Providers are responsible for the delivery of quality aged care, assisting consumers to make decisions about their care, and the financial management of government subsidies and consumers' fees. Only approved providers that meet the suitability requirements of the *Aged Care Act 1997* and meet the *Aged Care Quality Standards* can receive government subsidies to deliver aged care services. On 1 January 2020, the provider approval and regulatory functions of various agencies were transferred

5 https://www.legislation.gov.au/Details/F2017C00134

to the Aged Care Quality and Safety Commission[6] (the Commission). The Commission oversees provider approval[7], accreditation of residential aged care facilities, quality reviews, monitoring and complaints handling for all aged care services. It also provides information and education to providers.

When assessing an applicant's suitability to become an approved aged care provider, the Commission considers the applicant's experience of providing aged care or other relevant services, their demonstrated understanding of their responsibilities as a provider, the suitability of their systems and staff, and financial management practices. Approved providers must continue to meet these suitability criteria to maintain their approved provider status and notify the Commission of a material change that affects their suitability, though there is no formal review of compliance with these suitability criteria once approved-provider status is attained.

Since July 2019, the initial and ongoing assessment of the quality of aged care services has been against the unified *Aged Care Quality Standards*[8], which have an increased focus on consumer outcomes rather than providers' compliance with processes. There are eight individual standards: (i) consumer dignity and choice; (ii) ongoing assessment and planning with consumers; (iii) personal care and clinical care; (iv) services and supports for daily living; (v) organization's service environment; (vi) feedback and complaints; (vii) human resources; and (viii) organizational governance. Each of the standards is expressed as a statement of outcome for the consumer, a statement of expectation for the organization, and the organizational requirements to demonstrate that the standard has been met. Providers must demonstrate that they meet the standards prior to approval, and that they are committed to continuous improvement. There are processes for regular independent quality reviews (at least once every three years), and ad hoc reviews (announced and unannounced) if the Commission has cause to suspect that the standards are not being met (e.g. following a complaint). If the Commission deems that the service has failed to meet standards, it can direct a service to outline a plan for improvement and set a timetable for that improvement. The Commission must notify the Department of Health if it deems that non-compliance with the standards is a serious risk to the health or well-being of consumers. The Department may take action when providers do not comply, through the aged care legislation or through the funding agreement with the organization.

6 https://www.agedcarequality.gov.au/

7 The Commission oversees provider approval for all government programs except the Commonwealth Home Support Program, the Multi-Purpose Services Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Those services must still comply with the Aged Care Act and Aged Care Quality Standards.

8 https://www.agedcarequality.gov.au/providers/standards

3.3 Characteristics of purchasers and providers

There are different purchaser and provider relationships within each of the three mainstream aged care programs. As a grant-funded program, the federal government is the purchaser of **home support** services from providers under the CHSP. Eligible consumers then seek services from those providers. Some providers deliver a single service such as meal delivery, transport assistance or domestic services, whereas others provide a wide range of support services. Consumers who are assigned an entitlement to **home care** under the HCP are the purchasers of services since the care budget is assigned to individuals rather than to specific providers. Under the principles of consumer-directed care, consumers combine their national government subsidy and their own means-tested contribution to purchase services from a market of competing and approved providers and have control over how their budget is spent. Consumers with assessed entitlements to **residential aged care** subsidies may choose from approved providers in the market place. However, the government is the purchasing body since providers must apply to the Department of Health government for an allocation of subsidized bed licences (See Planning and control of supply).

Table 3 gives the number and ownership of approved aged care providers in Australia for home support, home care and residential aged care. The majority of providers are not for-profit organizations across all three programs, especially in the grant-funded CHSP where 70% are not-for-profit. However, data from the Aged Care Financing Authority suggest there has been a recent shift in ownership from not-for-profit to for-profit providers in the home care sector, stimulated by the 2017 *Increasing Choice in Home Care* reforms which uncapped supply-side controls. In June 2014, 20% of home care providers were for-profit, increasing to 35% in 2018, while the proportion of government providers remained stable at 12% (ACFA 2019).

Table 3
Number and ownership of aged care providers at June 2018

	Providers (n)	Services** (n)	Ownership (% providers)		
			Not-for-profit	For-Profit	Government
Home Support (CHSP*)	1,547	n/a	70%	7%	23%
Home Care (HCP)	873	2,599	53%	35%	12%
Residential	886	2695	56%	33%	11%

Source: ACFA (2019)
* includes equivalent program in Western Australia.
**number of home care services and residential aged care facilities.

3.4 Planning and control of supply

The national government applies three main types of planning and supply controls within the aged care system, aligned to the three mainstream programs described ins this paper.

The supply of home support is controlled by the national government capping the annual CHSP funding grants to providers. The annual budgetary determination of the quantum of grants available to service providers is based on a broad assessment of need and the government's fiscal setting. After years of low growth in funding, in the 2018-19 Budget the national government applied a real (after inflation) growth rate of 3.5% aligned with the rate of growth of the population aged 65 and over. However, providers advise that there remains unmet demand for entry-level home support services (ACFA 2019).

For home care and residential aged care (as well as the short-term care programs), the national government manages the planning of and expenditure on services by specifying a national target provision ratio. The 'aged care provision ratio' is the number of subsidized aged care places for every 1000 people aged 70 years and over and is an estimate of consumer demand. The current target is set at 125 places by 2021-22, comprising 78 residential aged care places, 45 home care places and two short-term care places (transition care and short-term restorative care) (Department of Health 2017). The national government also exercises individual program-level controls for the provision of home care, residential aged care and short-term care.

In home care, the 2017 *Increasing Choice in Home Care* reforms uncapped the supply of home care provision by assigning funding to individuals rather than providers (see *Home care*). This resulted in a significant initial surge in the numbers of providers from around 500 in the years up to 2016 to over 900 by 2019, and a shift in provider ownership toward the for-profit sector (ACFA 2019; Department of Health 2019a). However, the government exercises control over the size of the home care market through demand-side queuing. Older persons who have had an ACAT assessment and are eligible for a home care package are placed on a national prioritization queue for their package level according to the date of approval and their priority level ("high" or "medium" depending on care needs and personal circumstances). They are assigned a package when they are the next eligible consumer on the queue for that package and priority level.

The national prioritization queueing system allows the government to exercise fiscal control over the HCP while maintaining a consistent and equitable national approach to consumer access. The total number of packages available increases when the national government releases additional funding at the four package levels. The number of people assessed as eligible for home care exceeds the number of packages released by government, especially for those with

high care needs (Level 4). A funding boost to the HCP saw the number of people receiving packages increase by 30% between September 2018 and 2019, and a decline in the number of people waiting for a package at their assessed level (Department of Health 2019d). As at 30 September 2018, there were 112 000 people on the national prioritization queue awaiting a package at their assessed level, though the majority of these consumers already receive basic home support services through CHSP or a lower level home care package while they wait (Department of Health 2019d). Waiting time data for 2018-19 show that most people (90%) assessed as "high priority" by the ACAT accessed a Level 2 package in 2 months[9], Level 3 in 9 months and Level 4 in 13 months. Waiting times have tripled for those assessed as "medium priority" (Steering Committee for the Review of Government Services 2020).

The national government controls the size of the residential aged care market through supply-side capping of the number of places allocated to providers, known as bed licences. The number of additional residential aged care places made available in each state and territory is controlled by a periodic competitive allocation round for approved providers (the Aged Care Approvals Round). The number of places released in each allocation round is determined by the target aged care provision ratio for each state and territory. It is also influenced by: the level government funding expected in the forward estimates (budget projections for the three years beyond the current fiscal year); demographic projections; current levels of service provision (i.e. number of operational places, occupancy levels); and newly allocated places from previous rounds that are not yet operational. The number of places bid for by providers regularly exceeds the numbers of places released through each allocation. The median waiting times for future residents from the time of their ACAT assessment to accessing a residential aged care place in 2018-19 was 152 days (Steering Committee for the Review of Government Services 2020), though the provider or location of the aged care facility may not meet their preferences. Many people assessed as eligible for a subsidized residential aged care place choose to remain at home with their existing care arrangements. As noted earlier, many people waiting for a place in an aged care facility are in hospital awaiting discharge (see *Older people and hospital care*).

9 Some of those accessing a Level 2 package may have been assessed as in need of a higher level package.

4
Structure of payments and pricing for aged care services

Aged care services in Australia are paid for through a mix of government subsidies and supplements (77% of funding see Table 2) and consumer contributions. The level of government subsidies and some elements of consumer contributions are cost-based and government-regulated. For these regulated elements, consumer contributions are also means-tested. Market-based prices may be charged for some consumer contributions to some services and accommodation when the resident is required to pay the full amount.

The Minister for Aged Care determines the rates for subsidies, supplements and maximum allowable consumer contributions each year, and these are published as a schedule of fees and charges (Department of Health 2019c, 2020). This price-setting function is underpinned by a number of legislative instruments (e.g. *Aged Care Act 1997*, *Subsidy Principles 2014*, *Aged Care (Subsidy, Fees and Payments) Determination 2014*). In addition, the Aged Care Pricing Commissioner[10] has a role in regulating accommodation payments for residential aged care. The Aged Care Financing Authority[11] provides independent advice to the national government on aged care funding and financing issues. The following explains the structure of payments and pricing for home support, home care and residential aged care services.

4.1 Home support payments and pricing

The national government pays for home support services through CHSP grants to providers which are indexed annually[12]. Providers may be awarded a grant by the Department of Health through an open or targeted competitive tendering: responding to requests for expressions of interest or through direct selection by the Department. Table 4 shows that the distribution of grants issued under the CHSP in 2017-18 was weighted towards smaller grants: 58% were for less than half a million Australian dollars. Analysis by the Aged Care Financing Authority shows that, on average, CHSP consumers received services to the value of A$ 2762 per annum in 2017-18 with significant variation between consumers (ACFA 2019).

10 http://www.acpc.gov.au

11 https://www.health.gov.au/committees-and-groups/aged-care-financing-authority-acfa

12 Wage Cost Index 3 – composite index that comprises a wage cost component (weighted at 60%, based on increases in the national minimum wage) and a non-wage cost component (weighted at 40%, includes the consumer price index).

Table 4
Home support government payments and consumer contributions in AUD (2017-18)

Government Payments		Consumer Contributions
Size of grant issued	**%(n)**	**Client Contribution**
Less than $500 000	58% (845)	Non-compulsory fee charges in line with the *Client Contribution Framework.*
$500 000-$1 million	17% (244)	
$1-10 million	23% (336)	
$10 million plus	2% (31)	

Providers may charge a consumer contribution for home support services in line with the *Client Contribution Framework* so that those who can afford to contribute to the cost of their care do so while protecting those who cannot. Providers must publish a client contribution policy and a list of any fees charged. However, the client contribution element within the CHSP is currently non-compulsory, and many providers seek no or only minimal contributions from consumers regardless of ability to pay. Consumer contributions account for just 8% of total expenditure on home support services (see Table 2). A 2017 review of aged care services recommended that mandatory consumer contributions based on a consumer's ability to pay be introduced for home support services to improve equity between programs, but this is yet to be actioned (Department of Health 2017).

4.2 Home care payments and pricing

The level of government subsidy and supplements allocated to an individual consumer on a Home Care Package and paid to their chosen provider is determined by the comprehensive ACAT assessment (see Consumer access and eligibility above). This is combined with consumer contributions to give an overall care budget to spend on services with their chosen provider. Table 5 provides a description of the government payments and consumer contributions that comprise the HCP, with current daily rates. The largest component of a home care budget is the home care subsidy which is indexed annually[13]. There is no publicly available information on how the quantum for home care subsidies and supplements were originally set by government.

13 Wage Cost Index 9 – wage cost component (75%), non-wage cost component (25%).

Table 5
Home care package daily rates for subsidies, supplement and fees in AUD (2019-20)

Government Payments	Consumer Contributions
Home Care Subsidy Set by level of assessed need. Level 1: $24.07 ($8785 p/a) Level 2: $42.35 ($15 458 p/a) Level 3: $92.16 ($33 638 p/a) Level 4: $139.70 ($50 260 p/a) **Home Care Supplements** Payable to consumers with additional care needs or those who live remotely. Indexed annually. *Dementia and Cognition and Veteran Supplements* $2.77 - $16.07 by package level *Oxygen and Enteral Feeding* $11.72 - $20.86 by complexity *Viability supplement* $0 - $18.71 by geographical remoteness	**Basic Daily Fee** Non-compulsory fee priced at a maximum of 17.5% of the government age pension for a single person. Applies to all consumers unless they prove financial hardship, but is not collected by many providers. Maximum $9.52 - $10.63 by package level **Income Tested Care Fee** Dependent on income, applied as reduction to the home care subsidy paid by government. Annual and lifetime caps apply. **Additional Services Fee** Consumers can choose to pay for additional care and services that the Home Care Package would not otherwise cover. Charged at market prices.

Source: Department of Health (2019c, 2020) schedule of daily subsidies and fees.

The consumer-directed care approach within home care enables consumers to have choice, flexibility and control over the types of services they receive, how and when they are delivered, and who provides them. Consumers may also purchase additional care and services not covered by the home care package if they are willing to pay the market price. People who have not had an ACAT assessment may also access non-subsidized home care services on the open market.

Providers of subsidized home care must set out an individualized budget and issue monthly income and expenditure statements to provide transparency over what budget is available and how funds are spent. They are also required to publish the prices they charge for individual services within a package on the government's My Aged Care website. The published pricing schedule must include the basic daily fee, care management costs and approximate hours of service available within each package level for common home care services (e.g. personal care, care by a registered nurse, cleaning and household tasks). It must also include other costs such as package management, any exit fees, staff travel costs and any extra costs involved in obtaining services from other providers.

4.3 Residential aged care payments and pricing

Operational funding and capital financing of residential aged care facilities are provided under separate programs. The national government contributes to operational funding through a care subsidy for personal and nursing care (based on residents' assessed need), supplements to support any additional clinical and social needs, and an accommodation supplement for those residents who cannot afford to pay the full market price for their accommodation.

Residents make a means-tested contribution to the cost of their care, and this amount is deducted from the level of subsidy paid by the government. Residents pay a set rate for their basic daily services (set at 85% of the single age pension) as well as fees for any additional services that facilities may offer at market prices. Residents who are required to contribute to or pay the full cost of their accommodation can do so through a lump sum Refundable Accommodation Deposit, a rental-style Daily Accommodation Payment, or a combination of both. Table 6 provides a summary of the government payments and consumer contributions in residential aged care for 2019-20. Payments are usually indexed[14] biannually (accommodation-related) or annually (care-related). There is no publicly available information on how the government originally set the quantum of the residential aged care subsidies and supplements.

14 Accommodation-related payments indexed with the Consumer Price Index, care-related payments indexed with the Wage Cost Index 9 – wage cost component (75%), non-wage cost component (25%).

Table 6
Residential aged care daily subsidies, supplement and fees in AUD (2019-20)

Government Payments	Consumer Contributions
Basic Care Subsidy Set by assessed cost of providing care using the Aged Care Funding Instrument. Average daily subsidy* $178.21, varies considerably **Residential Aged Care Supplements** Supplements paid to services for residents with additional financial, clinical and social needs. *Accommodation Supplement* Means-tested for those eligible for assistance with accommodation payments. Maximum $59.47 *Hardship Supplement* Paid on behalf of care recipients in financial hardship unable to pay their aged care costs. *Homeless Supplement* $21.30 *Veteran Supplement* $7.18 *Oxygen and Enteral Feeding* $11.72 - $20.86 by complexity *Viability supplement* $0 - $74.98 by geographical remoteness	**Basic Daily Fee** Fee paid for day-to-day services e.g. meals, cleaning and laundry. Applies to all residents, priced at a maximum of 85% of the government age pension Maximum $51.63 ($18 845 per/annum) **Means-Tested Care Fee** Ongoing fee paid to the provider to contribute to cost of personal and clinical care. Dependent on income and assets, applied as reduction to the basic care subsidy paid by government. Maximum $252.20 (annual and lifetime caps apply) **Additional Services Fee** Provision of additional hotel-type services, e.g. a higher standard of food and services. Charged at market prices. **Accommodation payments** Payments made as a contribution to the cost of accommodation, means-tested. Paid as a lump sum refundable deposit, daily payment or a combination of both. Charged at market prices up to a maximum of $550 000† (lump sum).

Source: Department of Health (2019c, 2020) schedule of daily subsidies and fees.
* As of September 2019 (Department of Health 2019b).
† Higher with approval from the Aged Care Pricing Commissioner.

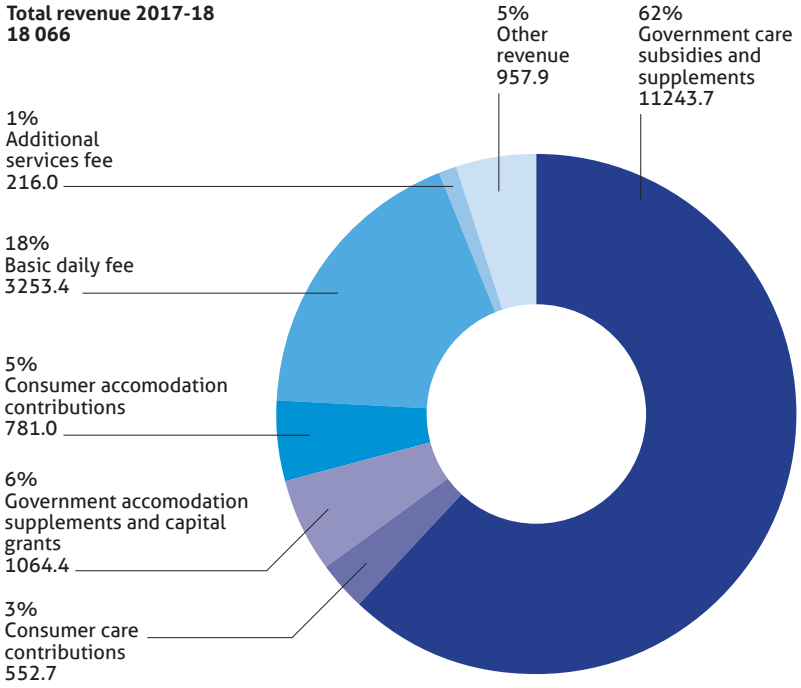
As for home care, the basic care subsidy comprises the largest government payment for residential services. The Aged Care Funding Instrument (ACFI) determines the level of care subsidy paid to a provider for a resident's care using assessment tools to establish their personal and clinical care needs. Currently, providers conduct the initial and subsequent ACFI assessments but are subject to audits by the Department of Health.

Capital financing for residential care providers is comprised of equity, including: retained earnings; loans from financial or other institutions; interest free loans from residents in the form of lump sum Refundable Accommodation Deposits; capital investment support from government through capital grants for eligible projects; and capital endowments. There has been a steady decline in the level of capital financing available to providers through lump sum Refundable Accommodation

Deposits and a commensurate increase in their income stream, as many residents choose to make their accommodation contribution as a rental-style Daily Accommodation Payment instead. Driving factors in this change include the length of stay of many residents and the time it can take for them to sell their home. For-profit providers place greater balance sheet reliance on Refundable Accommodation Deposits (62% at June 2018) and other liabilities (borrowings) (28%) than not-for-profit providers (54% and 12%, respectively). Conversely, not-for-profit providers had a net worth (equity) of 34% on their balance sheets, while for-profit providers were more highly geared and had a net worth (equity) of only 9% (ACFA 2019).

The balance between residential care providers' multiple sources of revenue is shown in Figure 1. The basic care subsidy and other supplements paid by government comprises the highest proportion of providers' revenue. The reliance on the basic care subsidy means pricing decisions around these ACFI-based payments have a major impact on providers' financial performance. An indexation freeze on ACFI payments implemented when the government believed inflation in ACFI claims exceeded the real increase in residents' acuity, resulted in profits in the sector reduced from A$ 1006 million in 2016-17 to A$ 435 million in 2017-18 (ACFA 2019). Despite indexation being restored, providers assert that increases in care costs still outstrip the level of funding received through ACFI, as discussed further in Staffing adequacy and pricing.

Figure 1
Proportions of total residential care provider revenue 2017-18 in AUD (in millions)



Source: ACFA (2019).

5
Challenges for the Australian aged care system

The funding and provision of aged care services in Australia has increased substantially in recent years, including a shift towards support for older people to remain in their own home, in line with community preferences. There have also been significant improvements in the choice and control consumers exercise over their care, especially in the home care sector. The majority of aged care consumers report they are satisfied with the range (71%) and quality (84%) of the services they receive (Steering Committee for the Review of Government Services 2020).

However, a number of high-profile failings in the quality of care provided in residential facilities and at home prompted the national government to establish the Royal Commission into Aged Care Quality and Safety[15] in 2018. The Royal Commission interim report (2019b) provides some personal accounts of poor quality care and inadequate social support for older people in the aged care system. It also emphasizes the unacceptable time many wait for a home care package, and the problems older people and their carers face in choosing a residential facility. A 2018 national survey confirms there remains significant unmet need for aged care services in the community: 34% of people aged over 65 living at home and in need of assistance reported that their needs were not fully met. This proportion was higher for those with a profound or severe disability (41.7%) than for those without a disability (20.5%) (Steering Committee for the Review of Government Services 2020). A consistent theme from the evidence provided to the Royal Commission (2019b) is that consumers and carers perceive Australia's aged care system to be complex and difficult to navigate.

In common with many other countries, successive Australian governments have grappled with the design of policy and pricing mechanisms that will stimulate innovation in delivering quality and sustainable aged care services. The following discusses three of the key challenges and proposals for reform in the Australian aged care system.

5.1 Assessment process

Getting the assessment process right is essential for ensuring timely and equitable access to appropriate aged care services and the sustainability of national budgets. There is a great onus on the assessment workforce, which is primarily trained in personal support and health care, to rigorously apply the eligibility criteria set by the government and to do so consistently across regions and over time.

15 https://agedcare.royalcommission.gov.au. A Royal Commission is the highest form of public inquiry in Australia. It is established by but independent from government and has powers to call evidence and witnesses in line with its specific terms of reference.

Aged care assessment in Australia is currently a complex, multi-stage assessment process, which evolved as different government programs were introduced, each with their own eligibility criteria and assessment workforces (see *Consumer access and eligibility*). For consumers, this means they face multiple assessments and delays in accessing the services they need. A further challenge for the assessment process is balancing the dual function assessors serve in determining the nature of the services an older person requires against a range of health, social and wellbeing indicators, while also acting as gatekeepers to government subsidies. Means-testing for determining the level of consumers' financial contribution is conducted independently from aged care assessments. There is some evidence to suggest that while there are many older Australians with unmet needs, others may have been assessed as eligible for a higher level of care than their current need would indicate. Data on the uptake of services show a number of people on waiting lists refuse a home care package when offered (Department of Health 2019d). Another indicator of possible 'over-assessment' is that there are large sums of unspent funds in consumers' packages. As of 30 June 2018, home care providers reported holding unspent funds of A$ 539 million, equating to an average of A$ 5898 of unspent funds per consumer (up from A$ 4613 on 30 June 2017). Other reasons for the accumulation of unspent funds include consumers 'saving' funds for possible future events, the lack of availability of desired services, a reluctance of consumers to use services, and misconceptions that the money not spent under the package belongs to the consumer (ACFA 2019).

A new framework for a streamlined consumer assessments for all aged care programs to be implemented in 2021 aims to reduce the number of assessments a consumer is subject to, make the assessment more targeted to consumers' likely level of need and improve the timeliness of access to appropriate services (Department of Health 2019a). Consultations with the aged care sector on the new framework emphasized the importance of consistent national training for the assessment workforce. Further, that training should focus on reablement and restorative approaches to prevent or delay the need for higher level care. Prevention and reablement will be the focus of future Australian government policy and investment across mainstream services and the short-term care programs (*Transition care* and *Short-term restorative care*), which currently comprise a small proportion of aged care spending. Creating the right framework and incentives for assessors to balance the needs of consumers with the fiscal impact on public funds is an ongoing challenge for the Australian government.

5.2 Allocation of residential aged care places

Australia has moved to a market-driven model for the allocation of home care places, albeit within the constraints of demand-side controls over the release of funds. In residential care, however, the national government manages its fiscal exposure

through the periodic competitive allocation of additional places (bed licences) to providers (Aged Care Approvals Round – see *Planning and control of supply*). A significant consequence of this supply-side capping of subsidized residential aged care services is that providers have historically regarded the government, rather than consumers as the customer. The allocation process itself has lacked transparency and has supported the building and operation of standardized aged care facilities that have little appeal to many older people. There is little incentive to improve infrastructure beyond compliance levels. Around 14% of aged care residents in Australia are still in a 'ward style' shared room with a shared bathroom (Department of Health 2019f). The allocation process has also had the effect of limiting consumer choice, as providers can obtain bed licences to crowd-out local competition. Conversely, providers can sell bed licences and circumvent the planning process and rationale underpinning the release of places. Further, there is an ongoing problem of allocated places not being made operational in a timely manner, as providers apply for places before they are 'bed ready'. Overall, the Aged Care Approvals Round process has resulted in a lack of competition between providers and limited innovation in the design of facilities and services which better reflect consumers' needs and preferences (Department of Health 2019f).

The national government has commissioned a review into the impact of transitioning from allocating subsidized residential aged care places to providers to assigning them to consumers, bringing residential care in line with home care. However, the challenge for government will be to retain fiscal control when supply is uncapped without imposing the demand-side queuing which has proved problematic in the home care sector. Any reforms to supply would also have to consider the challenge of designing an assessment process that supports equitable, appropriate and sustainable access to age care services. The threshold for eligibility for residential aged care may have to be increased and the assessment of approved providers made more rigorous, since a more open market may result in residential care being delivered in a wider range of accommodation settings.

5.3 Staffing adequacy and pricing

Adequate staffing is crucial for the provision of quality aged care. Staffing adequacy is determined by a number of factors including the number of staff per consumer, continuity of staff providing care to individuals, skill mix (proportion of care provided by registered health professionals versus vocationally trained care staff) and appropriate training (OECD & European Union 2013). Staffing adequacy is also determined relative to the personal, social and clinical needs of the consumers receiving care.

Australia currently has no specific minimum standards for the number, skill mix or qualifications of staff providing aged care

services at home or in a residential facility. Standard 7 of the 2019 Aged Care Quality Standards stipulates that providers must have "a workforce that is sufficient, and is skilled and qualified to provide safe, respectful and quality care and services". There are associated requirements on providers to demonstrate they have a workforce planning and utilization process, regular reviews of staff competency and performance, and appropriate training. This self-regulation approach to staffing was introduced in 2014 when the distinction between high care and low care facilities was removed, along with the requirement for a registered nurse to be on duty 24 hours a day in high care facilities.

An international comparison of staffing levels and skill mix in Australian residential aged care facilities conducted by Eagar, Westera et al. (2019) suggests that self-regulation has not resulted in adequate staffing. Using the casemix adjusted USA Centers for Medicare and Medicaid system for comparing staffing levels, that study found that more than half of Australian aged care residents (57.6%) are in facilities with 'unacceptable' levels of staffing. Of the remaining, 27% were in facilities with 'acceptable' staffing, 14.1% with 'good' staffing, and 1.3% with best practice staffing. The study estimates that raising the standard so that all Australian aged care residents are in a facility with 'good' staffing levels would require an overall increase of 37.2% in total care staffing. There is no comparable research on staffing levels in aged care services delivered at home. However, the Royal Commission (2019b) reports that providers experience significant challenges with labour supply, access to quality training, and providing continuity of care for individual consumers.

Staffing accounts for around 70% of the cost of aged care services, therefore, it is crucial that the price paid by government and consumers reflects the staffing required for quality services. In Australia, the indexing of government payments has a broad wage cost element based on increases to the minimum wage. Price-setting policy, through ACFI and home care package levels, attempts to reflect the relativities of providing care for consumers of different levels of dependency and acuity. However, the relationship between the prices paid and the actual staffing costs needed to provide quality care is tenuous. There is no publicly available information on how the quantum of the care subsidies in residential and home care packages programs were originally set. A proposed new resident classification system, developed by Eagar, McNamee et al. (2019), calculated real staff time use data and input from experts to strengthen the link between staffing costs and prices. It also aims to overcome some of the other limitations of the ACFI system by separating the fixed costs of providing care within a facility from the variable costs associated with the different acuity levels of residents. It proposes that the assessment process for funding purposes (to be conducted by external assessors) be separated from assessment for care planning purposes (to be conducted by providers). An

independent assessment process for funding purposes would remove the current financial incentives for providers to assess residents at a higher level of support than their current need, and incentivize a reablement approach to care. At the time of writing, the Australian Government is piloting the new classification system, but there are no similar reforms proposed in the home care sector.

6
Lessons from the Australian aged care system

The delivery and funding of aged care services in Australia have undergone significant reform over the last decade, with further changes planned. This section identifies three lessons from the Australian experience which may have broader applicability to a range of other countries, particularly those with less publicly funded resources to draw on.

6.1 Designing services that better reflect consumer wishes and improve fiscal sustainability

The Australian Government is in the process of transitioning its policy and public funding emphasis from services that provide residential care for older people to those that support people to live in their own home for as long as possible. Residential care will always be required for the most frail and dependent in the community, including those with high level symptoms of dementia and chronic and complex health conditions. However, the level of public funding for the 'care' component in residential care does not reflect the cost of the skilled staff required to deliver quality services for those with higher care needs. At present, a little over 50 percent of all aged care homes in Australia are operating at a loss, as providers are squeezed between meeting the minimum quality and safety standards and paying for sufficient numbers and skill levels of staff (StewartBrown 2019). The level of financial losses in rural and remote areas are even more acute.

Investment in quality and tailored home care services offers a more fiscally sustainable solution to long-term care and one that is in line with the wishes of most older people and their families. However, for home care services to perform their function of preventing or delaying admissions to costly residential facilities and hospital care, they must also be delivered by a skilled workforce and organized to promote continuity of care. Challenges in labor supply and the variable funding associated with individualized care budgets make it difficult for providers to achieve this quality and continuity of care. A system designed to prioritize home care must also consider financial and social support for informal carers, since this too improves the sustainability and acceptability of long-term care at home.

Australia is beginning to shift from a reactive approach to service provision that responds when older people experience a deterioration in their health, function or cognition, towards services directed at preventing or delaying admission to expensive residential or hospital care. Such services must provide earlier access to supportive technologies, interventions to prevent or slow older peoples' decline in health and function, as well as reablement approaches in response to health and other crises. As discussed earlier, the lesson from the Australian system is that the assessment process and payment system must support these more sustainable interventions, rather than incentivize the use of more costly, reactive services.

6.2 Household wealth and the sustainability of aged care financing

Australia's median adult wealth is among the highest in the world (Credit Suisse Research Institute 2019). A large part of this wealth is explained by a high rate of home ownership combined with high real-estate prices, as well as a compulsory superannuation scheme. The value of the family home is usually exempt from an extensive range of government means tests. One notable exception is in the calculation of the government's contribution of residential aged care accommodation fees, but only if no partner or dependents are living in the home. A person whose home is valued in excess of A$ 169 079 must pay full accommodation costs, a low threshold value given the mean dwelling price in Australia is in excess of A$ 660 000 (ABS 2019b).

There have been calls to widen means-testing to a broader range of aged care services and to include assets such as the family home to improve both sustainability and equity (Woods 2020). This is particularly important in countries like Australia, which have relatively low levels of taxation, are heavily reliant on income tax and have high household wealth. Further, financial instruments are needed to help older households unlock their assets. The Australian Government's Pension Loans Scheme is an example of this, but is currently limited to those who qualify for an aged pension and therefore have limited means. Broader eligibility criteria would make it simpler and less costly for wealthier older people to contribute to their aged care needs as they become frailer.

6.3 Market mechanisms, quality and price

Australia's approach to the long-term care of older persons uses consumer choice and control within a market-based system to drive competition on quality and price. While the majority of consumers are satisfied with the quality of the services they receive, evidence from the Royal Commission into Aged Care Quality and Safety suggests that market mechanisms and the regulation of the sector have not had a universally positive effect on quality. In the delivery of home care services, there is some evidence that providers are instead competing on

price. Given government subsidies are set at a fixed rate according to need and consumers are typically price-sensitive and on fixed pension incomes, this competition is achieved in part by providers lowering the rates of consumer contributions. At the same time, the consumer-directed care approach for stimulating competition has increased administration costs in the implementation of accounting systems to manage and report individual care budgets. Consequently profits in the sector have fallen significantly since the introduction of consumer-directed care (ACFA 2019).

The experience of providing services in remote and rural Australia illustrates the limitations of market-based systems for sparsely populated, geographically remote areas (see *Box 1*). The Multi-Purpose Service Program offers an example of a viable model for more sustainable, integrated health and residential aged care services for sparsely populated areas. In contrast, the market-based HCP does not work well for remote and rural Australia, since there is often little choice between providers and travel costs consume a high proportion of individual care budgets. Alternatives, such as a competitive grant scheme to become the preferred provider for a defined population, may improve access and sustainability in rural and remote areas, especially if combined with the delivery of other services, such as disability care.

Box 1: Aged care programs for regional and remote Australia

Providing health and aged care services in regional and remote communities is a significant challenge for Australian national and state governments. The population in regional Australia is older than in the cities due to younger, regional migrants settling in the cities, while in remote Australia the population is younger due to Indigenous Australians having relatively high birth-rates and lower life expectancy. People living in regional and remote communities have higher levels of disease and injury compared to people living in cities due to lifestyle and social disadvantage factors, as well as poorer access to health services (AIHW 2019d). These demand factors are compounded by supply side challenges for health and aged care providers: a limited professional workforce; high costs of travel, freight and utilities; ageing infrastructure; and limited population catchment areas resulting in smaller scale services. Within current funding arrangements, larger residential aged care facilities (over 40 beds) can achieve economies of scale and, generally, financially outperform smaller facilities (ACFA 2016). Seventy percent of residential facilities in rural and remote have under 40 beds. In home care, travel costs can consume much of a home care package budget, while assigning the funding to consumers means providers can no longer pool funding to manage limited resources within small communities (Royal Commission 2019b). These financial pressures mean there are few for-profit aged care providers and limited consumer choice. Under

the following two programs, funding is paid to providers as a grant for a set number of 'flexible care places'. This funding is used flexibly to deliver residential and home care for each community.

The **National Aboriginal and Torres Strait Islander Flexible Aged Care Program** supports culturally appropriate residential and home care services to older Indigenous Australians on Country (ancestral land), close to family, community and language, mainly in remote areas (Department of Health 2019e). In 2018–19, 35 aged care services received funding of 44.1 million Australian dollars to deliver 1072 flexible places (Department of Health 2019a). However, there remains a significant shortfall in culturally appropriate aged care service for Indigenous Australians, especially in remote locations (Royal Commission 2019b).

The **Multi-Purpose Service (MPS**) Program was developed in 1993 as a joint initiative between the national and state governments to support sustainable health and aged care services in sparsely populated communities. The national government's grant for aged care places is 'pooled' with state government funding for hospital and community health services. Most MPS have residential aged care beds for permanent and respite care, and provide home support. In addition, MPS usually have an emergency department, a small number of inpatient beds, and deliver community health services. State governments are responsible for the health and aged care infrastructure and staffing. Users of MPS aged care services do not have to complete ACAT assessments, nor are they assigned an ACFI classification. The level of consumer contributions is limited and varies between states, creating a lack of parity with mainstream services.

The special arrangements for MPS funding have a number of benefits and drawbacks. The certainty of grant funding protects services against the fluctuation in income caused by variable occupancy, essential when fixed costs are relatively high. The ability to pool health and aged care funding creates the economies of scope needed to sustain services in sparsely populated areas. However, the standard flexible care subsidy is not linked to acuity although the age and complexity of aged care consumers is increasing. The lack of national government support for aged care infrastructure is a legacy of the original program where there was an excess of hospital beds and low-care hostels. This infrastructure no longer meets community expectations or aged care quality standards, and many state governments are forced to invest in new aged care infrastructure, usually a national government responsibility.

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Case study

France

Zeynep Or and Anne Penneau

Institut de recherche et documentation en économie de la santé (Irdes)

Paris, France

Abstract

The French long-term care (LTC) sector is complex with multiple funders and care providers managed by different levels of government. While the statutory health insurance (SHI) system allows a unified and relatively good coverage of medical LTC needs, the type and funding of the personal and social LTC services vary depending on the local authority. This has resulted in large differences across French *départements* in prices of personal LTC services and out-of-pocket payments faced by the recipients. Prices and payment mechanisms used for funding providers vary also for medical and personal LTC services. Regardless, none of the payment mechanisms take into account the quality of service providers. Lack of information on actual costs and care quality of the LTC providers hinders the capacity for improving the quality and efficiency of care provision in the LTC sector.

This chapter provides an overview of the funding and price setting mechanisms used in the LTC sector today in France, with the objective of staging the mechanisms used and issues raised. It first presents the main providers involved in the LTC sector and the major institutions responsible for funding and managing LTC services. By analyzing price setting mechanisms for different providers, we aim to identify major issues and possible solutions for advancing LTC services in France and in other countries.

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Glossary

Abbreviation	French original (if applicable)	English translation/ description
ADL	-	Activities of daily living
AGGIR	Autonomie Gérontologie Groupes Iso Ressources	A reference tool to assess the level of dependency of elderly people
AIS	Acte Infirmier de Soins	Nursing care acts (hygiene and surveillance)
ALD	Affection de Longue Durée	Long-term and costly chronic conditions for which there is no cost-sharing
AMI	Acte médico-Infirmier	Medical Nursing Act
ANAP	Agence Nationale d'Appui à la Performance	National Agency to Support Performance Monitoring
ATIH	Agence Technique de l'Information sur l'Hospitalisation	Technical Agency for Hospital Information
APA	Allocation Personnalisée d'Autonomie	Personalized Autonomy Allowance: a cash-for-care scheme for personal care
ARS	Agence Régionale de Santé	Regional Health Agency
ASH	Aide Sociale à l'Hébergement	Social aid in the form of cash benefit for housing
CNAV	Caisse Nationale d'Assurance Vieillesse	National old-age insurance fund
CNSA	Caisse Nationale de Solidarité pour l'Autonomie	National Solidarity Fund for Autonomy
CPOM	Contrat Pluriannuel d'Objectifs et de Moyens	Multi-year funding contracts defining care objectives
DI	Démarche de soins Infirmiers	Nursing acts for preparing an individual nursing care plan
DRG	-	Diagnosis Related Groups
EHPAD	Etablissement d'hébergement pour personnes âgées dépendants	Residential nursing homes
EMSP	Equipes Mobiles de Soins Palliatifs	Mobile palliative care teams
ENC	Etude Nationale des Coûts	National cost study
FIR	Fonds d'Intervention Régional	Regional Investment Funds
GIR	Groupe Iso-Ressources	Iso-weighted resource groups defining the dependency score
GME	Groupes Médico-Economiques	Patient classification system used in skilled nursing facilities for adjusting payments; each group combines medical and nursing care needs
GMP	GIR Moyen Pondéré	Average GIR dependency score in residential nursing homes

Abbreviation	French original (if applicable)	English translation/ description
GMPS	GIR Moyen Pondéré Soins	Average GIR score weighted by healthcare needs (PMP)
HAH	Hospitalisation à domicile	Hospital at Home
IADL	-	Instrumental ADL
LISP	Lits Identifiés Soins Palliatifs	Dedicated palliative care beds in acute care hospitals
LTC		Long-term care
NGAP	Nomenclature Générale des Actes Professionnels	Nomenclature of professional acts reimbursed by the SHI
ONDAM	Objectif National de Dépenses d'Assurance Maladie	National Objective for Health Insurance Spending
PATHOS		Classification system used in residential nursing homes to assess care needs; there are 238 pathos based on 50 clinical profiles and 12 nursing care needs.
PMP	Pathos Moyen Pondéré	Average PATHOS score in residential nursing homes
SAAD	Service d'aide et d'accompagnement à domicile	Home-Care and Support Services
SPASAD	Services Polyvalents d'Aide et de Soins à Domicile	Multi-Purpose Services for Homecare
SSIAD	Services de soins infirmiers à domicile	Home-Care Nursing Services
SSR	Soins de suite et de réadaptation	Post-acute rehabilitation facilities
SHI		Statutory Health Insurance
USLD	Unité de soins de long durés	Long-term care departments in acute-care hospitals
USP	Unités de Soins Palliatifs	Palliative care unit in acute care hospitals

1 Introduction

The long-term care (LTC) policy in France cuts across different sectors including health, medico-social and social and involves different levels of governance. By definition, LTC involves a variety of services, provided in different places by different caregivers, to help people live as independently and safely as possible when they can no longer perform everyday activities on their own (NIH 2017). In order to analyze the organization and funding of LTC services, it is useful to distinguish the three main categories of services as defined in health accounts (OECD 2018):

- **Medical and nursing LTC** services include wound dressing, administering medication, health counselling, palliative care, pain relief, diagnosis and treatment with relation to a long-term condition. They can also include preventive activities to avoid deterioration in long-term health conditions or rehabilitative activities to improve functionality (e.g., physical exercise).
- **Personal LTC** services provide help with activities of daily living (ADL) such as eating (support with food intake), bathing, washing, dressing, getting in and out of bed, getting to and from the toilet and managing incontinence.
- **Social LTC** consists of assistance services that enable a person to live independently. It relates to help with instrumental (I)ADL such as shopping, laundry, cooking, performing housework, managing finances, etc.

In France, the government defines national health and social care policies, while the funding for LTC comes from a mixture of sources including social security contributions and local taxes. The statutory health insurance (SHI) fund covers **medical LTC services** for all the population. The system guarantees universal access to a large basket of health care but imposes significant co-payments for all services including primary and LTC. Co-payments for medical LTC are largely alleviated by a specific exemption scheme, *Affection Longue Durée* (ALD), created right at the inception of SHI in 1945, which aims to reduce the financial burden of medical care for beneficiaries suffering from long-term and costly chronic conditions. Irrespective of their income status, these patients are exempted from co-payments *(tickets modérateurs*) concerning treatments associated with a list of conditions including cancer, mental illness, dementia, etc. Medical LTC policies are implemented at the local level by de-concentrated State services: Regional Health Agencies (*Agence regional de santé*, ARS). The missions of the ARS include regulating the care supply (managing the authorizations for opening health or residential care facilities, number of places, etc.), monitoring and regulating the volume and quality of services and negotiating the medical portion of the funding for residential nursing homes.

The key policy for covering **personal and social LTC services** developed in the late 1990s is based on a cash-for-care scheme, initially called "Specific Allowance for Dependency" concentrating on persons with very high care needs (Le Bihan and Martin 2018). The scheme was reformed in 2002 and became the personal allowance for autonomy (*Allocation personnalisée d'autonomie* - **APA**), providing benefits to meet personal care and assistance needs which are not covered by SHI. APA is a needs- and means-tested allocation for elderly people which can be received at home or in residential care homes. It is funded both by national contributions and local taxes and managed locally by the local authorities *départements*. The *départements* are the level of government below the national level in France. There are 95 departments in metropolitan France, each administered by an elected body, called a departmental council, with tax raising powers. Their main areas of responsibility include the management of welfare allowances, social and medico-social action[1]. The 2014 law of modernization of the territorial public action strengthened the role of the departments as "leaders" in social and LTC policy. This decentralization means that the level of funding for personal and social LTC varies across *départements* depending on their wealth (resources) and policy priorities.

In order to improve the equity in funding of LTC across regions, financing mechanisms and the rules for reallocating public finances have been gradually reformed since 2002. In 2004, the National Solidarity Fund for Autonomy (*Caisse nationale de solidarité pour l'autonomie*, CNSA) was created to finance a common LTC policy for older and disabled people. Today, a part of LTC funding is provided via a national formula that takes into account the patient case-mix in LTC institutions and local care needs. In the past 10 years, the LTC sector has also undergone an organizational reform, which has led to a significant decrease in the number of LTC beds in hospitals, with a desire to favor care as much as possible in people's own household and to shift LTC beds to medical nursing homes. However, the recent public health crisis due to Covid-19 pandemic raised questions about the adequacy of funding for LTC in nursing homes and at home.

This chapter provides an overview of the funding and price setting mechanisms used in the LTC sector today in France, with the objective of staging the mechanisms used and issues raised. We start with a presentation of the main providers involved in the LTC sector, followed by a review of the major institutions responsible for funding and managing LTC services. By analyzing price setting mechanisms for different providers, we aim to identify major issues and possible solutions for advancing LTC services in France and in other countries.

1 Along with managing junior high schools, local roads and infrastructures, etc. (https://www.vie-publique.fr/fiches/les-departements)

2
Major providers of LTC services

Medical and personal LTC services are mainly provided in skilled nursing facilities, in residential nursing homes or at home.

2.1 Skilled nursing facilities

Skilled nursing facilities in France (called "post-acute and rehabilitation services", *Soins de suites et de réadaptation, SSR*) provide short term rehabilitation, patient education and medical support services usually after a hospitalization. They provide assistance with healthcare and ADL, but can also perform palliative care, preventive actions to reinforce mobility of the elderly patients, educate patients to self-manage their conditions, etc. Typically, they would have both inpatient and outpatient services. In 2017, there were 1646 skilled nursing facilities in France, 43% of which were in the public sector, about a third in the private non-profit sector and a third in the private for-profit sector (Table 1). About 1 million patients were treated in skilled nursing facilities in 2017 (ATIH 2018). Of these, nearly 65% were over the age of 70. The average length of stay in inpatient skilled nursing facilities was 35 days, and three quarters of the admissions were after an acute hospitalization.

Skill nursing facilities mostly support people who need short term assistance with medical and personal LTC (musculoskeletal, neurological and cardiovascular diseases, post-surgery, etc.), but they can also play an important role in the provision of LTC for people with severe mental or cognitive problems, especially older people with dementia or Alzheimer's disease when it is difficult to manage them at home or in residential care facilities.

2.2. Residential care facilities

There are two types of residential care facilities for older persons: those which provide medical care with personal and social care, and those that provide only personal and social care.

2.2.1 Medical residential facilities

Medical residential care facilities take care of complex elderly persons who need medical attention, as well as personal and social LTC services. For elderly persons who need long-term medical care, there are two options of residential care: residential nursing homes or hospital LTC departments.

Residential nursing homes (*Etablissements d'hébergements pour personnes âgées dépendants*, EHPAD) give shelter to older persons (over 60 years old) who need regular care and medical surveillance as well as assistance to perform ADL. This is the most common form of residential care for older persons in

France, with around 600 000 places in 2018 without counting day-care places (Statiss Database 2018). Almost 10% of people over age 75, and one in three people over the age of 90 live in residential nursing homes in France (Muller 2017a). Care providers in nursing homes are mostly paramedical staff (certified nursing assistants and practicing nurses), working usually with a part-time physician and sometimes with a psychologist. In 2017, there were 6992 residential nursing homes in France (Moreau and Toupin 2019), of which 42% were public, 32% were private-non-profit and 26% were private-for-profit (Table 1). The average age of elderly people living in nursing homes is 86 years old, and the average length of stay is about 2 years and 5 months (Muller 2017a). Around 70% of residents of nursing homes live there until the end of their lives. Nursing homes play an important role in palliative care in France. In 2015, about 75% of residents of nursing homes died in their residence and 25% in hospital (Muller and Roy 2018). In order to avoid hospitalizations and improve the quality of care at the end of life, nursing homes have been investing in palliative care skills and collaborations with mobile palliative teams in recent years.

LTC departments in hospitals (*Unité de soins de longue durée*, USLD**)** function like nursing homes in a hospital setting. The number of USLD beds went down significantly in the past 15 years. The LTC policy aimed to shift elderly patients needing medical LTC to residential nursing homes. Between 2001 and 2015, the number of hospital LTC beds was reduced from 84 000 to 32 000 (Statiss Database). The average age in USLD is 84 years old, and the average length of stay is around one year and 7 months (Table 1). Eighty percent of USLD patients die in the hospital (Muller 2017a). Generally, people in USLD have a more degraded state of health than people in nursing homes (Delatre and Paul 2016).

2.2.2 Non-medical residential care facilities

These facilities provide only personal and/or social services. The most common facilities are **social residences** (*residences autonomie*), which are regulated and partly funded by the *départements*. These are residential facilities where older people live in their own apartments and share common amenities. Elderly people who live in these are relatively independent to perform their own personal care, but they would need help with so called instrumental (I)ADL such as laundry, meals, social and recreational activities. Social residences can be partly funded by local authorities as part of their LTC policy. There were around 100 000 older persons who lived in 2267 publically funded social residence in 2015 (Leroux et al. 2018). About two third of the facilities under contract with local authorities were in the public sector, 28% in the private non-profit sector and only 4% in the private for-profit sector.

In addition, there are private "**care homes**", which are not regulated by the local authorities. In 2017, there were about

620 residences and roughly around 50 000 apartments (Mure 2018). Nevertheless, the private "care home" sector has been booming in recent years: between 2013 and 2017, there were 170 new private residences, representing a growth rate of 40% over that period.

2.3. LTC services at home

According to the CARE survey, in 2015, between 4% and 10% of people aged 60 or over who lived at home needed some help with their ADL (Brunel and Carrère 2017). LTC services at home range from hospitalization at home to nursing aid and domestic help provided by many providers. Different providers are financed from different sources and target different patient populations.

Hospital at home (hospitalization à domicile**, HAH)** is defined as "a service that provides treatment by health care professionals in the patient's home for a condition that otherwise would require acute hospital in patient care" (Shepperd and Liffe 2005). In 2018, almost 122 000 patients were hospitalized at home for 45 days on average (ATIH 2018). Half of the patients treated were over 65 years old, a constant rate for several years, which represents 63% of HAH days. HAH is also increasingly used in residential nursing homes in order to avoid hospitalizations, especially at the end of life. By demanding to put in place a HAH protocol, nursing homes can provide palliative treatments that require material and medical services that are not normally available. In France, certain medications which are allowed for easing pain at the end of life can only be prescribed in hospitals or in an HAH. The HAH in nursing homes keeps elderly persons and their families in a familiar environment during the end-of-life and may improve palliative care quality.

Self-employed healthcare professionals: Mainly self-employed independent nurses provide most of the medical and personal care at home. While they are supposed to perform mainly medical nursing care, they also provide a considerable amount of personal care. In 2018, there were 124 000 self-employed nurses in France. While there is no specific information on the case-mix of patients of self-employed nurses, more than 60% of spending for these nurses concerns diseases mostly prevalent in elderly people such as heart failure, neurological or degenerative diseases (Cour des Comptes 2018). Another key profession which provides LTC in the community is physiotherapists. They can provide services both at home and at community centres. The expenditure on self-employed nurses and physiotherapists has been increasing very rapidly, with an average annual growth rate of 5.7% between 2000 and 2015 (Cours des Comptes 2015).

There are also two formal structures specialized in providing LTC services to elderly people at home. **Home-care nursing services** (*Services de soins infirmiers à domicile*, SSIAD) are mostly non-profit associations or public organizations, whose

vocation is to provide nursing care for older people (over 60 years old). On medical prescription, they perform nursing services in the form of technical procedures (injections, bandages, preparation of drugs, etc.) and basic hygiene and comfort care. There were 124 000 home-care nursing places in 2018 (Statiss Database 2018). The average age of patients using SSIAD was 82 years old in 2008[2], and on average patients received nursing care at home for two years and three months (Chevreul et al. 2009).

Home-care and support services (*Service d'aide et d'accompagnement à domicile*, SAAD) are private or public organizations, authorized and regulated by local authorities, that provide personal and social care services, helping both with ADL and IADL such as home support, maintenance and promotion of physical and social activities for the elderly. There are about 6000 SAAD representing 75% of the domestic help supply in France (Libault 2019). Most of them are private non-profit organizations (60%), with only 11% public and 29% private-for-profit services.

Services provided by SSIAD, SAAD and independent nurses are not always well articulated, and often an elderly person receive services from many different providers who do not communicate well. Therefore, there were some efforts to bring together services provided by SSIAD (nursing) and SAAD (personal care) under the same structure called SPASAD (*Services Polyvalents d'Aide et de Soins à Domicile)*, which are multipurpose services for homecare. Nevertheless, while they were launched more than 10 years ago with the objective of integrating LTC services for the elderly, SPASAD have not effectively developed until now. In 2017, there were less than 100 integrated (SPASAD) services in France (FEHAP 2017).

Self-employed domestic help

Elderly people can also employ directly a more or less qualified professional for LTC services at home, except for medical LTC. There is a public system which allows to declare in a simplified way the employment and remuneration of domestic help at home and to receive tax reductions (50% of the total salary, with an upper limit). This measure, which is not specific to elderly care, can be used for any domestic help and aims to increase formal employment in this sector.

2.4 Palliative care

In France, there are three main palliative care providers. First, acute care hospitals play a major role in palliative care with dedicated beds for palliative care in different departments (*Lits Identifiés en Soins Palliatifs* , LISP) as well as palliative care units (*Unités de Soins Palliatifs*, USP)[3]. Second, HAH (see above) is proposed as an alternative for palliative care at the home setting and increasingly in residential nursing facilities. Finally, there are mobile palliative care teams (*équipes mobiles de soins*

2 These are the latest and only available statistics.

3 In 2018, there were 5479 palliative care beds in various hospital departments and 1776 beds in 147 palliative care units (Bohic et al. 2019).

palliatifs, EMSP), which assist and train healthcare providers involved in end of life care either in hospital or in other settings. These are multi-professional teams, usually involving physicians and nurses, and part time psychologists and physiotherapists, attached to a hospital, often a palliative care unit. Different from HAH, these teams do not provide palliative care, but they play an advisory and support role assisting both healthcare professionals involved (training for palliative approach in or out of hospital) and families (psychological or social support for caregivers). In 2015, there were 425 EMSP with, on average, 3.6 professionals[4] (Bohic et al. 2019). These teams can also assist with end-of-life care at home or in residential nursing homes. In 2015, 26% of the interventions by palliative care teams were at home, and 21% in residential nursing homes.

Table 1
Description of major LTC providers and their users, 2018 or latest year available

	Providers				Users		
	Number of facilities	Public	Private non-profit	Private for-profit	Number of users (person)	Mean age	Mean length of stay
Skilled nursing facilities	1600	43%	28%	29%	1 million	70	35 days for inpatients
Residential care facilities							
Residential nursing homes	7000	42%	32%	26%	600 000	86*	2 years and 5 months
LTC departments in hospitals	600	n / a	n / a	n / a	32 000	84*	1 year and 7 months
Social residences	2200	68%	28%	4%	100 000	81*	5 years and 1 month
Private care homes	600	0%	0%	100%	55 000 apartments	n / a	n / a
LTC services at home							
Hospital at home (HAH)	300	42%	41%	17%	122 000	63	42 days for women; 49 days for men
Self-employed nurses	124 000	0%	0%	100%	n/a	n/a	n/a
Home-care nursing services (SSIAD)	2100	36%**	63%**	1%**	124 000	82**	2 years and 3 months**
Home-care and support services (SAAD)	6000	11%	60%	29%	n / a	n / a	n / a

*Mean age when they arrived in the facility;
** Most recent data is from 2008.

Sources: ATIH (2018); Chevreul et al. (2009); Leroux et al. (2018); Libault (2019); Moreau and Toupin (2019); Muller (2017a); Mure (2018); STATISS database (2018).

4 Full time equivalent (FTE)

3
Funding and management

The funding and management of LTC services in France involve several levels of governance and different institutional actors which are not always well coordinated. Medical LTC services are essentially financed by the SHI, while personal and social care is financed by the local authorities (*départements*) and by the State jointly. Regional and local administrations implement funding, following the rules set at the national level, and monitor LTC provision, while decentralized local authorities have a large autonomy in provision and funding of personal and social care services.

3.1 Financing medical LTC

The main mechanism for defining and monitoring health and LTC budgets for SHI is macro-level expenditure targets, known as the National Objective for Health Insurance Spending (*Objectif National de Dépenses d'Assurance Maladie, ONDAM*). This involves setting an *a priori* global budget for health each year. ONDAM targets are set in monetary terms by the government for the forthcoming calendar year and give all stakeholders a precise objective in terms of spending. The overall ONDAM target is split into three sub targets for the main health service providers: outpatient, inpatient and medico-social services (Table 2).

Different LTC providers are funded from different ONDAM budgets. The spending for self-employed LTC providers in the community or working with older people at home, such as nurses and physiotherapists, are covered in outpatient budget in ONDAM. In 2017, the total expenditure for self-employed nurses represented 4% of total SHI spending (Table 2). The payments for skilled nursing facilities[5], HAH, palliative care in hospital and hospital LTC departments come from the inpatient budget, while residential nursing homes and home nursing services are in the medico-social budget, ONDAM's medico-social budget is distributed to regional health agencies by the CNSA mostly on the basis of past expenditures. In 2017, the total expenditure for LTC services was about €20 billion and represented 10% of the total SHI budget (Table 2). The SHI budget for medico-social care is further divided into two separate services for elderly people over the age of 60 and LTC services for people with disabilities under 60 years old. Indeed, in France LTC policy, benefits offered and providers vary sharply before and after 60 years old. In this paper, we focus on the LTC policy for elderly people (60+ years). SHI spending for medical LTC services for the elderly covered residential nursing homes and home-care nursing services and represented about 5% of ONDAM.

5 With €79 billion in 2017, these facilities represented 41% of total inpatient spending.

In August 2020, following the high death tolls in nursing homes due to coronavirus disease and the discussions on adequacy of funding for LTC, the government decided to create a new (5th) branch of social security for LTC funding (L.200-2 of the CSS). LTC spending which were previously part of the SHI budget and financed by ONDAM will be covered now by a new branch, called "autonomy" which will be managed by the CNSA. It will receive a share of tax funding from generalized social contribution (CSG) to finance the LTC services covered by health insurance before. The objective in the medium term is to increase significantly the budget and scope of services covered by the CNSA with transfers from other social funds (Vachet et al. 2020).

LTC services can also receive funding from the Regional Investments Funds (FIR) which are used for financing regional or local initiatives (often in the form of experimentation), aiming to improve the quality and efficiency of care provision, care coordination and safety. For example, the mobile palliative teams which play a role in improving care coordination at the end of life are funded from this envelop (about €150 million in 2018; FIR 2019).

Table 2
Distribution of statutory health insurance spending in France, 2017 (ONDAM)

	Spending (million euros)	Share of ONDAM
1. Total outpatient spending	**87 174**	**45.7%**
Self-employed nurses	7536	4.0%
Self-employed physiotherapist	3998	2.1%
2. Total inpatient spending (acute care, SSR, psychiatry, USLD)	**78 612**	**41.2%**
Skilled nursing facilities (only public and private non-profit sector)	14 716	7.7%
Hospital at home (HAH)	1000	0.5%
Hospital long-term-care departments (USLD)	1004	0.5%
3. Medical LTC services	**20 000**	**10.5%**
For elderly people (residential nursing homes, nursing and social services at home)	9050	4.7%
For people with disabilities (less than 60 years old)	10 950	5.7%
4. Regional investment funds (FIR)	**3240**	**1.7%**
5. Other	**1658**	**0.9%**
Total ONDAM	**190 683**	**100.0%**

Source: Cour des comptes (2018).

3.1.1 Long-term illness exemption scheme

The public health insurance in France covers 100 percent of the resident population and provides a comprehensive basket of care but requires cost sharing for all services, including doctor and nurse visits and hospitalizations. Therefore, a long-term illness exemption scheme, called *Affection Longue Durée* (ALD), was created at the inception of SHI in 1945, with the objective of reducing the financial burden of medical care for beneficiaries suffering from a list of long-term and costly chronic conditions. Initially introduced to cover four groups of diseases (cancer, tuberculosis, poliomyelitis, mental illness), the scheme was extended over time and now covers thirty-two groups of diseases. Irrespective of their income status, patients are exempted from the co-payments concerning treatments associated with these conditions. Nevertheless, they still have to pay any fees linked to extra-billings and deductibles and the co-payments concerning other health problems. In 2016, over ten million individuals were covered by the ALD scheme, representing about 17 percent of SHI beneficiaries and accounting for roughly 60 percent of health expenditures reimbursed by the SHI (Sécurité sociale 2019).

Self-employed nurses and physiotherapists, who play a central role in medical and personal LTC services at home, are directly funded by the SHI. For the general population, SHI reimburses 60% of the cost of nursing services (on the basis of negotiated prices). For people covered in the ALD scheme, the full cost of nursing related to the condition concerned is reimbursed.

3.1.2 The role of CNSA

The CNSA, introduced by the 2004 law on solidarity and loss of autonomy, is a national institution responsible for funding and implementing policies for the elderly and people with disabilities to guarantee equal treatment across the country. The CNSA had its own finances, amounting to €5 billion in 2018, mostly from the "solidarity day", a social contribution created by introducing an unpaid working day in 2006 and some other taxes. Until the creation of the autonomy branch in August 2020, SHI had transferred ONDAM budget to CNSA (€20 billion in 2018) to finance medical LTC services for the elderly and for people with disabilities. The CNSA distributed these funds (plus €1.3 billion from its own resources) to ARS that fund medical LTC producers (residential nursing homes and home-care nursing services, SSIAD). In 2018, CNSA also distributed €3.2 billion of financial assistance to local authorities, of which 2.3 billion were used to fund APA. Overall, 40% of total APA funds comes from the CNSA (CNSA 2019). These funds are redistributed to local authorities using a national formula based on four criteria: the number of elderly people aged over 75 years in the area (50% of endowment criteria); past expenditure on APA in the local authority (20%); tax potential in the *département* (25%); the number of low-income elderly (65+) people (5%). CNSA also financially supports local authorities to fund social residences (€40 million

in 2018). With the creation of a dedicated branch to autonomy, CNSA will have more resources and responsibility in funding medical LTC.

3.1.3 The role of ARS

Medical LTC providers in residential nursing homes and at home are paid through ARS. The ARS are deconcentrated government agencies[6], created in 2009, with the mission of managing health and social care services and health promotion actions. ARS are responsible for monitoring, financing and regulating health and LTC services at the regional level.

They finance residential nursing homes and home-care nursing services on the basis of multi-year funding contracts (*contrat pluriannuel d'objectifs et de moyens*, CPOM). These contracts are the major tools for the ARS to regulate the number of residential LTC places and the level of nursing resources. They fund basically the cost of medical care (nursing mostly) in residential nursing homes ("health care package" as explained below). In 2017, funding from the ARS represented on average 30% of the revenues in nursing homes (Moreau, El Amaroui and Toupin 2017). The cost of home-care nursing services (SSIAD) are totally funded by the ARS without any co-payment from the users. This is the only healthcare service in the French system, except the emergency department in hospitals, which is accessible without any co-payment.

The LTC budget that is available to each ARS is defined by the CNSA by using a "regional care allocation" formula. This is mainly based on past expenditures adjusted by the inflation, targeted number of new places (in nursing homes and SSIAD) and targeted payments to achieve the objectives set in ONDAM.

3.2 Funding of personal care and assistance services

The politics of medico-social care is under the responsibility of local authorities (*département*) which are decentralized bodies in France. The « *département* » is directed by a council elected by universal suffrage for six years. There are 95 « *départements* » in metropolitan France, with 800 000 inhabitants on average[7] (Insee 2020). Concerning personal care and social care services for elderly people, the *départements* have the legal authority and the obligation to define their local policy orientation, finance social care and regulate services. Home-care nursing services (SSIAD) and self-employed nurses are the exceptions, where providers are only funded by the SHI.

The main funding source for personal and social LTC services is the national allowance program (*Allocation personalisée d'autonomie*, APA). This is a cash-for-care scheme which is

6 Deconcentration is considered to be the weakest form of decentralization (Rondinelli, Nellis and Cheema 1983). It consists of a delegation of power to lower territorial levels within central governments and central agencies. The central government always decides on local affairs but decides locally via its services located on the territory (Polton 2004).

7 The median population of a department is about 500 000 inhabitants, but this varies from less than 80 000 inhabitants in Lozère to 2.5 million in the Nord (Insee 2020).

managed and, mostly, financed by the local authorities. APA is paid to any person aged 60 or over who needs assistance to accomplish everyday activities or needs to be continuously surveyed. The allowance can be received at home or in residential institution, and the amount depends on the level of dependency measured by a national scale.

In 2015, 1.3 million, or 8% of the people over 60 years old benefited from this program; about 500 000 of whom were in a residential nursing homes (Leroux et al. 2017). About 60% of APA is funded by local authorities through local taxes, while 40% comes from the CNSA (CNSA 2019). In 2015, total spending for APA was €5.6 billion (3.3 billion of which for home services), with an average spending per person of €4450 per year (Leroux et al. 2017). The amount of APA at home and in residential care facilities are set via two different financial mechanisms, with different price setting rules, as we present below.

3.2.1 APA at home

APA eligibility is defined by the *département* using a national assessment tool measuring dependency. The dependency score (*groupes iso-ressources*, GIR) is calculated using 10 variables of physical and mental activity (coherence, orientation, capacity of going to toilet, dressing, eating, continence management, getting out of bed and lying down, moving inside the home, moving outside, being alert[8]) and seven variables of domestic and social activity (cooking, household duties, using transport, shopping, managing finances, managing medications, having external activity[9]). There are six dependency levels, 1 being the highest level of dependency (needing continuous attention) and 6 self-sufficient (needing no help). Those in the first four levels of dependency are eligible for APA. Allowance is paid to finance a specific "care plan" at home elaborated by an interdisciplinary team (usually consisting of social assistants and nurses)" of the *département* after an assessment. The "care plan" defines the number of hours of personal and/or social care needed as well as needs for day-care and other living adjustments for maintaining the person in the community. Each level of dependency allows funding a maximum amount (for funding the care plan) set at the national level. Therefore, both the eligibility to APA and the amount to be paid (care need) are defined by the local authorities who are the main funders. This differs for younger people (under 60 years old) with disabilities, for whom an independent agency assesses the level of dependency and makes the decision for the eligibility and level of LTC funding for each person.

On January 2019, the maximum amounts paid for APA varied from €672 per month for level 4 (low dependency: help with washing and dressing, body care and meals) to €1737 per month in level 1 (high dependency: continuous surveillance).

8 Capacity to use a means of remote communication: telephone, alarm, doorbell, remote alarm, etc.

9 Practicing voluntarily, alone or in a group, various activities that create events breaking the monotony of everyday life.

The amount of the allowance is adjusted by the income of the recipients. For people with a monthly income below €800, 100% of the care plan is paid by the local authority. The rate of co-payments increases with income up to 90% for those with a monthly income of over €2948. On average, APA pays for around 80% of the care plan cost. In 2017, the average APA amount paid at home was €450 per month (varying from €293 for level 4 to €1072 for level 1) (Arnault 2019).

3.2.2 APA in nursing homes

In residential nursing homes, APA finances "the dependency bundle" covering the cost of personal and social services to help with ADL (c.f. section 5.2). The "dependency" bundle represents on average about 15% of nursing home revenues (Moreau, El Amaroui and Toupin 2017). The eligibility rule is the same at home and in nursing homes: people on the first four levels of the dependency score (GIR) are eligible. On average, about two-thirds of the cost of dependency bundle is covered by APA and a third by out-of-pocket payments. However, cost-sharing arrangements vary across *départements*. Some departments increase the cost sharing depending on the income of residents while others do not; some finance the nursing homes with global budget while others finance, as at home, directly the person who then pays the nursing home. The ARS partly monitors this policy, as they sign multi-year contracts defining care objectives and resources (CPOM) with local authorities.

Table 3
Personalized autonomy allowance (APA) to fund LTC services at home

Funding sources	About 60% of APA is funded by decentralized local authorities (*département*) via local taxes, while 40% comes from the CNSA
Eligibility criteria defined nationally	Over 60 years old Mid-to high dependency: the first four levels on the national dependency score (GIR) based on 10 variables of physical and mental activity and seven variables of domestic and social activity
Evaluation of a "care plan" by local authorities	Multidisciplinary teams of local authorities evaluate the GIR and define a "care plan" (medical and social)
Amount of the allowance: National rules	Maximum amount for the "care plan" by dependency level : – €674 per month in level 4 (low dependency) – €1011 per month in level 3 – €1399 per month in level 2 – €1742 per month in level 1 (highest level of dependency) Co-payment: depending on income. On average 20% of "care plan". Under €800 recipients do not have any co-payment, over €2900 contribute to 90% of the cost.
Definition of "care plan" amount	For each type of LTC provider at home (SAAD, self-employed domestic help, days-care), local authorities fix the reference prices. These prices are used by the interdisciplinary teams to calculate a "care plan" amount (number of days or hours multiplied by the reference price). Reference prices vary significantly across local authorities.

3.2.3 Others social cash benefits for LTC

Local authorities can also provide some other specific cash benefits to subsidize the **cost of housing** in residential nursing homes and in social services, called "social assistance for accommodation" (*Aide sociale à l'hébergement*, ASH), to help people with low income. The cost of accommodations in nursing homes represents around 50% of the total nursing home cost (Moreau, El Amaroui and Toupin 2017). The amount of allowance for accommodation is defined by the local authorities and consider the income of the resident (if it is lower than the accommodation fee), but, in the majority of cases, children and sometimes grandchildren have the obligation to cover the accommodation fees if the older person does not have the resources. The sums paid by the local authorities for accommodation are recoverable from the assets of the elderly person (if there is any) or if the financial situation of the person improves. Local authorities control the accommodation fees (prices) in nursing homes, which have places eligible for social assistance, and in social residences (part 5.1). In about two thirds of nursing homes, all of the places are eligible for social assistance, while in 17% a few places are eligible but not all (Muller 2017b).

3.3 Pension funds

Pension funds can offer financial assistance to retired people who need homecare but who are not eligible for APA because they do not have a high level of dependency for carrying out daily activities (GIR 5 and 6). The pension funds set the eligibility rules, often on the basis of household income. The "national old-age insurance fund" (*Caisse nationale d'assurance vieillesse*, CNAV), which is the main pension fund in France, spent €341 million in 2018 for 332 400 people benefiting from individual assistance for home support (CNAV 2019).

3.4 Central government tax benefits

In 2014, the central government funded around €2.4 billion for LTC (Libault 2019). There are two specific tax benefits that concern LTC at home and one in residential nursing homes. The first one is not specific for elderly LTC but plays a major role in funding personal and social LTC at home. This is a global tax benefit policy in France to encourage the legal employment of domestic staff at home (help for elderly, childcare, housekeeping, etc.). About 50% of the cost of domestic staff is recuperated by the employer as tax return (with a limit of €7500 per year[10]). Secondly, the beneficiaries of APA and people over 70 years old do not have to pay employers' social insurance contributions. Finally, older people can also benefit from a tax reduction in residential nursing homes if they have taxable income over their accommodation fee[11].

10 For people over 65 years old (the tax return maximum is €6000 before 65 years old).

11 A maximum of €2500 as a tax reduction per year.

3.5 Out-of-pocket payments

Concerning personal and social LTC needs, the out-of-pocket payments at home after APA and tax benefits is relatively reasonable and fairly well distributed according to income, while the out-of-pocket payments in nursing homes can be quite high (Libault 2019). At home, the average out-of-pocket payment is estimated to be around €60/month (varying from zero for incomes less than €810/month to €320 or more for incomes higher than €3600/month). However, in nursing homes, the average, out-of-pocket payment is around €1850/month, which exceeds older person's incomes in 75% of cases. About one person in five in nursing homes benefits from social subsidies for paying their accommodation fee, and many others are supported financially by their families. There is a specific LTC insurance to cover personal and social care needs, but most of the contracts do not cover high LTC risk. There are around 2 million people who own LTC insurance with coverage until death. In 2016, €246 million were paid by private insurance funds, while the total household out-of-pocket payment is estimated to amount €10 billion (Bennet and Fontaine 2017).

For medical LTC needs, on the other hand, the co-payment exemptions for the chronically ill (see part 3.1) reduce significantly the out-of-pocket payments of older people (Penneau, Pichetti and Espagnacq 2018). In general, the out-of-pocket payments for medical LTC (co-payments) are well covered by complementary private insurances. Given that 95% of the population owns complementary private insurance, inequalities in out-of-pocket payments are mainly linked to the costs of complementary health insurance, for which the premiums increase with age.

4
Base for payment

Most medical LTC providers are self-employed and paid by fee-for-services on the basis of a prescription from a general practitioner. Skilled nursing facilities, residential nursing homes and homecare nursing services are funded by global budgets. Historically, all these budgets were based on past expenditures or patient volume. In the past 10 years, most of the payment schemes have been adjusted slowly in order to take into account the characteristics of the care recipients (case-mix).

Personal and social LTC services are provided by a mixture of salaried personnel working in nursing homes or homecare service platforms, and self-employed helpers, often without much qualification. Local authorities distribute funds using mainly APA cash-for-care benefits paid to the care users and global budgets.

5
Price setting

Price setting for LTC services is complex and often poorly documented especially in the social care sector. Different local authorities use different reference prices for personal and social care without really justifying or explaining how this is set. The funding mechanism via APA makes prices for the same service vary within and between local authorities.

5.1 Price setting for skilled nursing facilities

Until 2017, skilled nursing facilities (SSR) were funded by annual prospective global budgets in the public and private non-profit sectors and through a fixed daily rate in private for-profit facilities. Since 2017, the global budgets have been adjusted to take into account the volume and case-mix of the patients treated. This is done by using a patient classification system that applies the logic of homogeneous medical resource groups as in DRGs (diagnosis related groups) in acute care hospitals. Since 2010, a common classification system proposing 750 groups called GME (*groupes médico-économiques*) has been used for monitoring services provided in these institutions. The GME are determined by a number of variables including principal and secondary diagnostics coded at admission, age, post-surgical care, level of dependency of the patient and medical procedures.

The funding reform started in 2017 (i.e. seven years after the development of the first classification and costs-base in SSR) and has been implemented very slowly. In 2020, only 10% of the budget came directly from activity-based payments using GME reference tariffs. The average costs for full or partial hospitalizations were calculated using data from the national cost study (ENC), which included 71 voluntary facilities (of which 30 were private for-profit) in 2017. Reference costs for different groups of patients have been estimated and updated annually by ATIH (Technical Agency for Hospital Information). The reference prices are set following a similar process to the one for the DRG tariffs in acute care hospitals, but there are a few differences. First, the scope of GME tariffs includes all personal costs both in public and private facilities whether they are salaried or self-employed. Second, there is a specific code for stays longer than 70 days, which allows facilities to bill some of the costs gradually. Moreover, the prices are weighted by an index of specialization taking into account the overall case-mix of the facilities. As in the acute care sector, prices are also weighted by a geographic coefficient for the Parisian area, Corse and overseas departments. Since 2018, the SSR can also benefit from the small pay-for-performance scheme used for acute-care hospitals. The performance indicators concern mostly patient safety and relate to structure and organization.

5.2 Price setting for residential care facilities

5.2.1 Residential nursing homes

Historically, the budget for nursing homes was negotiated according to the volume objectives of facilities and on the basis of past expenditures. Residential care facilities for older people, whether private for-profit, private non-profit or public are paid by a three-part tariff: a medical care package, LTC (or dependency) bundle and an accommodation fee.

The funding model gave very significant power to local authorities and to regional health agencies which adjusted the funding. At the end of each year based on the budget results, they both either recover any surplus or cover the deficits. Therefore, the facilities had no incentive to be efficient, but rather to spend more to assure future funding. The SHI fund that finances the health care package was the first to change the base for funding by linking the budgets to the activity and case-mix as early as 2007. The funding method was further changed in 2017, when the dependency bundle was also based on the actual case severity.

The medical care package

The medical care package is calculated for each facility using a synthetic indicator, called weighted iso-care group (GMPS), which corresponds to the average care needs and dependency level of people living in the facility. Care needs are measured by the coordinating doctor of the facility using a classification called "pathos" that identifies 50 clinical conditions with 12 profiles of care required by these conditions constituting 238 couples of "condition-profiles" (Ducoudray et al. 2017). For each of these condition-profiles, eight resource groups were identified (physician, psychiatrist, nursing, rehabilitation, psychometrics, biology, imaging and pharmacy) that define the level of care resources required. For health professionals, this corresponds, for example, to the time required for patients with a given profile. The average resource level required for each of the 238 couples was defined by specialists (geriatric physicians) and reported in terms of points per cost item. For example, for the couple "heart failure" with a profile "close monitoring", the specialists estimated that it requires 13 minutes of geriatrician time a day, 36 minutes of nurse time, etc. The average pathos score (PMP) is the sum of the points of care required in eight resource groups (RG) weighted by a coefficient depending on an RG expressed on average per individual. The care bundle is also adjusted by the dependency level, which is calculated by the AGGIR (Gerontology Autonomy and Iso-Resource Groups) model, which assesses the autonomy of a person for carrying essential daily activities (CNAMTS 2008). The GIR is based on 10 variables of physical and mental activity (coherence, orientation, toilet, dressing, food, etc.) and seven variables of domestic and social activity (cooking, housekeeping, transport, etc.).

Table 4
Prices in residential care facilities

		Dispersion		
		10th percentile	Median	90th percentile
Residential nursing homes (euros/day) *				
The health care package (euros/day)		27.4	**32.9**	42.8
LTC/dependency bundle (euros/day)	GIR 1-2 (high dependency)	16.9	**20.4**	24.2
	GIR 3-4 (mid dependency)	10.7	**12.9**	15.4
	GIR 5-6 (low dependency)	4.6	**5.5**	6.5
Accommodation fee (for a simple room) (euros/day)	Places habilitated to social assistance	49.2	**56.2**	66.8
	Places non-habilitated to social assistance	63.0	**82.2**	106.0
Social residence ** (prices for one room apartment and services)				
Social residences	Places habilitated to social assistance (euros/day)	16.3	**23.3**	43.8
	Places non-habilitated to social assistance (euros/month)	398.0	**581.8**	1000

*2017; **2015

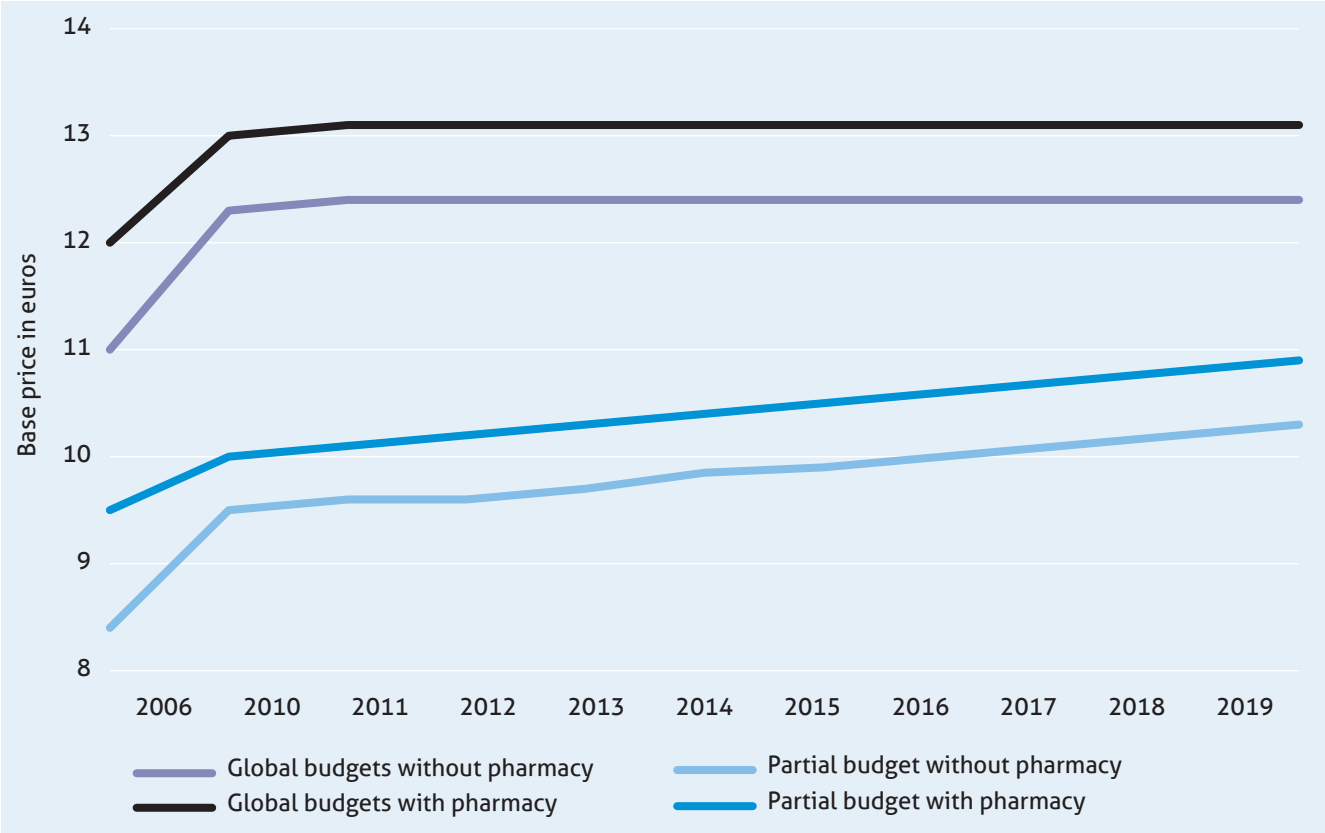
Sources: EHPA database[12] (2015); Moreau and Toupin (2018).

The amount of the medical care package for each facility is the weighted average score (GMPS) multiplied by a reference/index price per point defined at the national level (valeur du point) by the Ministry of Health. There are four different index prices for four different types of nursing homes: those with partial budget where only the cost of the inpatient medical care team is funded, those with global budgets where funds cover also the cost of outpatient care providers such as the general practitioner (GP), physiotherapist, biology and radiology. The nursing homes can also own their own pharmacy; in this case, the funding covers the expenditure for the medications. In 2016, 71% of nursing homes were in partial budget without a pharmacy (drug expenditures paid directly by SHI), 16% of nursing homes were in global budget covering pharmacy, and 11% in global budget without pharmacy (Moreau, El Amaroui and Toupin 2017). The base prices for global budgets have not changed in the past 10 years (Figure 1), while the prices for partial budgets have increased slightly.

12 http://www.data.drees.sante.gouv.fr/ReportFolders/reportFolders.aspx

In practice, the ARS are constrained in their LTC funding by the ONDAM envelop, i.e. the macro level budget which is allocated to them by the SHI (part 3.1). The regional LTC allocation does not always allow to pay the nursing homes the full amount calculated by the GMPS formula.

Figure 1
Evolution of national base price for medical care for different type of nursing homes between 2006 and 2019 (in euros).



Source: Ministerial decrees

The dependency bundle

The dependency bundle finances the cost of the caregivers in helping with ADL (personal and social care). Historically freely fixed by local authorities, a new national formula was defined to calculate the LTC/dependency bundle in 2017 with the objective of harmonizing the funding rules between nursing homes. The payment is calculated according to the GMP (average GIR score) of the facility and the value of the departmental GIR point fixed by the local council (*Conseil départemental*). The value of the departmental GIR point, that is, the basis for funding by the local authorities which determine the generosity of the allocations for LTC varies greatly between *départements* as a function of local policy and wealth, ranging from €5.7 in the Alpes-Maritimes to €9.4 in the South of Corsica (Moreau and Toupin 2018). In 2017, the price for dependency bundle was on average €5.5/day for low dependency persons, €12.9/day for moderate level of dependency and €20.4/day for highly dependent persons (Table 4).

While this funding reform helped to harmonize payments between nursing homes within a local authority, it did not reduce the disparities in funding between local authorities. The objective set by the government in the future is to have a unique national price for each level of GIR to reduce regional disparities in personal LTC funding. However, these policies intervening on LTC funding and increasing the central control are not always well received by the local authorities.

Accommodation fee

Tariffs for accommodation fees are set freely depending on the "standard of services" offered by the facility (comfort of the rooms, quality of the cooking, etc.) when the facility is not receiving social aid for their residents. Nursing homes with dedicated places to receive social/public aid cannot ask for a higher accommodation price than the one set by the local authorities[13]. The majority (83%) of the facilities, whether private or public, have places eligible for public support (Muller 2017b)[14]. However, the maximum prices set vary largely across local authorities from €49/day in the first decile to €67/day at the 9th decile (Moreau and Toupin 2018).

The prices of places that are not eligible for public support are set freely, but the rate of increase is monitored each year and regulated by the central government. In 2017, the maximum rate of increase allowed in residential care prices was set at 0.46%.

5.2.2 Social residence

Social residences regulated by local authorities receive two payments: LTC (or dependency) bundle and payments for the rent of the apartment. The dependency bundle is funded by the CNSA to local authorities which finance the facilities. This funding, managed by the local authorities, allows the social residences to recruit specific personnel or engage external stakeholders for implementing preventive actions (nutrition, dietetics, memory, sleep, physical and sports activities, prevention of falls, etc.). The dependency bundle is fixed by the local authorities depending on each facility's preventive action project and local policies. Services provided in the residence (laundry, meals, etc.) are not funded by the dependency bundle but comprised in the rent. The residential apartment prices are supervised by the local authorities for places eligible for social assistance (ASH). In 2015, the average price of a place eligible for social assistance was €780/per month[15] (ranging from €510 to €1410 per month), while the average price for a one room apartment not eligible for social assistance was €655/per month (from €329 to €1308 per month) (EHPA Database 2015).

13 It is not very clear how these prices are set, but likely to be on local prices and social policy.

14 In the public sector, 100% of facilities had places eligible for social aid (93% for all places). In the non-profit sector, 91% of facilities had places eligible for social aid (73% for all places), and in the private for-profit sector, 41% of facilities had places eligible for social aid (generally for few places).

15 Initially estimated per day: €26/per day.

Prices are freely set for private care homes which are not regulated or financed by the local authorities. Historically, introduced in France in the 1970s, these residences were for the elderly who owned an apartment and paid for complementary service charges included in overall co-property charges. This has evolved in recent years towards a new model where residents (owner or not) pay for specific assistance services (laundry, meals, etc.). There is little information on prices of these social residences with services.

5.3 Price setting for LTC services at home

LTC services at home are provided by several professionals often providing the same or otherwise complementary services but paid on a different basis.

5.3.1 Self-employed nurses

Self-employed nurses are paid on a fee-for-service basis by the SHI. The prices of nurse practice acts and their evolution are fixed by the SHI in negotiation with the representatives of self-employed nurses (which are not very powerful in France). The prices are defined for three types of basic nursing acts using a general nomenclature of professional acts (NGAP). The first one, called "medical nursing acts" (AMI), refers to technical acts relating in particular to wound management, injections and swabs. In NGAP, there are 16 groups of AMI corresponding to a combination of one to 15 acts. The price of AMI acts varies from €3.15/act (for example, a simple injection) to €47.25/act, equal to 15 AMI (for example an infusion session lasting more than one hour with continuous monitoring for people with cancer). The second one, called "nursing care acts" (AIS), refers to acts of assistance with ADL (hygiene and surveillance). There are five nursing care acts, and prices depend on the level of need and time required (hygiene or surveillance). In 2019, the AIS base price was €2.65. AIS act prices ranged from €7.95 for 3 AIS, for example, for a half an hour care session, to €42.4 for 16 AIS for constant surveillance at home between 8 p.m. and 8 a.m. Finally, there is a specific act, called "nursing approach" (DI), which pays €10, with a maximum of five prescriptions per year to prepare a nursing care plan for the person. There are extra payments for night and weekend work, distance traveled, single acts and for coordination (Table 5).

Table 5
Prices (in euros) for self-employed nurses (2020)

Nurse practice base price		
Medical nursing acts (AMI)		3.15
Nursing care acts (AIS)		2.65
Nurse planning (DI)		10.00
Extra payments		
Night work	From 8pm to 11pm and from 5am to 8am	9.15/act
	From 11pm to 5am	18.30/act
Weekend		8.50/act
Distance traveled		2.5/person + 0.35 / per kilometre
Single act		1.35/act
Coordination		5.00/act

Source: Ameli (2020)

From fee-for-service to per-day fee
In the latest negotiations voted in March 2019, it was decided to replace the prices of the AIS by a per-day fee. This reform will be applied gradually from 1 January 2020 first only for people over 90 years old, with an objective of generalization in 2023. Three daily prices are fixed depending on the person's level of dependence: €13/per day for low dependency, €18.2/ per day for intermediate dependency and €28.7/per day for high dependency. Nurses may, in addition to these packages, invoice certain technical acts (from 1 May 2020).

5.3.2 Home-care nursing services (SSIAD)

Home-care nursing services are funded by the regional health agencies from the regional budget allocated to ARS by the CNSA using a needs-formula taking into account demographic and socioeconomic parameters such as the number of APA allowance recipients and the average income of the elderly in the region. The ARS finance home-care nursing services on the basis of a fixed allocation per installed place. This "capitation" type of payment is operated through a flat-rate allocation per place/per patient and is not adjusted by the care needs of the patients (age, dependency, etc.). The only elements taken into account by the ARS in defining budgets are the salary costs, travel and other operating costs (supplies, etc.) in these services. Thus, the SSIAD are pushed to select their patients in order to maintain their budgetary balance.

The only cost study on SSIADs dates from 2008 (Chevreul et al. 2009) and shows that there is great heterogeneity in the type of care provided per patient and costs, which vary in a range of 0.1 to 3.5 times the amount of the average payment per patient

allocated by the ARS. This study points to the difficulties encountered in the field by these services.

Since 2012, the government has been negotiating to fix a national formula based on the activity and case-mix of the service providers, but without success. A new proposal for a national formula is supposed to be made soon after a cost survey carried out in these facilities in 2018 (ATIH, 2018).

5.3.3 Personal care and assistance at home

Personal and social care services can be funded by APA at home using home care and support services (SAAD), self-employed domestic help or in day-care facilities. For some of these services, the local authorities define reference prices. When prices are free, local authorities use the APA price as the reference for calculating the amount/budget of "care plans". There are quite large disparities in APA reference prices across local authorities and across LTC providers (SAAD, self-employed domestic help and day care) within local authorities.

Price setting for SAAD

SAAD are statutory services authorized and regulated by local authorities. In a minority of cases (for 23% of SAAD) the prices are fixed by the *département*, while the rest of the services set their own prices (Libault 2019). When fixed by the local authorities, the prices seem to reflect historical costs, but there is not much information on price setting process. In any case, there are significant disparities in prices, pricing processes and rules between local authorities. Most local authorities use different reference prices depending on the activity of SAAD[16], for example, taking into account their services in weekends and public holidays. Across local authorities, there are also differences in the method of payment; some set global budgets (although without a clear basis), while others provide funding on the basis of the number of hours worked per elderly person in APA. Within the local authorities, which use a fixed reference price for LTC for all SAAD providers, the price varies from €13/hour to €22/hour (Table 6).

The majority of SAAD fix their own prices and propose a global budget to the local authority based on an estimated volume to obtain the authorization. If the operating costs presented is too high compared with the prices in the other authorized SAAD or for the budget of the local authority, the authorization can be refused. The rate of increase in SAAD tariffs from one year to the next is regulated nationally. For example, in 2020, the prices cannot grow more than 3%. People benefiting from APA in fixed priced SAAD do not pay any additional charge other than APA co-payment (see section 3.1). In other services, the difference between the price fixed by SAAD and the APA reference price (fixed by the local authority) is paid by the recipients. Therefore, APA prices influence indirectly the prices in the LTC market.

16 In 2015, only 25% of the local authorities had the same price for all SAAD.

In 2016, the average price charged by SAAD was €20/hour (of which €19 was paid by APA) (FEDESAP 2018). The latest reforms implemented in 2015 as well as the experiments launched recently aimed to develop a global budget for funding SAADs on the basis of multi-year contracts negotiated between the local authority and SAAD to set service objectives and resources needed.

Table 6
APA reference prices for different personal (non-medical) LTC providers

	% of local authorities using fixed prices	Variation in price across local areas	
		Lowest price	Highest price
Home-care and support services (SAAD)	25%	€18/h	€29/h
Self-employed domestic helpers	100%	€8/h	€13/h
Day care in nursing homes	49%	€14/day	€59/day

Note: For funding home-care and support services (SAAD), 25% of local authorities in France use fixed prices (same price for all SAAD in the territory), while 75% negotiate prices individually with each SAAD. Across local authorities using fixed prices, the prices range from €18/hour to €29/hour.

Source: Solvapa database (2015).

Prices for Self-employed domestic help

Prices for self-employed domestic help are freely fixed on the market respecting the French labour code (minimum wage, social security contributions, etc.). To be included in the "care plan" of APA, the self-employed workers need to be accredited by a regional labor and employment agency (DIRRECTE). Local authorities fix an APA reference price for self-employed domestic help. This is the amount reimbursed from APA to people employing self-employed domestic aid, but the actual prices can be much higher. The reference prices for self-employed help are much lower than those in SAAD, ranging from €8 to €13/hour, because local authorities support the deployment of SAAD in which they can control the care standards.

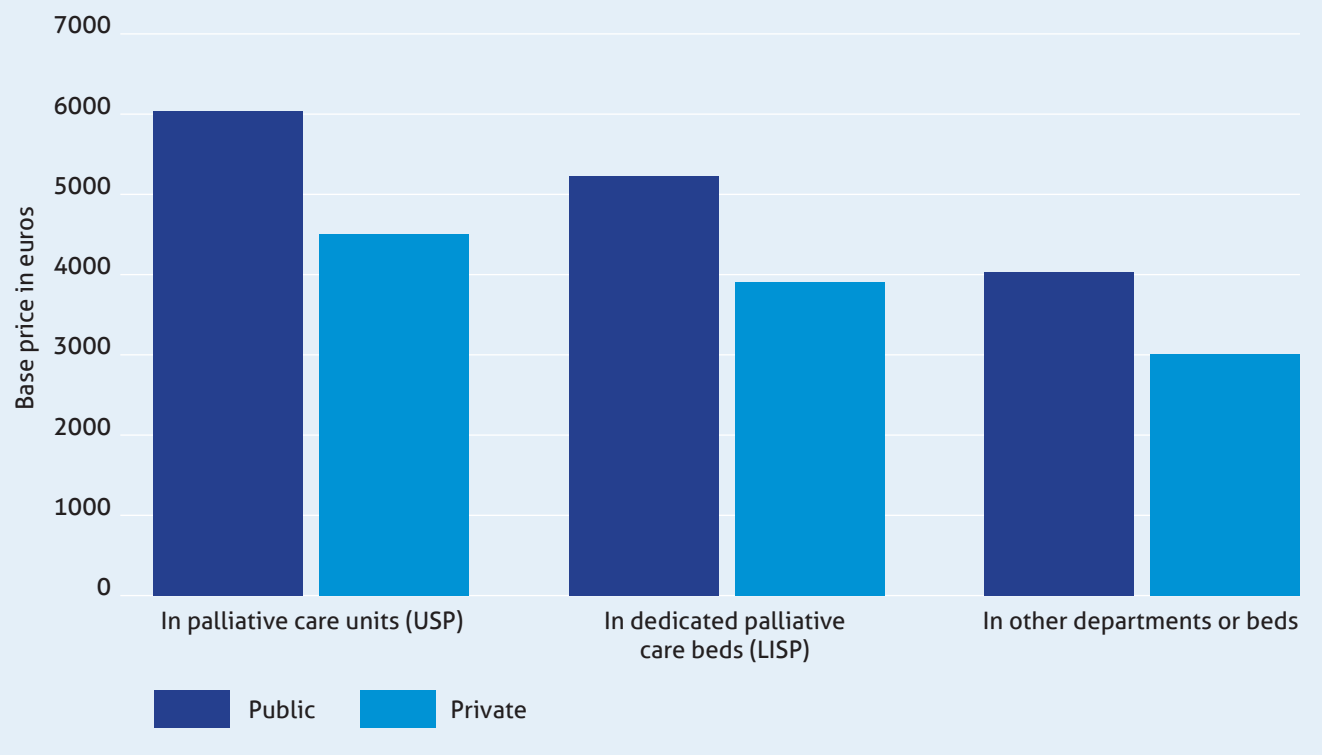
Prices for day care centres

The prices of day-care services often provided in residential nursing homes are freely set by the providers. Day care can be funded by the local authorities in the individualized "care plan" of an APA within the limit of a maximum amount fixed nationally (see part 3.1.2). The APA price of day care used in calculating the "care plan" varies between local authorities. A survey from 2015 showed that 9% of local authorities did not propose any funding for day care, 49% proposed a fixed price (same for all day care centres in the territory), and 43% had varied prices depending on the day-care centre. In local authorities which fixed a reference price, the prices varied between €14 per day to €59 per day (Table 6).

5.4 Price setting for palliative care

The funding of palliative care in the hospital is based on the DRG-based payment, which fixes a price per palliative care stay. The prices are adjusted upwards if a patient is in a dedicated palliative care bed or in the palliative care unit within the hospital (see Figure 2). Prices also differ between public and private hospitals as any other acute care. The mean price is further adjusted downward for very short stays (< 4 days) and increased in cases of long stays (> 12 days). This upper bound was set at the median length of stay, which was 12 days (Veran 2016). According to ATIH cost data, palliative care in hospitals is overpaid with DRG prices by almost 98%, or just over €50 million at the national level.

Figure 2
Prices for palliative care in acute care hospitals 2019 (in euros)



Source: ATIH (2019).

The palliative care in HAH, is also paid by an activity-based payment scheme using palliative care DRGs. In 2019, the price was fixed at €105/per day (ATIH 2019). The price is slightly reduced for people receiving HAH in residential care facilities (-13%) and for those receiving home nursing care from SSIAD (-7%).

Mobile palliative care teams (EMSP) are funded by global budgets. The price is set by the ARS according to the number of full-time-equivalent persons working in the team and considers the travel costs. The payment also includes a contribution to the structural costs of the hospital that the team is attached to. The amount of payment for organizational costs may be assessed by the ARS on the basis of hospital accounting data.

6
Issues and evaluation

With a multitude of care providers funded and regulated by different institutions at different levels of government using different payment rules, the French LTC system is complex. This complexity has several consequences in terms of the cost, quality, accessibility and equity of LTC services.

6.1 Cost and accessibility of LTC

Medical LTC services are funded by SHI from different envelops defined at the national level (ONDAM) and distributed by using different rules. The majority of medical LTC providers at home are paid on a fee-for-services basis, which is inflationary and difficult to regulate (Cour des comptes 2018). Between 2012 and 2016, spending on self-employed nurses increased by about 25% (€1.2 billion). On the other hand, personal and social LTC services are funded and managed by the local authorities, which have different level of resources and policies for LTC. While the cost of medical LTC services are covered relatively well by SHI, the cost of personal/social care services faced by older people and families could be quite high. The solvency of the residential facilities and platforms providing LTC services at home depends on the base prices fixed at the national or local level. However, the prices used for paying these providers vary largely within and between local authorities, and they appear to be mostly disconnected from the actual costs of care for providers. In nursing homes, where the national reference price has not increased since 2009, the main margin for balancing the budget is increasing the accommodation fees. The average out-of-pocket costs left to residents estimated to be around €1850, and this exceeds the monthly income of three residents out of four (Libault 2019). There are also significant disparities across local areas in the availability of LTC services at home and in residential facilities. The place of private providers and the out-of-pocket payments for the recipients are very much linked to the political colour of the local authorities, who define largely the LTC policy.

6.2 Coordination of LTC services

Improving the coordination between existing institutions, funding schemes and care providers has been on the policy agenda for a long while. Different initiatives (such as MAIA[17] for people with complex care needs including Alzheimer's disease

17 MAIA (Maisons pour l'autonomie et l'intégration des malades Alzheimer) were initially created by the Alzheimer Plan 2008-2012 as pilot structures. They are intended to coordinate the care for people suffering from Alzheimer's disease and to support caregivers by developing new management strategies. They were renamed in 2016 as "Methods for action for integrating long-term care and social services" in order to target a larger population with complex needs, to improve the continuity of care in complex situations where many professionals from different disciplines (social, medico-social and health sectors) are handling high-need patients and to support home care.

and PAERPA[18] for the population over 75 years old) that aimed to improve the coordination of local actors involved in LTC for complex elderly people have had only limited success (CNSA 2017; Or et al. 2020). The creation of successive measures with more or less the same objectives without a coherent population-based policy appears to create confusion both for the actors concerned and the LTC users.

Moreover, the measures proposed by the central government and executed by the ARS are not always supported by the local authorities. The collaboration (or lack of it) between the ARS and the "département" impacts directly the organization of the LTC services, their coordination and efficiency at the local level. In order to improve the collaboration between different financing institutions and encourage the coordination of LTC actors at the local level, a new body was created in 2015, "Conference of the funders preventing loss of autonomy of the elderly" (*conférence des financeurs de la prévention de la perte de l'autonomie des personnes âgées*). The funders' conference had the ultimate objective of sustaining the financing of the LTC sector by better coordinating the services at the local level. It had three main missions: providing an overall diagnostic of care needs for the elderly population in France, identifying ongoing local initiatives for improving care coordination, and defining a coordinated program for funding actions aiming to prevent the loss of autonomy. The CNSA supported the actions defined by the conference of funders with about €140 million in 2018, but it is not really clear what are the priority measures to be financed and how these will be defined.

6.3 Care quality

The lack of information on costs and quality of care of different providers is an important problem both for the funders and users. Globally there are very few cost studies on home-based LTC services in France. But even when there is a cost survey, it is not clear how and if the quality of care is taken into account and what the link is between these cost studies and the prices used for funding.

Since 2002, social and medico-social facilities have been required by law to carry out regular assessments of their activities and quality of the services they provide. The National Authority for Health (HAS) provides recommendations of good professional practices in the social and medico-social sectors. The facilities have to carry internal evaluations (three evaluations every five years) as part of the process of continuous quality improvement. They also need to have an external evaluation carried out by a private organism of their choice but only once

18 PAERPA (Healthcare Pathways for Seniors, Parcours de santé des ainés) launched in 2014 in nine pilot territories with the objective of improving coordination at the local level of various health and social care providers for better care management of the population over 75 years old in order to prevent a loss of autonomy and avoid inappropriate hospital and drug utilization. While the measures are well defined and financed within the framework of the experimentation, they are implemented quite unequally from one area to other.

every five to ten years[19]. There are also no clear recommendations for quality indicators to monitor these evaluations. There are a few surveys collecting data on the conditions of nursing care homes and patients' well-being in these facilities, but data from these surveys are not available to public (ANAP 2019; Anesm 2015; Drees 2015). There is almost no public information on the quality of individual nursing care facilities.

In the past ten years, while there has been a shift from using global budgets simply based on historical costs towards adjusting payments by the volume and case-mix of patients cared for, the care quality does not appear to be integrated into payment yet. Recently, two national agencies (ANAP, ATIH) have developed a panel of quality indicators to use in the LTC sector in order to help the ARS and local authorities to better monitor and negotiate the budgets with care providers (in CPOM). However, the indicators proposed relate mainly to overall activity (bed-occupancy, type of authorized places, turnover rate of residents, etc.), staff structure (staff turnover rates, absenteeism rate) and financial situation (debt ratio, etc.).

For the users, there is almost no information on the quality of different LTC providers (nursing homes or homecare services). The government has set up since 2016 a website which allows viewers to consult the prices and out-of-pocket payments in residential nursing homes and in social residence, but there is no information available on the quality of care. It is quite difficult for older people and their families to identify best providers and decide what will be the most appropriate care solution for them. One measure put forward in PAERPA is the creation of a unique local information platform for elderly populations, their families, and care providers involved in LTC. While these platforms help the users and health and social care professionals identify available services in their territory, it would be important to make the available services easier to assess and develop quality indicators which reflect the experiences of LTC users and their families.

6.4 Evaluation of recent reforms

Faced with an increasing demand for LTC, the 2015 Act on adapting society to an ageing population aimed to deal with the challenges of sustaining a high-quality LTC sector. This Act had the objective of reinforcing the provisions for LTC care at home and delaying as much as possible nursing home stays. The key proposals were to increase APA funding at home, to recognize the role played by the informal family caregivers by supporting them financially, to improve the coordination between medical and social LTC actors and to strengthen prevention for maintaining the autonomy of the elderly population. Only a few actions concerned residential care facilities, one of which was the creation of a website for elderly persons and their families, allowing them to compare the prices of residential care facilities. An evaluation carried out in 2017 evoked two positive impacts of the measures introduced

19 From a list of certified organizations.

(Firmin le Bodo and Lecoq 2017). First, the increase in APA allowances contributed to reducing out-of-pocket payments of the users. Second, "informal careers" who provide significant support to elderly and younger persons who need help with ADL are defined formally, and their investment in LTC provision is officially recognized, with financial measures for supporting their involvement. Nevertheless, the financial measures introduced for helping informal careers are deemed insufficient (Firmin le Bodo and Lecocq 2017).

In 2019, a grand consultation was carried out among LTC actors to make concrete propositions to improve the quality of services and the sustainability of finance in the LTC sector (Libault 2019). While supporting the efforts already made in the previous laws for strengthening home care and helping informal caregivers, this consultation highlighted two important issues overlooked until now. The first is th0e increasing difficulty of recruitment in the LTC sector because of difficult working conditions, low wages and the lack of recognition of care providers. The second issue raised is the need for improving the quality in residential nursing homes, the need for increasing the staff ratios, renovating the structures, etc., while reducing out-of-pocket payments (Destais N 2013). This consultation also showed the need to integrate LTC care services at home and in residential care facilities. Indeed, in the past couple of years, several experiments at the local level have tested the possibility of using residential nursing homes as a technical platform for elderly people staying in their home (i.e., outsourced nursing home services for elderly people at home). The parliament was planning to discuss these recommendations in March 2020. Sadly, the COVID-19 crisis and the high dead tolls in nursing homes in France during the first wave of pandemic proved how pertinent these observations are and showed the urgency of improving the connection at the local level between LTC providers in different settings.

Consequently, the government recognized ageing as a new risk and a new branch (autonomy) for social insurance adding to the first four (health, family, employment, retirement) by the law of August 7, 2020. This law shifts the responsibility for national regulation and funding of medical LTC from SHI to CNSA, and it increases the power of the CNSA in piloting LTC in France. However, the creation of the 5th branch does not modify the structural weaknesses of the LTC funding in France, and it does not help to reduce regional inequalities in financing LTC. The funding of personal and social LTC services remains under the responsibility of local authorities and varies according to their political program and wealth. Moreover, the local governance of LTC shared between the ARS and local authorities, which have very weak connection, appeared to be particularly problematic during the COVID-19 crisis. Thus, all the questions raised during the conference of funders and in this chapter on adequacy of prices and financing, quality of care and sustainability of out-of-pocket payments for long-term care are more than ever on the political agenda in France.

Conclusion

The French LTC sector is complex with multiple funders and care providers managed by different levels of government. While the SHI system allows a unified and relatively good coverage of medical LTC needs, the type and funding of the personal and social LTC services vary depending on the local authority. This has resulted in large differences across French *départements* in prices of personal LTC services and out-of-pocket payments faced by the recipients.

Prices and payment mechanisms used for funding providers vary also for medical and personal LTC services. While for medical LTC services the payments are usually adjusted by taking into account the severity of the patients cared for, this is not always the case in personal and social care sectors. Regardless, none of the payment mechanisms take into account the quality of service providers. Generally, there is very limited information on actual costs and care quality of the LTC providers. This hinders both the scope for improving the quality of LTC services and the efficiency of care provision in the LTC sector.

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Case study

Germany

Ricarda Milstein

University of Hamburg
Hamburg, Germany

Michael Mueller and Luca Lorenzoni

Organisation for Economic Co-operation and Development
Paris, France

Abstract

Germany is one of the oldest countries in the OECD. Some 22% of the population is 65 and above, and 6.2% are 80 years and older (OECD 2020a). Its population is projected to both age and decrease in size. Net immigration and recent increases in the birth rate are unlikely to offset these trends. The result is an increasing dependency of long-term care (LTC) beneficiaries on contributors. Beneficiaries are covered by LTC insurance (LTCI), which was introduced in 1995, making it the "fifth pillar" of the social insurance system. LTCI is mandatory. Roughly 90% of the population is enrolled in social LTCI and contributes with a share of their salary. Contributions are pooled on an aggregate level. Enrolees in the private LTCI scheme build up their own capital reserves over their professional careers to finance future LTC expenses.

In 2019, 4.25 million inhabitants received benefits from the LTCI (Bundesministerium für Gesundheit 2021b). The care needs for beneficiaries are assessed through a test, which allocates the beneficiary to one out of five potential care degrees. Benefits increase with increasing LTC need. Beneficiaries are free to choose between home and residential care arrangements. In home care, they can choose between cash and in-kind benefits. In 2019, almost four out of five beneficiaries received home care, and the remainder were in nursing homes.

The system favours home care over residential care and employs a set of different complimentary benefit schemes for home care to enable beneficiaries to remain at home for as long as possible. Beneficiaries also enjoy free provider choice among all contracted providers. Providers that agree to offer LTC services and be reimbursed by LTCI funds agree to a service contract on the number, content and quality of services, and a reimbursement contract. The *Land* identifies general criteria in framework contracts. In 2019, there were 14 688 home-care providers and 15 380 residential care providers (Statistisches Bundesamt 2020). The rate of providers has doubled over the past three decades, but the number of beneficiaries has tripled, resulting in an increase of beneficiaries per provider. In both sectors, the number of private providers has increased over the past 2.5 decades.

Price-setting in LTC is less formalized than in the inpatient and outpatient sectors. Prices are negotiated at the local level. LTC providers negotiate prices with LTCI funds on an individual basis. In home care, services are weighted based on points that reflect the time intensity and/or the complexity of the services. These points translate into prices. In residential care, prices cover nursing costs, board and accommodation and infrastructural costs. Nursing costs largely result from the ratio of personnel per resident depending on the nursing care needs. Beneficiaries make co-payments for home and residential care services with their own financial resources.

Germany has struggled to balance the increase in expenditures with the increase in the contribution rate to the LTCI scheme and increase in co-payments. Several policy reforms have expanded the number of beneficiaries and the amount of benefits. They have also augmented the LTC workforce and improved their working conditions. As a result, expenditures have tripled over the past three decades. Germany has tripled the contribution rate to accommodate increasing expenditures. At the same time, beneficiaries have experienced increased co-payments. Several policy reforms are in progress. Among them, there is an increase in the LTC workforce, a stepwise augmentation of the minimum salary for LTC workers, and the introduction of nationwide, mandatory staffing regulations by the mid-2020s. These reforms are likely to further increase expenditures. It is not clear whether this will result in a further augmentation of contribution rates, higher co-payment rates for beneficiaries, or alternative solutions.

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1
The context

In 2018, Germany had a population of 82.91 million inhabitants (OECD 2020b)[1]. This makes it the most populous country in the European Union (EU) and the fourth most populous in the OECD after the United States, Mexico and Japan (OECD 2021b). At the same time, it is also one of the oldest countries of the OECD. In 2018, 21.4% of the population was 65 years and above, making it the sixth oldest country after Japan, Italy, Greece, Portugal and Finland (OECD 2020a). In addition, 6.2% of the population was 80 years and above, with only Japan, Italy, Greece and Portugal having higher shares.

Life expectancy has increased, but at a slower pace than the OECD average

In 2018, life expectancy at birth in Germany was 81 years, slightly above the OECD average of 80.6 years (OECD 2020c)[2]. This is a substantial increase from 70.6 years in 1970 (against an OECD average of 69.6 years). However, life expectancy has increased at a lower rate compared with the rest of the OECD countries. A slower improvement in life expectancy can largely be attributed to an increasing burden of disease among older persons. Mortality improvements have slowed down for selected disease groups, such as cardiovascular diseases, and mortality has increased for dementia including Alzheimer's disease (Raleigh 2019).

In 2018, life expectancy was 4.7 years longer for women (83.3 years) than for men (78.6 years) (OECD 2020c). The gender gap has narrowed considerably since the mid-1990s, from formerly 6.1 in 1970 and the largest difference of 6.7 years in 1987. This change has resulted in a life expectancy increase that was steeper for men than for women.

Germany's population is projected to age and to decrease in size

Germany's population is likely to decrease due to an already ageing demographic and birth rate of 1.60, which is considerably below the OECD average of 1.7 and the net replacement rate of 2.1 (OECD 2019b, 2021a; Statistisches Bundesamt 2019b). Projections range between 74 and 84 million by 2060 (OECD 2020b; Statistisches Bundesamt 2019a). The population share 65 years and above is expected to increase from 24% to 30%, and the share of people 80 years and above from 9% to 13% by 2060 (OECD 2020d; Statistisches Bundesamt 2019a).

The fertility rate has increased to 1.60 between 2010 and 2018, after ranging between 1.24 and 1.38 in the 1990s and 2000s. Migration rates have been very volatile. In 2015, Germany had seen a sharp increase in immigration with a net

1 Data for 2019 were not available.
2 Data for 2018 were not available.

immigration of 1.1 million people. This growth was largely due to an increase in the number of asylum seekers. Migration rates have declined since then. In 2018, Germany recorded a net immigration close to 400 000 people (Bundesministerium des Inneren, für Bau und Heimat und Bundesamt für Migration und Flüchtlinge 2020). Migration rates are expected to decrease in the future, and they are unlikely to compensate for a low birth rate and high mortality rate due to a high share of older persons (Statistisches Bundesamt 2019b).

The ageing of the population has correlated with increasing morbidity rates. More than half of the population 65 years and above suffers from at least one chronic disease, faces restrictions in daily living and rates their health as fair to very bad (OECD 2019a; OECD/European Observatory on Health Systems and Policies 2019). These rates are roughly comparable to the OECD average. In 2017, 58.2% of the population 65 and above rated its health as fair to very bad compared to an OECD average of 56.8%. A quarter (24%) reported severe limitations in daily activities, and 13.2% reported very severe limitations in daily living. These rates are slightly better than the OECD averages of 32.8% and 17.3%, respectively (OECD 2019a). In selected disease categories, Germany faces significantly higher rates than other OECD countries. The estimated prevalence of dementia is 20.9%, ranking Germany more than five percentage points higher than the OECD average of 15.3% (OECD 2019a). The gap is expected to widen: By 2060, the rate is expected to increase to 36.8%, compared to an OECD average of 29.1% (OECD 2019a).

2 Long-term care insurance

In 2018, Germany's expenditures for LTC amounted to 2.1% of GDP, including voluntary insurance and out-of-pocket-spending. Expenditures for compulsory government schemes amounted to 1.5% of the GDP, which is below the OECD average of 1.7% (OECD 2019a)[3].

LTCI is the dominant financing scheme for LTC and is mandatory for enrolees in the statutory or private health insurance. Enrolees in a sickness fund for statutory health insurance are automatically enrolled in their respective LTCI fund (social LTCI) and contribute a share of their income. Individuals covered by a sickness fund for private health insurance have to enrol in an LTCI fund of the private health insurance system. Both systems largely provide the same benefits. In 2019, 73.05 million inhabitants were covered by the social LTCI system. Among them, 56.9 million people contributed financially to social LTCI. In contrast, 9.22 million were covered by the private insurance system (Bundesministerium für Gesundheit 2021c; GKV-Spitzenverband 2020).

3 Data for 2019 were not available.

Germany introduced the LTCI as a "fifth pillar "of the social security system in 1995

Social LTCI was introduced in 1995 as a separate sector of Germany's security system making it the "fifth pillar" along with unemployment insurance, social health insurance, the statutory pension scheme and social accident insurance. It was introduced for home care in 1995 and residential care in 1996. Prices for nursing homes should cover both infrastructure and running costs to ensure competitive conditions and incentivize efficiency (Deutscher Bundestag 1993). Rules are largely defined in the 11th book of the Social Code and provide access to a range of LTC services (Busse et al. 2017). Before that, LTC services were partly covered by statutory health insurance funds and partly paid out-of-pocket. This resulted in an increasing number of requests for social aid. Private health insurance funds had started to offer LTCI at the same time. However, services were largely financed by municipalities as part of social welfare if people in need of LTC services were not able to afford them.

Employers and employees contribute to social LTCI with a share of their salary

Social LTCI was conceived as a pay-as-you-go scheme. Total annual revenues finance annual expenses based on the principle of solidarity (Campbell et al. 2010). This is similar to the German health insurance system. Employees contribute to social LTCI with 3.05% (3.30% if without children)[4] with a potential increase to 3.40% (Bundesministerium für Gesundheit 2020). This rate is the same across all employment and age groups, is set by the legislator (§ 55 Art. 1 of the 11th book of the Social Code), and does not differ between social LTCI funds. The contribution is shared equally between employers (1.525%) and employees (1.525%)[5]. Over the past decades, the contribution rate has tripled from 1% in 1995. Employees with earnings below €450 per month, students, non-working spouses and children are exempt from contributions. People who are retired contribute 3.05% to 3.30% of their pensions; since 2002, they have been required to pay the full contribution rate themselves. For selected population groups (e.g. the unemployed), other federal agencies cover the contributions. Contributions are only levied on employment income (up to an annual income of €56 250 in 2020) (Bundesregierung 2019b). Income from other sources (such as capital income) and income above this ceiling are not taken into account.

Financing principles are different under private compulsory LTCI. As with private health insurance, capital reserves should be built up over one's professional career to finance future LTC expenses. Hence, premiums are not income- but risk-related.

4 The add-on payment of 0.25% for employees above the age of 23 without children was introduced in 2005 and is borne entirely by employees.

5 This differs in Saxony, where 1.025% is financed by the employer against 2.025% by the employee. This is due to an additional working holiday in that Land. To compensate for this loss, employers enjoy a lower contribution rate.

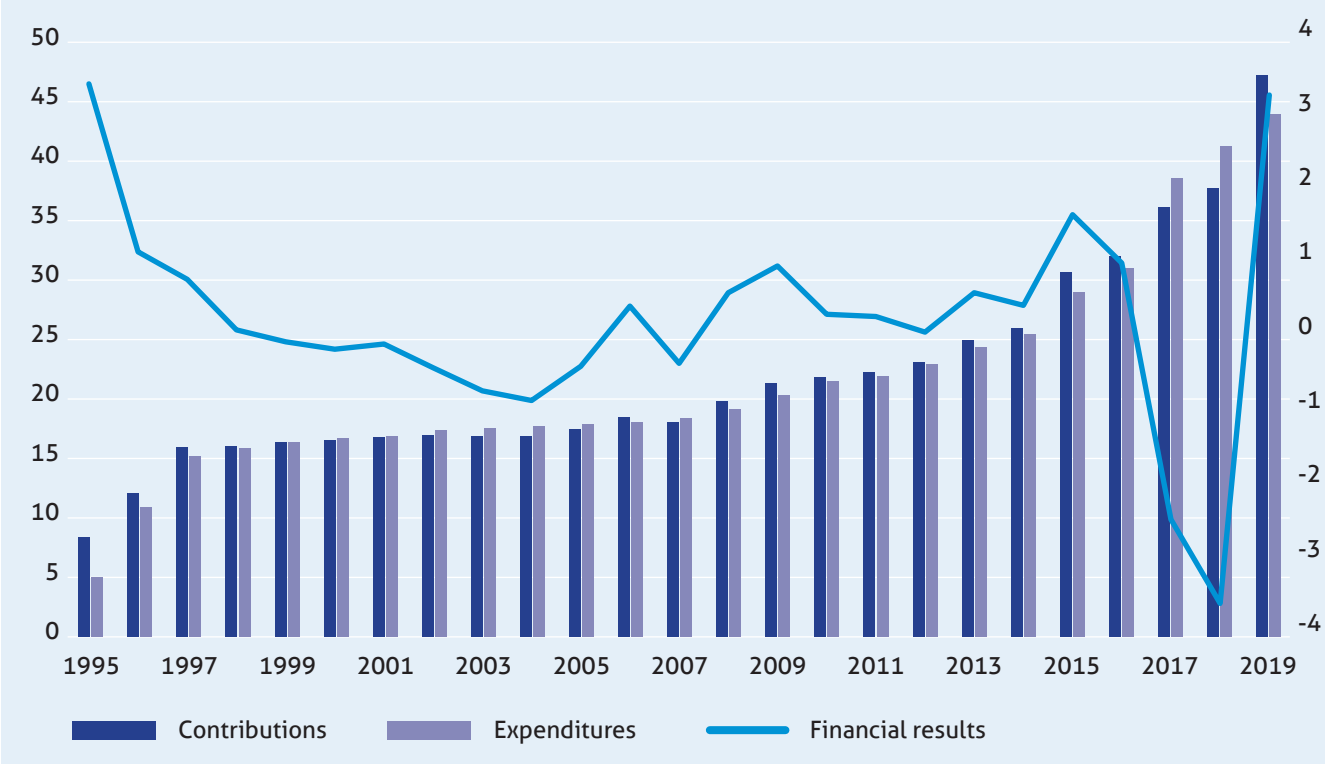
The premium is largely determined by the health status and age of the enrolees. Premiums are not allowed to exceed the maximum contribution rate of the social LTCI (€138.40 per month and €69.90 for civil servants receiving residual private health insurance in 2019). In line with the social LTCI system, employers co-finance the premium up to 50%.

In 2015, Germany introduced a Capital Reserve Fund (Pflegevorsorgefonds) for social LTC to stabilize the contribution rates of future generations (Deutscher Bundestag 2014). Since then, 0.1% of the overall annual contribution rate (more than €1 billion per year) has been directed to this reserve fund managed by the Bundesbank (central bank of the Federal Republic of Germany). The depletion of accumulated reserves will start in 2035, when the "baby boom generation" will become eligible for LTC.

The rate of beneficiaries has increased over the past three decades

In 2019, 4.25 million inhabitants received benefits from social and private compulsory LTCI (Bundesministerium für Gesundheit 2021b). Beneficiaries receive LTC benefits based on their needs. Need is determined by an assessment of care dependence. Beneficiaries are assigned to one out of five care degrees (*Pflegegrade*) based on their restrictions in independent living. Benefits increase with increasing LTC need, ranging from in-kind LTC allowances of €125 per month for the lowest category (care degree 1) to €2005 for residential care in the highest category (care degree 5). The system favours home over residential care. Beneficiaries in home care can choose between cash and in-kind benefits and a combination of both. In 2019, almost four out of five beneficiaries opted for home care. Among them, about four in five selected cash benefits. The number of beneficiaries in social LTCI has almost quadrupled from 1.06 million in 1995 to 4 million in 2019. An increase in the eligibility for LTC benefits in 2017 led to an increase of more than 1.25 million beneficiaries between 2016 and 2019. Benefits have been increased on a recurring basis (Rothgang and Müller 2019). Between 2015 and 2017, Germany expanded the eligibility criteria for LTC and increased the amount of benefits.

Figure 1
Contributions, expenditures (left axis/bar graph) and financial results (right axis/line) of social LTCI, in billion EUR, 1995-2019.



Source: Bundesministerium für Gesundheit (2021b).

An ageing population and the expansion in beneficiaries and benefits lead to increasing expenditures

In 2019, expenditures of the social LTCI amounted to €43.95 billion against contributions of €47.24 billion, leading to a surplus of €3.29 billion (Bundesministerium für Gesundheit 2021c; GKV-Spitzenverband 2020). From 1997 to 2015, both expenditures and contributions have doubled from about €16 and €15 billion in 1997 to roughly €31 and €29 billion in 2015 (Figure 1). A substantial expansion of the benefit scheme in the following years led to an increase in expenditures by 40% by 2019. Contributions have caught up with an increase of 53% over the same period. The social LTCI has a volatile history of surpluses and losses. From 1997 to 2015, changes in contributions and expenditures have resulted in financial results between €-1 billion and €1 billion. The expansion of the benefit scheme in 2015 led to an increase in losses of up to €3.5 billion. Increases in the contribution rate from 2.35% (2.60% if without children) in 2013 to 3.05% (3.30% if without children) in 2019 have finally caught up and led to a surplus of €3.3 billion in 2019.

Expenditures are highest for residential care, with about 32% (€13.04 billion) in 2019, followed by cash benefits representing 29% (€11.74 billion) and in-kind benefits with 12% (€4.98 billion) (GKV-Spitzenverband 2020). Expenditures have increased for all components, but at different rates. The increase has been stronger for home care compared with

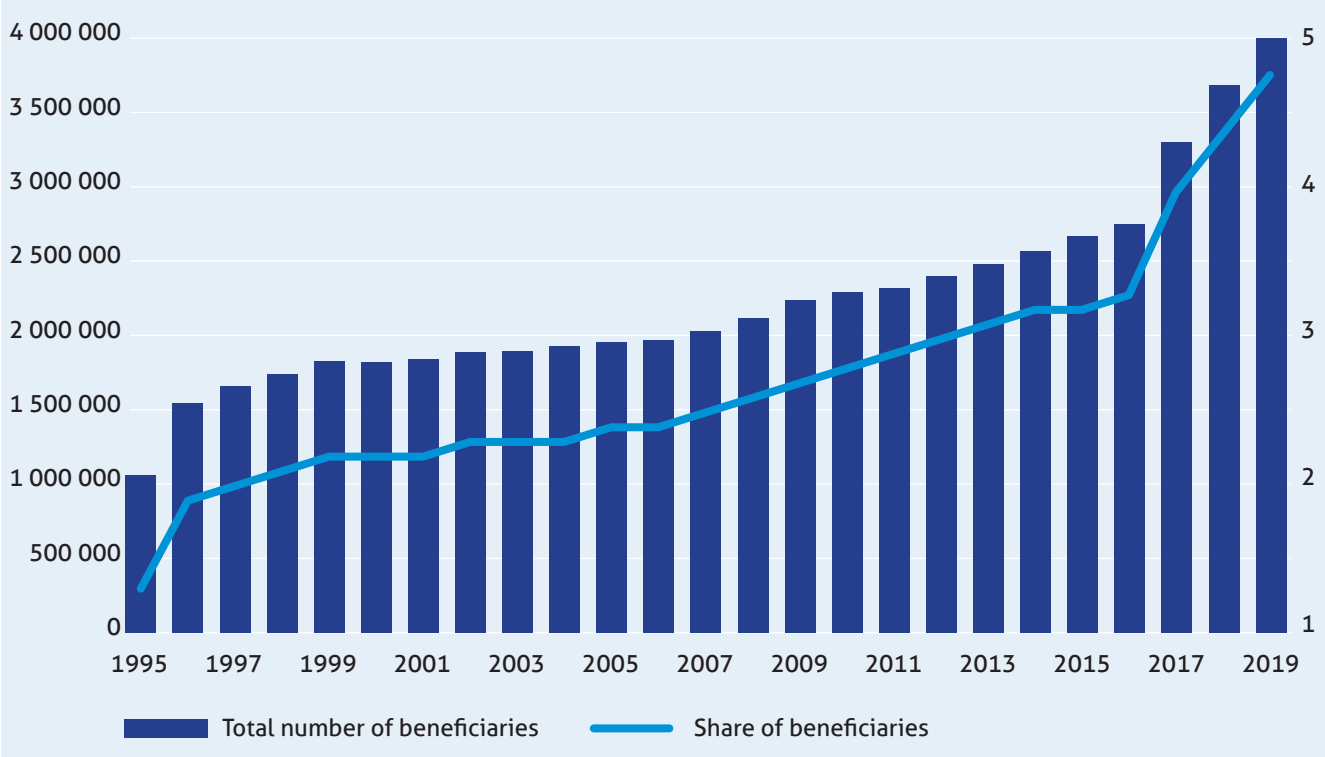
residential care. Expenditures for cash benefits and in-kind benefits have almost tripled from 1997 to 2019, with increases from €4.32 billion to €11.74 for cash benefits and from €1.77 to €4.98 for in-kind benefits. Over the same period, residential care expenditures have doubled from €4.32 billion to €13.04 billion. This increase mirrors a tripling of beneficiaries of home care and a doubling of beneficiaries in residential care.

In 2019, the private LTCI reported €3.21 billion of revenue against €1.57 billion of expenditure (Verband der Privaten Krankenversicherung e.V. 2020).

3 Beneficiaries at a glance

In 2019, 4.25 million inhabitants received benefits from the LTCI[6]. Of them, 3.34 million received home care and 0.91 million received residential care, and 4 million were covered by social LTCI and 0.25 million by private compulsory LTCI (Bundesministerium für Gesundheit 2021b)[7].

Figure 2
Total number of social LTCI beneficiaries (left axis) and as a share of the total population (right axis), 1995-2019.



Note: Residential care was added in 1996.

Source: Bundesministerium für Gesundheit (2021b), Authors' calculations.

6 The Federal Statistical Office reports a total number of 4.13 million beneficiaries. Differences might be due to different sources in reporting.

7 The GKV-Spitzenverband reports 3.87 million excluding beneficiaries in residential care for the disabled (§ 43a of the 11th book of the Social Code)

There has been a large increase in the number of social LTC beneficiaries in recent years (Figure 2). This is due to both an ageing population and to the introduction of new and broader LTC eligibility criteria in 2017. From 1995 to 2016, the number of beneficiaries in the social LTCI had increased from 1.06 million to 2.75 million. The expansion of eligibility criteria for LTC benefits led to a sharp increase in the number of beneficiaries to 3.30 million in 2017, 3.69 million in 2018 and 4 million in 2019, resulting in a growth of more than 1.25 million beneficiaries in the social LTCI compared to 2016. Assuming no changes in this trend, the number of LTC-dependent people is projected to reach 5.06 million in 2060 (Schwinger, Klauber and Tsiasioti 2020).

In 1995, 1.3% of the total population received benefits from social LTCI. From 1996 to 2012, this share increased rather slowly from roughly 2% to 3% and reached 4% following the expansion of the benefit scheme. In 2019, 4.8% of the population received social LTCI benefits.

The number of beneficiaries increases with age and care degree, and is higher for females than for males. In 2019, the share of beneficiaries ranged from 1.8% among those below 75 years old to 76% among those 90 years old and above. All age groups have seen an increase in the share of beneficiaries, which is mainly due to an ageing population and to an expansion of eligibility criteria. The increase is largest among beneficiaries 90 years old and above. The number of beneficiaries below 75 years old increased from 0.44 million in 1995 to 1.43 million in 2019, from 0.30 million to 1.31 million for those 75 to 85 years old, from 0.20 million to 0.71 million for those 85 to 90 years old, and from 0.12 million to 0.56 million for those 90 years old and above (Bundesministerium für Gesundheit 2021a). The share of beneficiaries within their age group (quota of care) increases by age. It amounts to less than 2% among those below 75 years old, roughly 20% among those 75 to 85 years old, about 50% among those 85 to 90 years old and increases to more than 75% among those 90 years old and above (Gesundheitsberichterstattung des Bundes 2020a)[8]. The rate has increased across all age groups. In 1999, the share amounted to 0.9%, 14%, 38% and 60% in the aforementioned age groups.

In 2019, roughly 62% of the beneficiaries were female. The share of female beneficiaries among all beneficiaries has slightly declined from 68% in the late 1990s and 65% in the mid-2000s due to a steeper growth rate in the number of beneficiaries among men (Bundesministerium für Gesundheit 2021a). The gender gap widens with increasing age. For those 75 years old and below, the share of female beneficiaries within their age group equals the share of males. The female quota of care is higher for females than for males and the difference increases with age, ranging from less than 2% for both females and males below 75 years old to 81% among

8 Total number of beneficiaries reported by the Federal Statistical Office and Federal Health Monitoring differs slightly from the German Federal Ministry of Health.

females 90 years old and above compared to 64% among men in the same age group. This is an increase from 65% and 42% among females and males 90 years old and above in 1999 (Gesundheitsberichterstattung des Bundes 2020a).

Four out of five beneficiaries receive home care

In 2019, almost four out of five beneficiaries (78%) received LTC services at home. The number of beneficiaries receiving home care by the social LTCI has roughly tripled from 1.06 million in 1995 to 3.14 million in 2019. Over the same period of time, the number of beneficiaries receiving residential care by the social LTCI has more than doubled from 0.38 million in 1995 to 0.86 million in 2019 (Bundesministerium für Gesundheit 2021b).

Beneficiaries in residential care facilities are older and more dependent than those receiving home care. About three quarters of beneficiaries in home care are assigned to care degrees 2 and 3, compared to around half of beneficiaries in residential care being assigned to the more severe degrees 3 and 4. Beneficiaries in home care are younger compared with those in residential care (Figures 3 and 4). The share of home care beneficiaries is largest for beneficiaries between 80 to 85 years old, and declines afterwards. The share of beneficiaries in residential care increases with increasing age, with more than half being 80 years old and above, and almost a quarter being 90 years old and above (Bundesministerium für Gesundheit 2021b).

Figure 3
Total number of beneficiaries of home care by age group and care degree, with 5 being the most severe, 2019. .

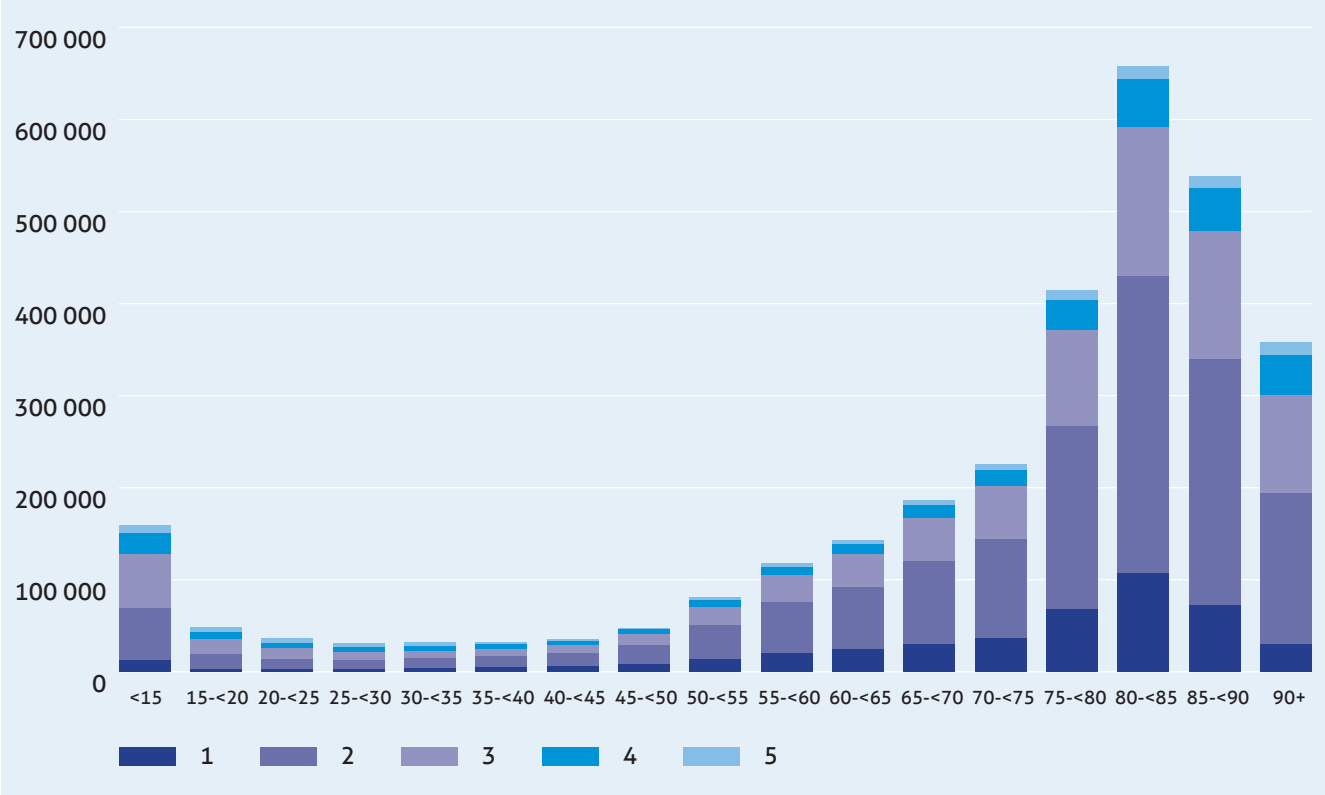
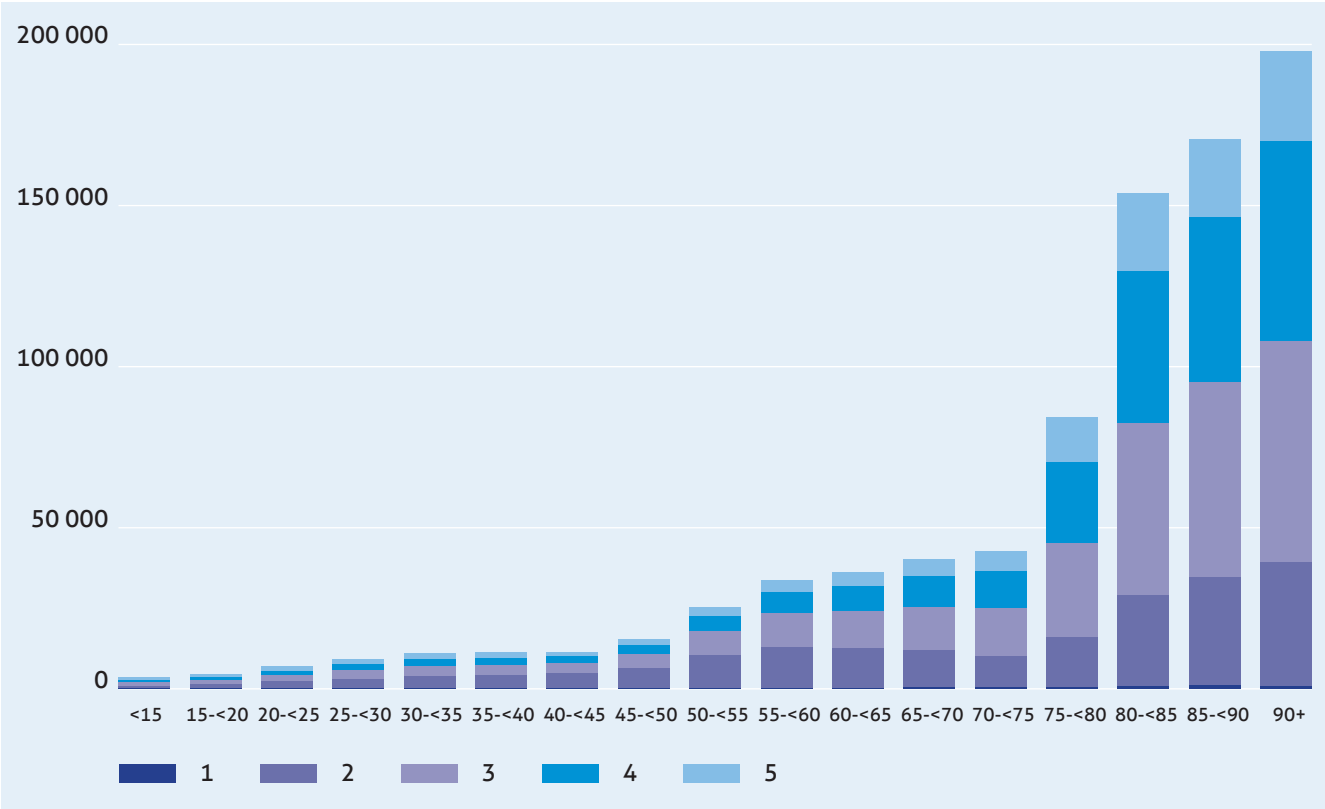


Figure 4
Total number of beneficiaries of residential care by age group and care degree, 2019.



Source: Bundesministerium für Gesundheit (2021b).

3.1 Eligibility for LTCI benefits

LTCI grants access to services on the basis of LTC needs and it is not means-tested. Everyone with LTC needs is entitled to receive the services they require regardless of age, income, wealth, personal circumstances (such as living with a carer) and medical diagnosis (whether physical or cognitive). A needs assessment recognizes whether an individual should receive benefits and the amount. Individuals have to take a needs-based, uniform assessment test, which assigns them to one out of five potential "care degrees" (Pflegegrade) ranging from 1 – "little impairment of independence" to 5 – "hardship". The stages define the amount of benefits that the individual receives.

Table 1
Domains and related points for overall assessment of care dependence

#	Domain	Points
1	Mobility	10
2	Cognitive and communication skills	15
3	Behaviour and psychological issues	
4	Self-care	20
5	Coping and dealing independently with illness and treatment-related demands and stresses	40
6	Planning day-to-day living and maintaining social contact	15

Source: Medizinischer Dienst der Krankenversicherung (2019).

The procedure is the same across the country, all LTCI funds and age and care groups. The assessment evaluates the individual's ability to manage their life independently in terms of six domains and combines the assessment into a single score between 0 and 100 points (scores in each domain are weighed differently for the overall assessment) (Table 1). The lowest care degree (Pflegegrad 1) is assigned if the total score ranges between 12 and 27 points (of a total of 100 points), the most severe degree (Pflegegrad 5) from at least 90 points. The higher the care degree, the more benefits a person is entitled to under social LTCI. Finally, an individual is considered eligible for LTCI benefits if they require care for a period that is likely to exceed a minimum of six months due to sustained physical, cognitive or mental impairments or health-related requirements[9].

Anyone can refer themselves or be referred for a care needs assessment. For statutory LTCI, this assessment is managed by the Medical Review Board (Medizinischer Dienst der

9 The assessment was modified in 2017. Before then, eligibility was strongly related to somatic illnesses and restrictions of personal hygiene, nutrition and mobility functions. It largely focussed on physical limitations requiring help in performing certain activities, excluding general supervision and support for people with limited psychological and cognitive capacity (Deutscher Bundestag 2015).

Krankenkassen), an independent body contracted by social LTCI funds. The Board contracts an independent medical expert to assess the eligibility and need within three weeks after receiving the application. The evaluators are generally medical doctors, but can also be nurses who have received ad-hoc and ongoing training. In 2019, individuals applied for a total of 1.17 million assessments and 78% of them resulted in a positive decision. Expansions in the benefit scheme have also translated in a higher rate of positive decisions, which ranged slightly above 70% prior to the expansion (Bundesministerium für Gesundheit 2021c).

3.2 Entitlements for LTCI benefits

In Germany, the system favours home care over residential care (§ 3 SGB XI). It intends to facilitate independent or assisted living at home to enable beneficiaries to remain in their own home for as long as possible. In its design, the system seeks to balance universal entitlement with the self-governance of payers and providers[10] and with individual and family responsibilities.

The amount of entitlements depends on the care degree as determined by an assessment. Benefits increase with increasing care degree (Table 2). The entitlements are fixed for each of the five degrees of care and do not vary according to where a person lives, or their age, means or personal circumstances. Entitlements provide partial but not full coverage of costs. They guarantee up to a minimum level of care. Beneficiaries make co-payments with their own financial resources.

The pooling of risk at the national level is at the heart of the system, based on the premise that no individual should have to bear catastrophic care costs. Instead, costs are shared across society.

Table 2
Monthly financial entitlement by LTC service by care degree, in EUR, 2019.

Care degree	LTC allowance	Home-care cash benefits	Home-care in-kind/ day/night care	Residential care
1	125			
2	125	316	689	770
3	125	545	1298	1262
4	125	728	1612	1775
5	125	901	1995	2005

Source: Bundesministerium für Gesundheit (2021b).

10 In 2004, self-governance was strengthened through the establishment of the Federal Joint Committee, a major payer–provider structure given the task of defining uniform rules for access to and distribution of health care, benefits coverage, coordination of care across sectors, quality and efficiency.

The system favours home care over residential care

All beneficiaries receive a monthly in-kind contribution of up to €125 irrespective of their care degree and care setting. It serves as a voucher and is restricted, e.g. day and night care services, short-term care and short-term support for carers. Beneficiaries in home care can choose cash benefits, in-kind benefits or a combination of both. Beneficiaries who opt for cash benefits (a "cash allowance") are responsible for organizing their own LTC care. They generally rely on informal carers, mostly family members. Informal caregivers can receive additional benefits including financial support for their social insurance contributions and pension entitlement[11]. Beneficiaries who choose cash over in-kind benefits are inspected by local care providers every half year (for care degrees 2 and 3) or quarter (for care degrees 4 and 5). This is intended to offer support and training to carers and ensure that cash beneficiaries are not abused, neglected or financially exploited. In-kind benefits are reserved for professional home care providers. Beneficiaries use their benefits to employ one of 14 688 home care providers.

Germany has introduced several additional benefit schemes to reduce the burden of care for informal and professional LTC workers and to cover reconstruction work and rearrangements. These means can be combined. As a result, the amount of benefits for home care can outperform the amount for residential care. First, beneficiaries can receive up to €40 per month for nursing aids. Second, they can apply for short-term assistance. They can receive up to €1612 per year for up to six weeks for care substitutes (stand-ins) to reduce the burden of care on informal and professional LTC workers, or up to €1612 for short-term stays, day or night stays of up to 8 weeks in residential care. Both schemes are only available for care degrees 2 to 5. They are intended to allow for interim support to reduce the workload on (informal) carers. Beneficiaries who intend to share their apartment with other beneficiaries can receive €2500 per person or €10 000 per shared apartment and up to €214 per month for additional support with daily living. Additionally, they can apply for €4000 to €10 000 per person or shared apartment per intervention. These means can be combined. Germany may increase the benefits of home care and ease the administrative procedure. It plans to introduce an annual nursing care budget for short-term care and interim support (Bundesministerium für Gesundheit 2020)

Financial support for residential care amounts to €689 to €1995 for part-time residential care, and €770 to €2005 for full-time residential care.

11 There are more than 900 000 people registered as informal caregivers at the pension insurance. The LTCI pays pension contributions for these people.

Most beneficiaries opt for cash benefits for home care, but expenditures are highest for residential care

Residential care represents the highest single cost component. In 2019, expenditures for residential care amounted to €13.04 billion, compared to €11.74 billion for cash benefits and €4.98 billion for in-kind benefits in home care covered by social LTCI (GKV-Spitzenverband 2020). These cost components represent more than 70% of all LTC expenditures. Other benefits covered by the scheme include day care, short-term care, respite care as well as the costs of social protection for informal caregivers and medical devices and the costs for refurbishments and rearrangements to adapt homes to the needs of older persons.

Cash benefits are the most frequent support. In 2019, roughly 50% of all beneficiaries received cash benefits. Out of all beneficiaries receiving home care, 84% received cash benefits compared to 16% choosing in-kind benefits (both including combinations with other services of up to 50%) (Bundesministerium für Gesundheit 2021b).

Out of all beneficiaries, about half opted for cash benefits, about 20% for a combination of cash and in-kind benefits, only 4% for in-kind benefits and the remainder opted for alternative means of short-term support (Bundesministerium für Gesundheit 2021b).

Benefits have been expanded since 1995, most notably in 2015/2017

From 2008 to 2017, benefits have widened across all schemes at irregular intervals, and new types of benefits have been added after remaining on the same level from 1995 to 2008. In-kind benefits in care degrees 2 to 5 increased from €384-1918 in 2008 to €689-1995 in 2017. Cash benefits increased from €205-665 in 2008 to €316-901 in 2017. In line with this change, residential care benefits increased from €1023-1688 in 2008 to €770-2005 in 2017 (Rothgang and Müller, 2019).

In 2015, Germany increased benefits for the 2.7 million beneficiaries at that time. LTC benefits had increased by €1.4 billion per year for people living in their private homes and by €1 billion per year for people living in residential facilities. The services available for care at home were expanded. Staff numbers in residential care homes had also increased significantly. Nursing-centred LTC services still remain essential in LTCI, but regular benefits were expanded by services for personal support and daily living assistance. The three care levels (Pflegestufen) have been replaced by five new care degrees (Pflegegrade). Because the new assessment criteria led to an increase in the number of people entitled to LTC services, LTC benefits have been set to increase by more than €2.5 billion.

4
Providers of home and residential care

Over the past three decades, Germany has seen an increase in home care and residential care providers. However, the increase in beneficiaries has been even steeper, leading to a higher number of beneficiaries per provider. Both sectors recorded a change in the market structure from private non-profit to private for-profit providers. The change is more pronounced in home care than in residential care. The staff in home and residential care has not kept up with the increase in beneficiaries and faces increasing shortages.

4.1 Home care providers

In 2019, 14 688 providers offered home care services (Table 3). The number had increased by around 36% compared to 1999 (from a total of 10 820 providers). At the same time, the number of beneficiaries receiving support by home care providers doubled from 415 289 to 982 604. This resulted in an increase of beneficiaries per home care provider by almost 75%, from 38.4 beneficiaries in 1999 to 66.9 in 2019.

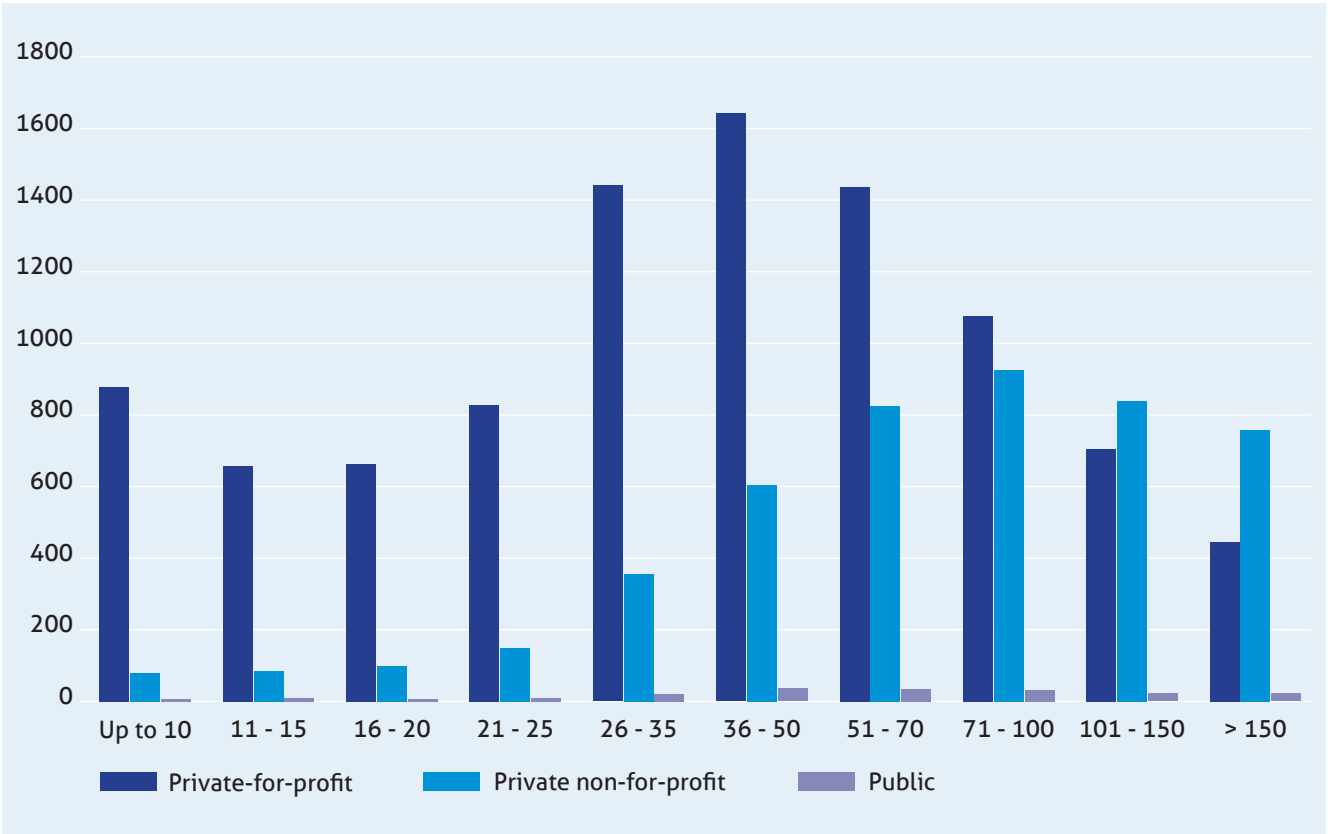
Table 3
Comparison of the number of providers, beneficiaries and beneficiaries per provider by ownership, 1999 and 2019, home care

	1999		2019	
	Total number	%	Total number	%
Total number	**10 820**	**100**	**14 688**	**100**
No. private non-profit (%)	5103	47.16	4720	32.14
No. private for-profit (%)	5504	50.87	9770	66.52
No. public (%)	213	1.97	198	1.35
Total no. beneficiaries	**415 289**	**100**	**982 604**	**100**
No. private non-profit (%)	259 648	62.52	453 230	46.13
No. private for-profit (%)	147 804	35.59	514 243	52.33
No. public (%)	7837	1.89	15 131	1.54
Ratio beneficiaries/provider	**38.4**		**66.9**	
Ratio private non-profit	50.9		96.0	
Ratio private for-profit	26.9		52.6	
Ratio public	36.8		76.4	

Source: Gesundheitsberichterstattung des Bundes (2019).

All ownership types have seen an increase in the number of beneficiaries per provider over the past two decades (Table 3). Among them, private for-profit providers tend to be smaller organizations than other ownership types (Figure 5). The number of private for-profit providers almost doubled from 5504 in 1999 to 9770 in 2019. At the same time, the number of beneficiaries more than tripled from 147 804 in 1999 to 514 243 in 2019. As a result, the ratio of beneficiaries per provider almost doubled for for-profit providers. Over the same period of time, the number of private non-profit providers has declined from 5103 in 1999 to 4720 in 2019, but the number of beneficiaries increased by 75% from 259 648 in 1999 to 453 230 in 2019, resulting in an almost doubling of beneficiaries per provider from 50.9 in 1999 to 96.0 in 2019. The increase in the ratio of beneficiaries to providers was strongest for public providers. The number public providers declined from 213 in 1999 to 198 in 2019. At the same time, the number of beneficiaries doubled from 7837 in 1999 to 14 376 in 2019, resulting in a more than doubling of the number of beneficiaries per provider (76.4 in 2017 compared to 36.8 in 1999) (Table 3) (Gesundheitsberichterstattung des Bundes 2019).

Figure 5
Number of providers by number of beneficiaries per ownership, 2019, home care



Source: adapted from Statistisches Bundesamt (2020).

4.2 Residential care providers

In 2019, there were 15 380 residential care facilities with a capacity of 969 553 beds, which corresponded to roughly 53.6 beds per 1000 inhabitants 65 years old and above. This is above the OECD average of 47 beds per 1000 inhabitants (OECD 2019a). Some 73.6% offered full-time residency. The number of residential care providers increased by about 74% from 1999[12] to 2019 (Table 4). The increase was higher for residential care than for home care, which increased by around 36% over the same period of time. The number of beds increased by 45% over this same period. However, the number of beneficiaries almost tripled over the same period of time.

Table 4
Comparison of the number of providers, of places available and of residents per provider by ownership, 1999 and 2019, residential care

	1999		2019	
	Total number	%	Total number	%
Total number (full-time residency)	**8 859 (8 073)**	**100**	**15 380 (11 371)**	**100**
No. private non-profit (%)	5017	56.63	8115	52.76
No. private for-profit (%)	3092	34.90	6570	42.72
No. public (%)	750	8.47	695	4.52
Total number of places available (full-time)	**645 456 (621 502)**	**100**	**969 553 (877 162)**	**100**
No. private non-profit	406 705	63.01	521 720	53.81
No. private for-profit	166 637	25.82	393 308	40.57
No. public	72 114	11.17	54 525	55.62
Ratio residents/provider	**66**[1]		**62**	
Ratio private non-profit	73[1]		65	
Ratio private for-profit	50[1]		58	
Ratio public	84[1]		76	

Note: [1]Data from 2001. No data was available for 1999.
Source: Gesundheitsberichterstattung des Bundes (2020b) and Statistisches Bundesamt (2020).

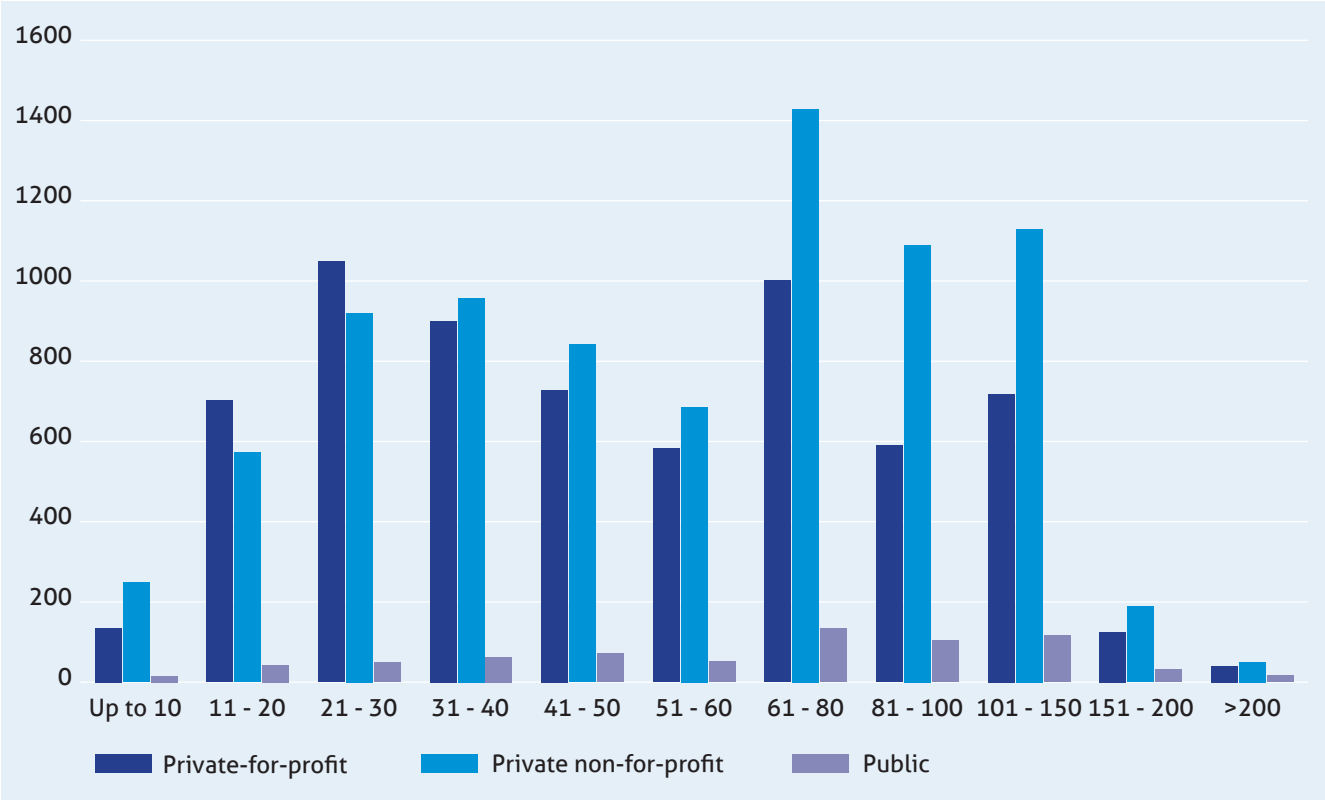
In contrast to home care, private non-profit providers dominate the market, but their market share is declining (Table 4). The share of private non-profit providers declined by almost 4 percentage points following a steep increase in the number of private for-profit providers from 1999 to 2019. From 1999 to 2019, the number of private non-profit providers increased by 62%, whereas the number of private for-profit providers increased by 112% over the same period of time. The increase

12 No data from pre-1999 was available.

was more pronounced for the number of beds offered, which increased by almost 30% in private non-profit providers, but by 136% in private for-profit providers during the same period. Public providers declined in terms of both the number of facilities and beds available (Gesundheitsberichterstattung des Bundes 2020b).

Similar to home care, residential care private for-profit providers tend to be smaller organizations than providers by other ownership types. More than half (53%) of private providers of residential care serve less than 50 beneficiaries, as compared to 44% for not-for-profit and 35% for public providers (Figure 6).

Figure 6
Number of providers by number of places available per ownership, 2019, residential care



Source: adapted from Statistisches Bundesamt (2020).

4.3 LTC workforce in home and residential care

In 2019, the LTC workforce amounted to 1.22 million people. The rate of LTC workers per 100 inhabitants 65 years and above was slightly above the OECD average, at 5.1 compared to 4.9 (OECD 2019a). Of all LTC workers, about one third (421 550 people/ 228 268 full-time equivalents (FTE)) was employed in home care and the remaining two thirds (796 489 people/557 307 FTE) were employed in residential care (Statistisches Bundesamt 2020). The workforce is predominantly female and works part-time. In 2019, more than 80% of LTC workers in both residential and home care were female and less than a third (28% in both sectors) worked full-time.

Both sectors have seen increases in the number of staff. The number of LTC workers in FTE has more than doubled in home care (183 000 people/125 400 FTE in 1999 compared to 421 550 people/288 268 FTE in 2019). The increase was less steep in residential care (440 900 people/345 100 FTE in 1999 compared to 796 489 people/557 307 FTE in 2019).

In 2019, LTC workers earned a median gross salary of €2146-3032 per month (FTE-adjusted) depending on their level of qualification (Carstensen et al. 2020). Salaries have increased by about 28% from 2012 to 2019. The salary of LTC workers varies between sectors. In home care, monthly median gross earnings in FTE range from €2039-2721, compared to €2182-3099 in residential care depending on the level of qualification. This is considerably below the median salary of nurses working in hospitals, which ranged from €2939 to €3684 (FTE-adjusted) in the same year depending on their qualification (Carstensen et al. 2020). Germany might see a drift of the LTC workforce from the LTC sector to the inpatient sector (Greß and Stegmüller 2020). A higher salary in the inpatient sector, policy reforms to improve the number and working-conditions of nurses in the inpatient sector, and the merger of three separate vocational training systems to one joint scheme are likely to increase the attractiveness of the inpatient sector (Greß and Stegmüller 2020).

Germany faces shortages in its LTC workforce. In 2019, it recorded 23 500 open LTC positions, and positions remained vacant for up to 200 days (Bundesagentur für Arbeit 2020). The number of vacancies has increased by 110% over the past decade, and shortages are expected to persist. Given Germany's ageing population projections, the demand for LTC workers is likely to increase. The scenarios are very heterogeneous. Projections range from an additional 130 000 to 150 000 LTC workers in FTE required by 2035 against a base-line scenario from 2015 (Flake et al. 2018); other scenarios estimate between 667 000 to 1 million additional LTC workers needed by 2050 (in FTE) against a base-line scenario from 2009 (Schulz 2012).

Germany has introduced a set of policies to increase the number and improve the working conditions of its LTC workforce. From 2010/2011 to 2014/2015, Germany augmented the capacities of vocational training facilities by 10% per year and introduced policies to facilitate the return to the labour force. Furthermore, Germany introduced minimum wages for nurses in 2010 and for all employment sectors in 2014. This improved the salary of nurses in selected parts of the country (Harsch and Verbeek 2012). However, it is unclear whether these measures will be sufficient (Flake et al., 2018). In 2019, Germany started the "concerted action on nursing" (*Konzertierte Aktion Pflege*) to increase the number of LTC workers and to improve their working conditions and salary. In 2020, Germany merged its formerly three vocational training tracks for LTC nurses, general nurses and paediatric nurses and announced a 10% increase in training capacities

(Bundesregierung 2019a; Deutscher Bundestag 2017). Furthermore, it announced an increase of a nationwide, uniform minimum gross salary of €2175-2669 by 2022 depending on the level of qualification (Bundesministerium für Arbeit und Soziales 2020). From mid-2020, Germany is introducing a federal instrument to harmonize the ratio of LTC workers to residents in residential care. An improved ratio of LTC workers to residents is likely to increase expenditures in LTC. It is not clear whether the cost increase will be borne by LTCI funds resulting in higher contribution rates, or by beneficiaries leading to an increase in co-payments (Rothgang and Müller 2019). In 2021, Germany has introduced an act to increase the number of auxiliary LTC nurses by an additional 20 000 in residential care. Additional costs will be covered by the LTCI by providing add-on payments to residential homes and not by increases in co-payments (Deutscher Bundestag 2020a, 2020b). Furthermore, the act discusses making tariff-based salaries mandatory for the accreditation of home and residential care LTC providers (Bundesministerium für Gesundheit 2021b).

5
Choice and service pricing

LTC is understood to be a "concerted action". Germany's 16 *Länder* (states) are responsible for ensuring sufficient LTC to their *inhabitants* (§ 9 SGB XI). LTC legislation differs between the 16 *Länder*, reflecting the federal governance structure of the country. Social LTCI funds, in return, are in charge of providing sufficient LTC to their *enrollees* (§ 69 SGB XI). To do so, they contract with home and residential care providers on the type, content and amount of services they have to provide and their reimbursement (§ 72 SGB XI). Social LTCI funds have to ensure that expenditures do not exceed contributions. The facilities are supervised by the *Land* or the *Kommune*. They have to meet quality criteria to be eligible to offer care. Depending on the *Land*, LTC facilities are supervised by the Land itself (in 10 *Länder*), the municipality (*Kommune*) (in 5 *Länder*) or a joint responsibility by the two (1 *Land*).

Germany has sought to develop a stable and competitive provider market by creating a national regulatory framework to coexist alongside market principles (Nadash and Cuellar 2017). As such, it aims to balance cost containment, social equity, consumer choice and local flexibility. The reimbursement system as laid out in the Social Code aims to foster competition between providers in order to contribute to an efficient service infrastructure through economic incentives. It further stipulates that the care infrastructure must be well-functioning, demand-oriented and cost efficient, and assigns responsibility for service provision to the federal states.

Beneficiaries enjoy free provider choice among those facilities that have contracted with state associations and social LTCI

funds. Benefits do not differ accept private-for-profit, private-non-profit and public providers. Beneficiaries have been able to receive support in advice centres since 2008. However, these centres have been criticized for not operating effectively, offering poor support and being under construction.

5.1 Price-setting in home care

Home care providers negotiate two contracts to provide LTC and to be reimbursed by social LTCI funds. First, they contract care provision with the state associations of the social LTCI funds (§ 72 SGB XI). Second, they have a reimbursement agreement (§ 89 SGB XI) with these state associations and social welfare organizations. Minimum standards are defined in regulatory frameworks at the state level (§ 75 SGB XI).

Contracts on care provision define quality criteria for home care providers and define the services and their content of (instrumental) assisted daily living to be provided by home care providers. Among them are for example hygiene of the beneficiary, food intake, mobility and shopping. Beneficiaries can choose from a set of services. LTCI funds are generally billed monthly.

Prices for home care follow a point system and are negotiated individually. Services are translated into points depending on the time intensity of the services provided and/or their complexity. Some of the services are restricted and can be billed up to three times a day, weekly or twice a year. Furthermore, selected services are mutually exclusive. Points translate into a price (see Table 5 for some examples). The number of points per service and the financial amount per service differs between states and providers. The base value is around €5-6 per 100 points. Prices are economic, efficient and cover the duties of care. Since 2015, costs originating from collective labour agreements cannot be rejected for economic reasons. At the same time, LTCI funds can require evidence on whether reimbursements are used to meet collective labour agreements.

The German Federal Ministry of Health, the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth and the Federal Ministry of Labour and Social Affairs are mandated to decide on a uniform fee schedule for home care if deemed necessary (§ 90 SGB XI).

Table 5
Points and corresponding prices for selected services in framework contracts in two Länder, 2019.

	Brandenburg		Bavaria	
	Points	Price (in EUR)	Points	Price (in EUR)
First visit	450	22.64	1000	60.50
Journey (mobility)	84	4.23	-	4.54
Washing hair	129	6.49	100	6.05
Changing bedsheets	50	2.52	80	4.84
Cooking main dish	240	12.07	300	18.15

Source: AOK Nordost et al. (2019) and Pflegekasse bei der AOK Bayern et al. (2019).

Co-payment rates are unclear in LTC

Beneficiaries make co-payments for care costs with their own financial resources. However, the amount of this co-payment is largely unknown. Estimations range from €143 to €482 per month depending on the care level. There are no estimations following the expansion of benefits and re-classification of care (TNS Infratest 2017).

5.2 Price-setting in residential care

Residential care follows a framework similar to home care. Residential providers negotiate two contracts to provide LTC and to be reimbursed by social LTCI funds. Providers of residential care have a contract on care provision with state associations of social LTCI funds (§ 72 SGB XI). Contracts regulate all matters between the LTCI funds and service providers in terms of, for instance, the appropriateness of nursing staff, the content and scope of services as well as issues of quality assurance. Second, they have a reimbursement agreement (§ 85 SGB XI) with state associations of social LTCI funds and social welfare organizations. Residential care providers can negotiate add-on payments for additional comfort services and additional staffing. Contracts are subject to regulatory frameworks at the state level (§ 75 SGB XI). The (agreed) remunerations and charges for care have to be economic and efficient, and retroactive reimbursement of costs (potential loss) is not possible (European Commission 2017).

Prices are negotiated individually on a regional or state level between a residential home, welfare organizations and LTC funds, whose enrolees contribute at least 5% of the residential home days (Pflegesatzverhandlungen). Prices are negotiated separately for nursing services, board and accommodation and investment costs. Board and accommodation and investment costs are the same for all residents, but nursing costs and reimbursements grow by increasing care degree (Table 6)

(Rothgang and Wagner 2019). Nursing costs are largely based on the number of nurses per beneficiary and vary depending on the beneficiary's care degree. The ratio of nurses to residents varies greatly across the *Länder*. Germany plans to introduce a nationwide, uniform instrument to assess nurse staffing requirements by mid-2020 (Rothgang and Müller 2019).

Residential homes can apply for negotiations on their care charges whenever they deem it necessary. Residential homes submit all cost data[13] to the negotiating parties including among others, staffing costs, aggregate patient data and infrastructure and material costs. By and large, negotiations follow a two-step approach (Schreyögg and Milstein 2019). In the first step, residential homes have to explain why higher charges have become necessary and appropriate, for example, due to tariff increases, additional personnel and increases in material costs ("plausibility check"). If approved, the residential home cost data is benchmarked against other residential homes of similar size in the same Länder ("external comparison"). Residential homes with costs in the lower third are deemed cost-efficient. Residential homes above that benchmark are further investigated. Negotiations on care charges are limited to six weeks. If the parties fail to reach an agreement, an arbitration board decides. This board is composed of representatives of the LTCI funds (both public and private) and the residential home on equal terms, a non-partisan chair and two non-partisan members. The non-partisan members are appointed by the decision of the two parties and drawn by lot if necessary. If they fail to reach an agreement, the State Ministry of Health makes the decision. It also supervises the arbitration board and defines its rules of operation. Both parties can sue the decision of the arbitration board at the Superior State Social Court.

As negotiations are undertaken regularly and consider current and future cost increases, providers have a high degree of certainty. Because the contract and fee agreements include all costs (with the exception of service charges and additional services over which providers have some freedom), providers are not able to inflate the portion of the costs that are passed onto individual beneficiaries beyond what is stated in the contract. In addition, individual providers are not able to charge differential rates to people receiving the same services. These local negotiations allow flexibility for services to be designed to meet local needs, but also allow for large variations in the prices paid by beneficiaries.

13 To date, it is not clear which data residential homes have to submit. Only few Landers have implemented state-wide regulations on this matter.

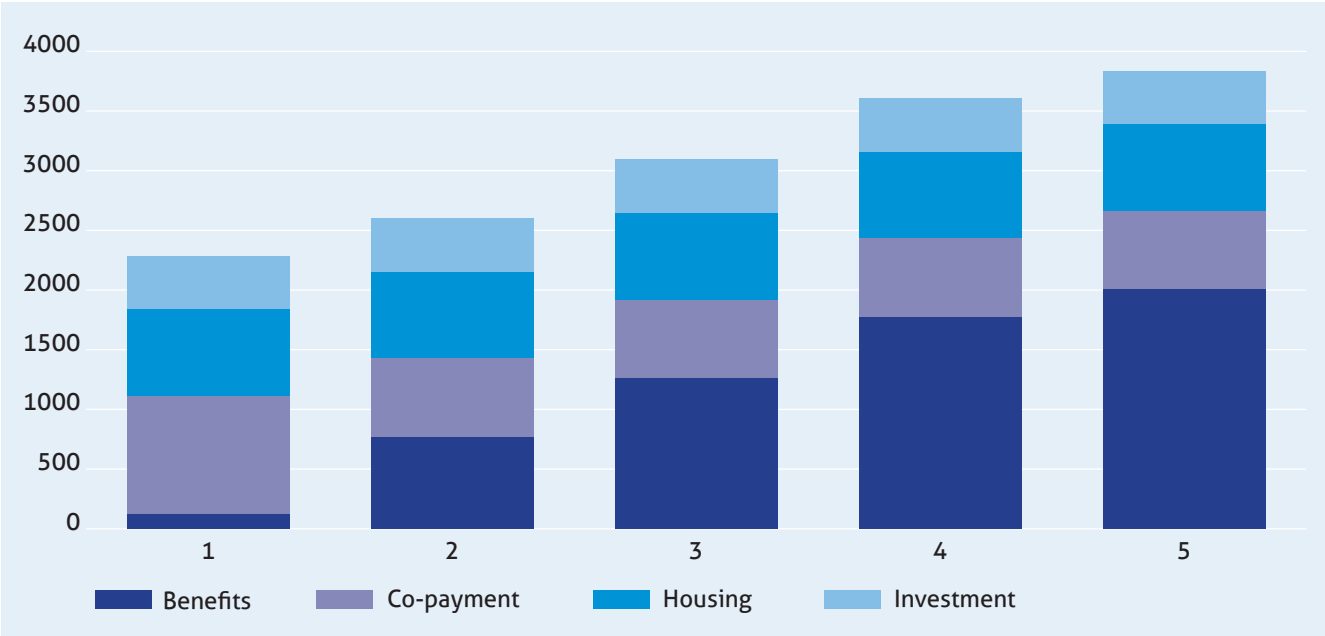
Table 6
Reimbursement per day per person by care degree, residential care, 2019, country average (in EUR).

	Residency (in EUR)		Day-care (in EUR)	
Care degree	Full-time	Short-term	Day	Night
1	40.62	61.12	42.36	31.90
2	51.65	70.46	47.99	36.34
3	67.77	81.81	52.51	40.79
4	84.55	93.23	57.06	45.27
5	92.18	99.36	60.67	49.68
Board and accommodation	24.89	27.43	14.36	23.05

Source: adapted from Statistisches Bundesamt (2020).

The nationally defined benefits schedule, which is paid directly to providers, covers part, but not all, of the negotiated price. People in need of care are invoiced for those parts of the receipt that exceed the defined coverage of the care insurance, the costs for accommodation and meals and a contribution to investment costs[14]. The amount that an individual has to pay depends on the total cost of their care.

Figure 7
Monthly rates in EUR by component by care degree, 2019, residential care.



Note: Data reports monthly rates by enrolees covered by the largest group of LTCI funds (about 28 million/market share of 38.4%). Data from other LTCI funds may differ slightly.
Source: Verband der Ersatzkassen (2019).

14 Germany's 16 Landers are responsible for subsidizing the investment costs of LTC facilities. Details, in particular the nature and extent of financing, are governed by state laws. However, there is no mandatory legal obligation to fund investment costs of the LTC infrastructure by the Landers. While daily operating and care costs are to be paid by the users and residents or the LTC fund, some contributions to investment costs not covered by state subsidies have to be paid by the residents of care homes ("investment surcharge").

Beneficiary co-payments have increased over the past decades

In 2019, total monthly average costs ranged from €2284 for degree 1 to €3835 for degree 5. The co-payment rate per provider amounted to €1830 in care degrees 2 to 5 (Figure 7). LTCI benefits ranged from €770 to €2005 depending on the degree. The co-payment rate differed among the *Länder*, ranging from €1218 per month in Saxony-Anhalt to €2252 in North Rhine-Westphalia with an average co-payment of €1830 in 2019, excluding co-payment for training. Nursing costs ranged from €286 in Thuringia to €906 in Bade-Wuerttemberg, housing costs ranged from €549 in Saxony-Anhalt to €996 in North Rhine-Westphalia and investment costs varied from €286 in Saxony-Anhalt to €541 in Hamburg (Verband der Ersatzkassen 2019). By and large, co-payments are higher in South-West and Western Germany than in the North-East. Differences result, among others, from differences in salaries, state regulations, e.g. on staffing, differences in ownership and size (Haun 2020).

The co-payment rate has increased in past years. From 1999 to 2015, the monthly co-payment increased from €995 to €1523 in level 1, from €1097 to €1739 in level 2 and from €1410 to €1969 in level 3 (Rothgang and Müller 2019). In 2017, following the split into five care degrees and changes in the distribution of co-payments across care degrees, monthly co-payments have amounted to about €2100 for care degree 1 and €1750 for care degree 2 to 5 per month for beneficiaries in residential care (Rothgang and Müller 2019). In 2019, co-payments they increased to €2159 for care degree 1 and €1830 for degree 2 to 5 (Verband der Ersatzkassen 2019).

People who cannot meet the additional costs of care can apply for social assistance. In order to access this safety net, they must undergo a means test, which takes account of their income, savings and assets and those of their close family. While adults are legally obliged to financially contribute to the care costs of their LTC eligible parents, a reform that came into effect in 2020 introduced an income threshold of €100 000 per year. If the gross income of the children is below this value, they do not have to contribute to the nursing home costs of their parents. Furthermore, Germany has tabled a proposal to limit the co-payment for nurse-related provider costs to €700 for up to 36 months (Bundesministerium für Gesundheit 2020). More recent discussions suggest a reduction of co-payments for nursing costs by 25% if the resident's length of stay exceeds 12 months, by 50% if it exceeds 24 months and by 75% if it exceeds 3 years. Additionally, the *Länder* should co-finance investment costs by €100 per full-time resident (Hommel 2021).

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Case study

Japan

Naoki Ikegami
Keio University
Tokyo, Japan

Abstract

Health care and long-term care (LTC) services are an entitlement to all older people in Japan. However, the government's responsibility in health care differs markedly from its responsibility in LTC. In health care, social health insurance (SHI) covers and pays all effective services and pharmaceuticals that are available at the point of delivery. The amount paid by the patient is capped to an affordable level. Extra billing and balance billing are strictly regulated. In contrast, in public LTC insurance (LTCI), benefits are restricted to the amount that is set by the individual's eligibility level. This level is based on a computer algorithm that sorts the applicant's responses to a 74-item questionnaire on his or her functional and cognitive performance. There are no cash benefits. Those eligible choose their care manager who draws the care plan and organizes services that would best meet the client's needs. Although users can purchase more services by paying out-of-pocket, very few actually do so. Following its implementation in 2000, services have greatly expanded. In particular, the development of special "housing" that offers 24X7 hour coverage has blurred the difference between care in the community and in institutions.

In both SHI and LTCI, payment is basically fee-for-service. However, not only the fee (price), but also the volume of each item is controlled by setting strict conditions of billing. The Fee Schedule is revised every two years in SHI and every three years in LTCI. The process starts by the prime minister deciding the global revision rate for SHI and LTCI that is based on the amount to be allocated from the general expenditure budget. Next, the fees and conditions of billing are revised on an item-by-item basis following negotiations with provider organizations. Some fees are increased; others are lowered. The conditions of billing are relaxed in some, leading to increases in volume, and tightened in others, leading to decreases in volume. The national claims databases of the SHI and the LTCI are used to calculate the effect of revising each item. The cumulative effect of these revisions must be respectively made equal to the global budget of the SHI and of the LTCI.

In health care, Japan's payment system offers an alternative to the orthodox form of capitation for primary care and DRG (Diagnosis Related Group) for inpatient care. By setting the global revision rate, despite the fee-for-service payment, expenditures are contained to the level set by the government. By revising the fees on an item-by-item basis, providers are nudged to deliver services in line with policy goals. However, the same method has been less successful in LTC because ageing has had a greater impact on costs and because users are more pro-active in choosing services.

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Introduction

The goals of Universal Health Coverage (UHC) are to make appropriate services available to all irrespective of gender or age and to prevent impoverishment from health care costs (WHO 2018). Services for an "older person" should be developed within this generic context, as it could otherwise lead to stigmatization by age. In Japan, there was a public uproar when the government introduced a consultation fee for discussing end-of-life (EOL) options for elders 75 and over in 2008. The public feared that elders would be pressured to forgo services. This fee was removed from the Fee Schedule only three months after being listed (Ikegami 2017).

However, the context for long-term care (LTC) is different. When the government introduced the public LTC insurance (LTCI; Kaigo Hoken in Japanese) program focused on elders 65 and over, it was welcomed by the public and has since expanded rapidly (Ikegami 2019a). This suggests that social health insurance (SHI) and LTCI have different paradigms and values. LTC has been defined as "a variety of ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability. Service can be provided in an institution, the home, or community, and includes informal services provided by professionals or agencies" (IoM 1986). Once LTC services begin, they usually continue until the person dies, which means that EOL care would be included in the final stage of the continuum.

LTC objectives are to promote the individual's independence and to mitigate the care burden of the family. Unlike the egalitarian standards that are the norm in health services, in LTC, "topping-up" (paying out-of-pocket for more and/or better services) is socially accepted. For example, in Japan, there are no hospitals that provide services exclusively for the rich, but there are nursing homes that do. Because of this normative difference, LTC must be clearly differentiated from health care in the way services are paid and regulated. However, at the same time, the two sectors must also be coordinated as an older person is likely to require services from both sectors (Ikegami and Campbell 2002).

Sections 1 and 2 will respectively describe how health and social services have developed in Japan. Section 3 will describe public LTCI. Sections, 4 and 5 will respectively focus on the structure and revision process of the SHI and LTCI Fee Schedules. In both sectors, the Fee Schedule has been the key to controlling expenditures and allocating resources. Although providers are paid on a fee-for-service basis, the government has respectively set a global budget for the services financed by health insurance and for the services financed by LTCI. Within the global budget, the prices and the conditions of billing are revised on an item-by-item basis, not only to contain costs, but also to incentivize providers to deliver services in line with policy objectives. Section 6 will explain the challenges

facing Japan's health insurance and LTCI. Section 7 will distil "best practices" in price setting and regulations to provide possible lessons for other countries. This report will complement last year's report on price setting and price regulations in health care (Ikegami 2019b). Refer to that previous report for details on the payment of acute hospital care and the pricing of pharmaceuticals.

1
Development of health services

1.1 Historical background

Payment has historically been made for visits made by physicians to the patients' home and for visits made by patients to physicians' clinics. However, in the West, patients usually did not pay for hospital services because most hospitals were established as charity institutions for the poor. Private practice physicians were willing to provide their services without pay because being appointed to a hospital position was considered to be an honor and recognition of their skills by peers (Starr 1982). These non-monetary rewards have continued to be important in setting payment for physicians.

This distinction between payment for physician services and payment for hospital services did not develop in Japan because, historically, there were no welfare institutions. As a result, hospitals were established from the start as medical institutions when the country opened its doors to the West in the latter half of the nineteenth century. Public sector hospitals were built to serve the military, to teach medical students and to quarantine patients with infectious diseases. Later, they expanded to provide high quality services mainly for the elite. The majority of hospitals developed from clinics established by private practitioners. The family, and not the hospital, provided nursing care, bedding (futon) and meals until reforms were carried out by the occupying forces after defeat in World War II.

However, to this day, there is no clear functional differentiation between hospitals and clinics. Nearly all hospitals maintain large outpatient departments and most of their patients come without referral. The patients' "free access" to health facilities has discouraged the development of primary care. Almost all physicians are trained as specialists and have identity as such (Kato and Ikegami 2019). In 2019, only 2% of physicians completing the mandatory two-year post-graduate training chose general practice as their specialty (Nihon Ijishinpousha 2018). However, once they go into private practice or move towards a small hospital, most tend to focus on primary care because they are not able to use hospital facilities or receive the support of hospital staff.

Historically, private-sector hospitals have been dominant. They compose four-fifths of the total number of hospitals, and

two-thirds of all hospital beds. Within the private sector, physician-owned family concerns compose the majority (MHLW 2019a). Investor-owned hospitals have not been allowed to be established since 1948[1]. Public-sector hospitals tend to focus on high-tech acute services in urban areas and basic services in rural areas. Note that in Japan, the "public sector" encompasses not only the hospitals owned by the national and local governments, but also those owned by designated organizations with "public characteristics" such as the Red Cross[2].

Payment to virtually all providers has been controlled by the Fee Schedule. The Fee Schedule sets the same rate and conditions of billing for the same procedure, regardless of whether the facility is in the public sector or the private sector, or where the facility is located. All SHI plans have adopted and used the same Fee Schedule since 1958. By paying providers the same amount for the same service, the Fee Schedule has assured all patients would be treated equally.

Population coverage was later achieved in 1961 by making it mandatory for all permanent residents in Japan to enroll in SHI (Ikegami, Yoo and Hashimoto 2009). However, at that time, there still remained financial barriers to access. Most of the population, including nearly all elders, had to pay a 50% coinsurance rate. This situation changed dramatically in 1973 when health care became "free" (no coinsurance) for all elders 70 and over. This led to huge increases in utilization[3]. The number of hospital inpatients 70 and over increased twenty-fold in twenty years (MHW 1995). Many hospitals became or were newly established as facto nursing homes. This is the main reason why Japan has the highest per capita number of hospital beds in the world (OECD 2019). Hospitals have since expanded to deliver not only acute care and LTC, but also post-acute care. The next section will describe the government's efforts to reform the delivery system.

1.2 Regulating the number and function of hospital beds

"Free" medical care for elders not only increased the number of hospital beds, it also exacerbated geographical disparity. This is why the Ministry of Health and Welfare (MHW; from 2001, the Ministry of Health, Labour, and Welfare, MHLW) introduced regional health planning in 1985. The prefectural governors were ordered to implement health planning, designate planning areas and set caps on the number of hospital beds in each prefecture. However, it is doubtful whether these measures have contained the growth of beds. It may even have been counterproductive because many hospitals rushed to

1 The decree was issued following the enactment of the Medical Care Act. Hospitals that had been established before 1948 by for-profit companies primarily for their employees and families were allowed to continue. Since then, although for-profit companies have not been allowed to open hospitals, they have purchased hospitals from physician owners and control the board. However, the hospital continues to be legally defined as a non-profit organization and is not allowed to issue dividends.

2 These hospitals do not receive subsidies to cover deficits but they are exempted from taxes that are paid by private sector hospitals.

3 A cap on the coinsurance amount for non-elders was also introduced in this year.

increase beds before the caps were enforced. Hospital beds continued to increase until 1995 (MHLW 2019a). Their subsequent decrease probably owes more to revisions of the Fee Schedule.

Despite, or perhaps because of its limited impact, the government legislated "Regional Health Care Vision" (Chiiki Iryou Kousou) in 2015 (MHLW 2015a). The goal is to set the number of "needed" hospital beds for each of the following functional categories: high-level acute, acute, recovery, and chronic care[4]. The cut-of points that divide beds into the four categories have been determined by experts based on the distribution of per diem inpatient costs. Beds that had per diem costs higher than ¥30 000 were categorized as "high-level acute", below ¥30 000 but above ¥6000 as "acute", below ¥6000 but above ¥1750 as "recovery", and below ¥1750 as "chronic" (the amounts exclude basic hospitalization fees). The number of beds in each functional category was then appropriated to the 341 planning areas based on their estimated population in 2025, adjusted for sex and age composition.

Meanwhile, hospital directors were ordered to classify their units into these four categories based on the clinical conditions of the majority of the patients in the unit. When the numbers reported were added and compared with the "needed" bed numbers in each area, there were too many "acute" and "chronic" beds, and too few "recovery" beds. The government believes this discrepancy has occurred because hospital directors have been too focused on delivering "acute" care and not on "recovery" care that is needed by the ageing population. Pressure has been put on hospitals to change the category of their units from "acute" to "recovery" care.

In 2019, the MHLW expanded the scope of the "Health Care Vision" to promoting the merger of public sector hospitals. For this purpose, the names of the 464 public sector hospitals that had low volume and/or significant duplications of services within each planning area were publicized on September 26, 2019 (MHLW 2019b). They were listed if they were in the lower 33.3 percentile of the hospitals in the planning area for delivering procedures such as cardiac by-pass operations and services such as emergency care[5]. The basis for selecting these particular features and the cut-off point has not been explained. Moreover, the planning areas have been idiosyncratically drawn by the prefectures, and their population ranges from 20 000 to nearly 3 million. For example, Gunma Prefecture and Tochigi Prefecture, which are adjacent and located to the north of Tokyo, both have a population of 2 million, but the former has 10 and the latter has 5 planning areas. Thus, the "Health Care Vision" is not likely to have much impact on the way services will be delivered in the future, but it may facilitate the merging of public sector hospitals by providing funds to build new facilities.

4 The "needed" number of beds in each category was adjusted by the projected age and sex composition of the population in 2025.

5 Patients with pneumonia and fractures, which are common conditions for frail elders to be admitted, were not included.

2
Development of social services

The responsibility of providing LTC has been historically placed on the extended family and the local community in Japan. The government first gave in-kind support to the very destitute, which included elders living alone, in 1874. The first institution, the Elder Protection Institute (Yourouin), for destitute elders was established in 1929 under the Protection Act (Hogohou). In 1963, the Elders' Welfare Act (Roujin Fukushi Hou) established a new type of institution called Special Protective Homes for Elders (SPHE, Tokubetsu Yougo Roujin Houmu)[6]. Although all elders who needed care were eligible, priority was given to the indigent and to those without family. The Elders' Welfare Act also introduced residential homes, i.e. Homes for Elders with Low Costs (Keihi Roujin Houmu), which provide housing, meals and basic support (the extent differs by type), and community services in the form of home-helpers (who were named Family Service Providers; Katei Houshiin in Japanese) for low-income elders living alone without family support (Ikegami 2017).

Social services were expanded by the Five Year Plan to Promote Health and Social Services (referred to as the "Gold Plan"), which was launched in December 1989. The motive of the ruling Liberal Democratic Party lay in winning back votes (especially female) after they had lost the upper house election following the introduction of the unpopular consumer tax. Although the program was named to "Promote Health and Social Services", it was overwhelmingly focused on social services. The three major targets of expansion were SPHE, the day services delivered in them, and the development of "Home Care Support Centers" (Zaitaku Kaigo Shien Centers) that provided consultation and displayed care equipment such as wheelchairs. The Gold Plan turned out to be very popular and was extended for another five years to 1999 (referred to as the "New Gold Plan"). From 1990 to 1999, the number of full-time equivalent home-helpers was planned to increase from 38 945 to 170 000, and the number of adult day care centers from 1615 to 17 000. These targets were generally met in 1999 (MHLW 2001).

However, access to services was controlled by the local government's social welfare office, which made the process slow, bureaucratic and arbitrary. Charges were levied based on a sliding scale with priority given to the poor and to those without any family. This made it difficult for those with means to access services. There was also considerable geographical disparity because decisions to expand services were made by the municipal mayors. Finally, expenditures were consuming an increasing share of the government's budget. To address these issues, a new social insurance scheme for LTC appeared to be the solution.

6 They were named "special" because care services were provided and to distinguish them from the Elder Protection Institute (renamed Elder Protection Home). Note that the official translation of SPHE is "nursing homes". This is misleading, because nurses are not required to be on duty 24X7 and may be on duty for only a few days per week.

3
LTCI

3.1 Basic design

Public LTCI was established as the fourth pillar of social security following employment, health and pensions. From the health sector, about half of the designated LTC hospital beds, Health Facilities for Elders (HFE, facilities providing intermediate care), respite care, day care, visiting nurse services and rehabilitation therapy services were transferred[7]. From the social welfare sector, SPHE, respite care, day care, home-helper services, loan of assistive devices (such as wheelchairs) and home renovation (such as installing ramps) were transferred. However, the services from the two sectors were not integrated. For example, the day care facilities that were transferred from SHI had a slightly higher staffing ratio of therapists and had a physician within the facility, but their function was similar to those transferred from social welfare.

LTCI services became an entitlement for all elders 65 and over and for those aged 40 to 64 whose needs had resulted from age-related diseases such as stroke or Alzheimer's. LTCI premiums are paid by all those 40 and over together with SHI premiums. For those employed, employers contribute half. The municipalities (the 1717 cities, towns and villages) are the insurers. The premiums levied from those 40 to 64 are pooled at the national level and redistributed to the municipalities. When doing so, the differences in the income level and the proportion of elders from 65 to 74 and those over 75 among the municipalities are equalized. The benefits are in kind and restricted to the services delivered by certified LTCI providers. There are no cash benefits. The services available are listed in the MHLW's LTCI Fee Schedule.

Figure 1 shows the process for receiving LTCI services. First, the applicant must have his or her eligibility level assessed by the municipal government. The assessor, usually a nurse, uses a 74-item questionnaire concerning the applicant's functional and cognitive performance. A computer-based algorithm then groups the responses into one of seven eligibility levels or as ineligible. The final decision is made by the expert committee established in each municipality. In doing so, it reviews the additional written statements from the assessor and from the applicant's attending physician. All must be recertified once every five years, but they could ask to be recertified earlier if their condition was to decline.

7 There were two reasons why not all LTC hospital beds were transferred to LTCI. The first was that the insurers of LTCI plans, i.e. the municipalities, opposed their transfer because it would increase costs which they would have to finance by increasing their premium rates. The second was that the hospital physician directors preferred to be paid by health insurance and not by LTCI.

Figure 1
Flow chart for receiving LTCI services



Currently, about one sixth of the population 65 and over has been certified as being eligible (MHLW 2019c). Among those who were certified for the first time, only about 2% to 5% have been certified as ineligible (MHLW 2009). About one fifth of those certified are currently not receiving any benefits (MHLW 2019d). They may have wanted to be sure they would be able to receive services without any delay, or they could currently be hospitalized.

There are seven eligibility levels: two "Youshien" (Need Support) light levels and five "Youkaigo" (Need Care) heavier levels[8]. In home and community-based care, benefits range from ¥50 030 to ¥360 650 per month[9]. Those eligible can purchase more services out-of-pocket, but only 1.3% actually do so (Niki 2016). These benefit amounts were determined by experts based on the services that would be appropriate for that level and the fees for these services. The benefit amounts have not been revised, but fee increases have been marginal (see Section 5.2). Those eligible use only about half of the amount to which they are entitled, perhaps because of the coinsurance and/or simply not having the need. The coinsurance rate was initially 10% for all, but has been increased in 2015 to 20%, and again in 2017 to 30% for those

8 The number of eligibility levels was initially six. Most of those in "Youkaigo 1" were transferred to the newly created "Youshien 2" in 2006.

9 Home renovation benefits are not included. This benefit is available once in a lifetime for up to ¥200 000.

with high income. There is a cap on the monthly coinsurance amount that varies according to the income level.

In community care, the services are not directly purchased by those who are eligible but by the care manager agency chosen by the beneficiary. The care manager draws a care plan based on the client's preferences and needs and the services available. If the client agrees to the plan, the care manager contracts providers and coordinates services for her client. In complex cases, the care managers are responsible for organizing care conferences attended by all providers, but in practice, they are seldomly held. Care managers were newly created by LTCI. They have received their certificate by passing a multiple-choice examination and then undergoing a short training course. Initially, most used to be nurses but now most are former care workers.

If the applicant's eligibility level is Eligibility Level 1 or higher, they can opt for institutional care at the facility of their choice[10]. There is no process for triaging admissions to the four types of facilities despite the fact that the per diem rate differs by nearly two-fold between SPHE and LTCI hospital beds. The fee also differs according to the eligibility level of the resident. The per diem rate ranges from ¥208 500 to ¥397 720 per month.

Hotel costs (room charges, utilities and meals) charges were introduced in 2005. The amount is ¥135 000 per month for a private room, but about half this amount for a room with four beds. These hotel costs are reduced up to a third of the amount for residents in the lowest income level for the "official" institutional care facilities of SPHE, HFE, LTCI hospital beds and LTCI medical facilities (Kaigoiryouin)[11]. The balance is paid by LTCI, not by public assistance. The average amount paid by residents is lowest in SPHE because SPHE have the lowest fee and tend to admit those with low income who would have more of their hotel costs covered by LTCI. In theory, providers can set their own charges for hotel costs since they are not listed in the LTCI Fee Schedule.

3.2 Development of LTCI

LTCI was planned to expand as services developed and as the population aged. Cost containment was initially NOT a major issue. The MHW's priorities were first to expand services. Because people now have to pay LTCI premiums and since there was no option of cash benefits as in Germany, services had to be expanded to make them available to all in need (Ikegami 2007). To expand services rapidly, for-profit providers were allowed entry into the market[12].

10 Except in SPHE, where admission is limited to those in Eligibility Level 3 or higher. This was introduced in 2015 to shorten the long waiting list.

11 LTCI hospital beds are being converted to LTCI medical facilities, which were established in 2018. They basically have the same level of staffing, function and payment as those of the former. The number of LTCI hospital beds decreased from 120 700 in 2006 to 36 574 in 2017.

12 However, they were not allowed into the three "official" types of institutional facilities because of the opposition from providers.

Their second priority was to have no one disadvantaged as a result of the transfer of services to LTCI, especially vulnerable elders who had been receiving services from social welfare. This meant that low-income, relatively functionally independent elders living alone who had been receiving home-helper services or who had been admitted to SPHE would continue to receive the same amount of services as before the implementation of LTCI[13].

Table 1
Expansion of LTCI

	2000	2018	2018/2000
65+ Population	22 million	35 million	1.6
No. certified eligible	2.18 million	6.44 million	3.0
No. of service users	1.49 million	4.74 million	3.2*
Average premium (in yen)/month for 65+	2911 yen	5869 yen	2.0
LTCI expenditures (in yen)	3.6 trillion yen	11.1 trillion yen	2.9

Table 2
Increase in LTCI users and the ratio of for-profits

	2000	2016	2016/2000
Home help users	446 679	906 508	2.0
Percent by for-profits	30.3%	64.1%	2.1
Day care users	616 967	1 054 418	1.7
Percent by for-profits	4.5%	44.9%	10.0
Visiting nurse users	203 573	422 400	2.1
Percent by for-profits	6.0%	47.2%	7.9
Institutional care users*	518 227	921 117	1.8*

*For-profits are not permitted in designated institutional care facilities

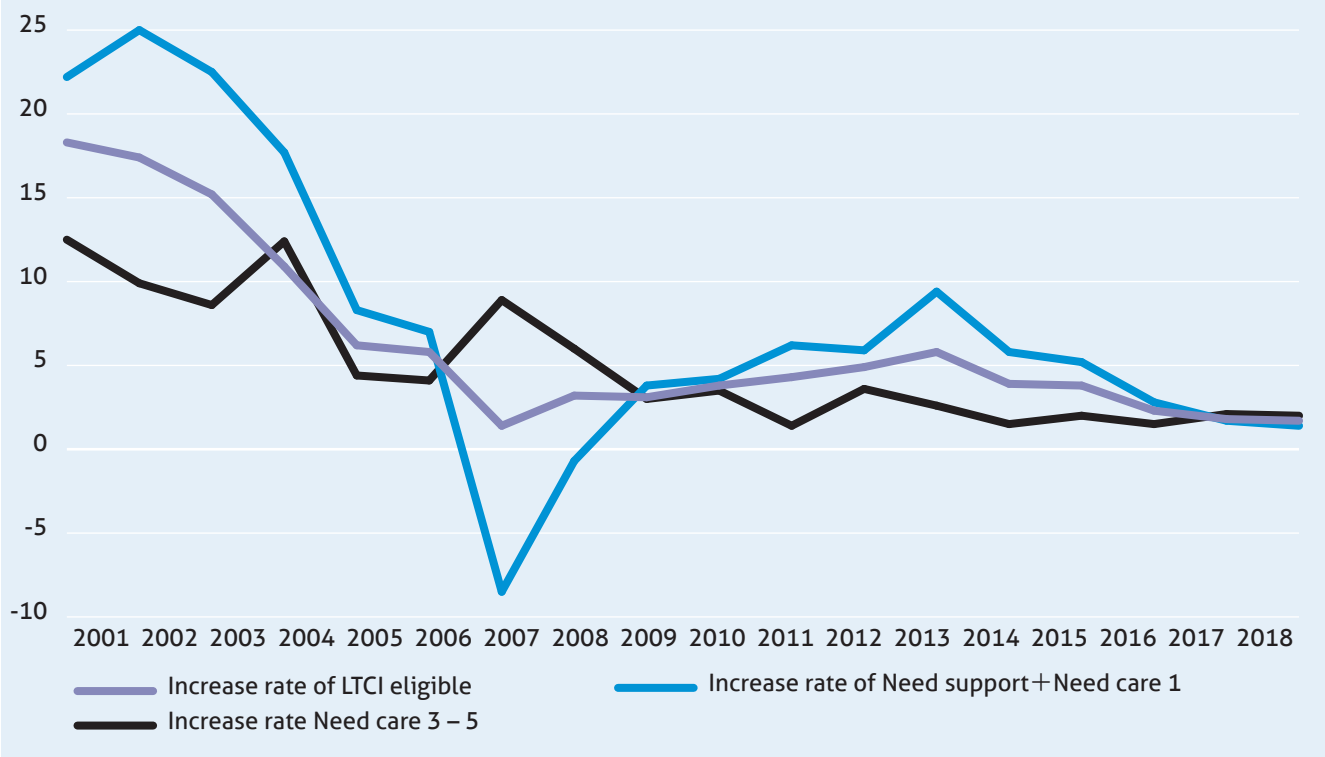
These two priorities led to setting generous benefits for LTCI[14]. When services became available based on their functional level and not on their income or the amount of family support available, LTCI expanded rapidly. The number of services users and costs tripled from 2000 to 2018, which was twice the growth rate of the population 65 and over increased (Table 1).

13 This was one reason why those in Eligibility Level 1 or higher were able to choose between institutional care and community care when LTCI was implemented.

14 The programs for those with physical, intellectual and mental disabilities remained separate. Each had developed independently, but their benefits were harmonized in the Support Independence for those with Disability Act in 2005.

Most of the expansion came from an increased number of for-profit providers (Table 2). Among users, the increase in the lighter levels of "Needs support" and "Need care, Level 1" were initially greater than in the heavier levels of "Need care, Level 3-5" (Fig. 2). The growth rate declined in 2007 following the lowering of the benefits in 2006.

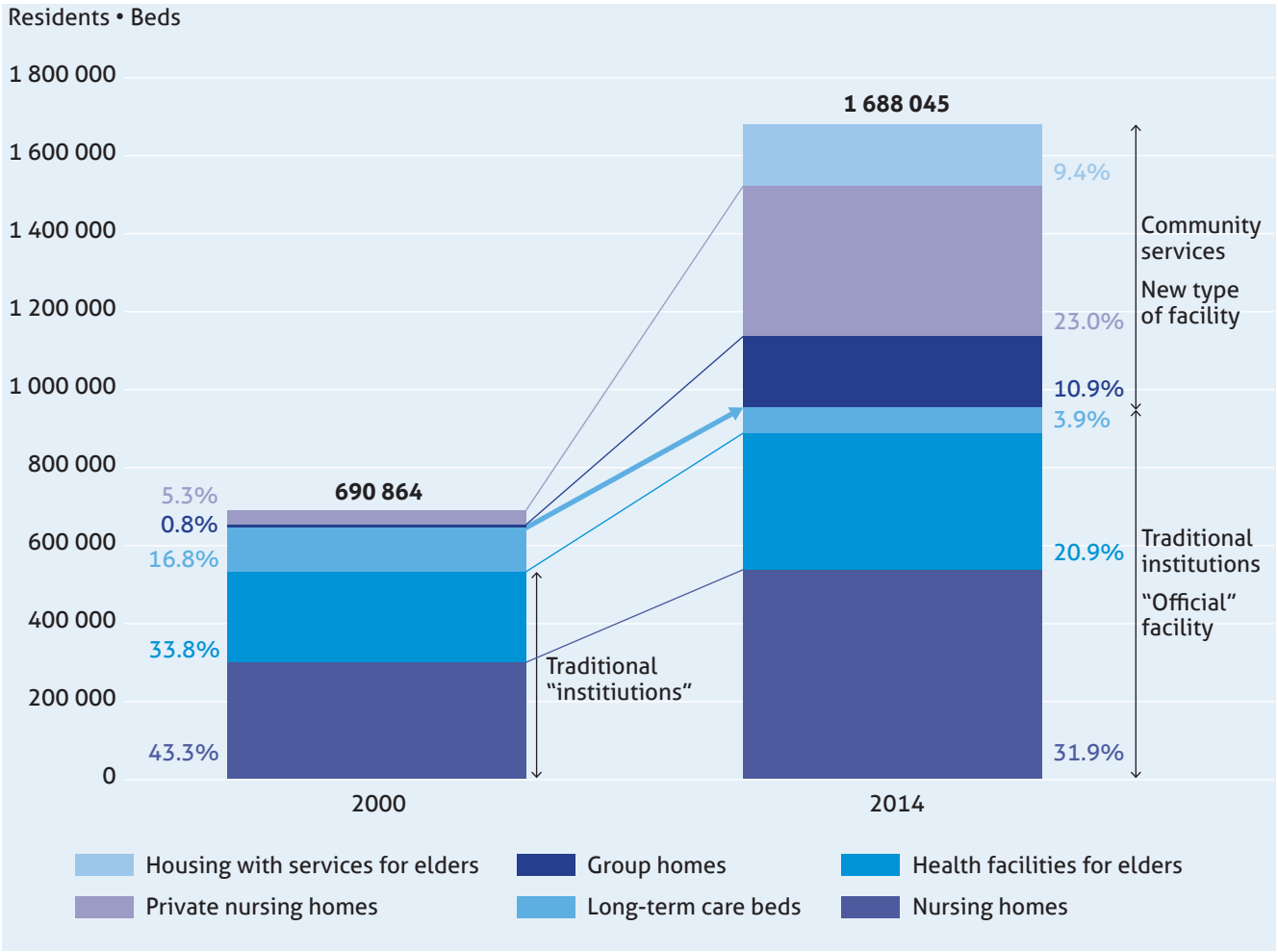
Figure 2
Increase rate among those eligible for LTCI: Total, heavy, light care level



The expansion of home care services has not led to decreasing the demand for institutional care: the waiting list for SPHE numbers 366 000 (MHLW 2017). Many of those waiting could be residing in the quasi-institutional care facilities (their residents are officially included in "community care") that have developed rapidly after LTCI had been implemented (Fig. 3). These facilities were of two types: the Homes for Elders with Charge (Yuryo Rojin Houmu) and the Group Homes for Elders with Dementia (GH). The former increased because most of their care costs became covered after LTCI had been implemented. The latter also grew rapidly after its introduction in 1997, but the increase slowed down after the maximum number of units (nine residents in each unit) became limited to two, and admissions were restricted to those who had been residing in the municipality where the GH was located. This restriction was introduced because the municipalities did not want outsiders moving into a GH within its jurisdiction because it would lead to increases in their LTCI premium rate[15].

15 GH have since been categorized into Services Closely Attached to the Community. The other services in this category include 24X7 scheduled and on demand home care visits by home-helpers and nurses.

Figure 3
Increase in LTCI facility beds



Source: MIAC (2017)

The latest type of quasi-institutional care is the Housing with Services for Elders (Sabisutsuki Koureisha Muke Jutaku), sponsored by the Ministry of Land, Infrastructure, Transport and Tourism, in 2012. The name "Housing with Services" is misleading: the facility's services are limited to consultations and to an emergency alert system. The care services are contracted to "community" providers. However, these providers may be located in the same building so that it would be de facto "institutional care". The floor space per resident must be more than 18m^2 per unit (25m^2 after the common space for dining and so forth has been appropriated), and the floor must be barrier free. Being classified as pure "housing" has meant that providers need not obtain approval from local governments. They have increased to 247 664 units in September 2019 (Satsuki-jutaku, 2019).

The reasons why institutional and quasi-institutional care have increased despite the expansion of community care services are the following. First, 24X7 care, which is especially needed by those with behavioral problems, is not available in community settings. Moreover, in Japan, the family is legally responsible for the elder's behavior should they cohabit. In 2007, a 91-year-old man with dementia walked into a railway

crossing and was hit by a train. This led to the suspension of train services. The Japan Railway Tokai sued the family for the costs of diverting passengers to other railway companies. The Supreme Court dismissed the case on the grounds that the family could not be held responsible: his spouse had been certified as being eligible for LTCI services and his son had been living apart for more than twenty years (Bengoshi Dotcom News 2016). However, this means that if the son had been living together, the family would have had to pay for the damages.

Second, the standards in institutional care facilities have greatly improved after the MHLW issued a directive that required all newly built or renovated facilities to be of "unit care" type. In "unit care", all rooms must be single and be more than 13.2m^2. The number of rooms per unit must be ten or less. Each unit must have its own dining and living room (MHLW 2017).

Third, compared with "community care", the out-of-pocket amounts are likely to be lower in "institutional care" facilities, especially in SPHE which has the lowest care service fees. If the resident is of low income and pays only about half the full amount of the hotel costs, the out-of-pocket amount would definitely be less.

Thus, from the user's perspective, the best option would be SPHE, which is why they have long waiting lists, especially for rooms with four beds that have the lowest hotel costs. The excess demand has been met in quasi-institutional care facilities. Elders and their families have found it difficult to make informed choices because the conditions and the amount they have to pay differs according to the facility. The amount levied would be composed of the following: the coinsurance for the care services, the charges levied for bed and board, and in the new type of facilities, the balance billed for a higher staffing level and sometimes an entrance fee. Moreover, elders and their families must often make decisions at short notice after being told they will be discharged from hospital.

4
Health Insurance Fee Schedule

4.1 Basic structure

The Fee Schedule set by the MHLW is enforced on all SHI plans and virtually all providers. Physician services and hospital services are not differentiated and are listed in one manual. There are also manuals for grouping patients into DPC (Diagnosis Procedure Combination) groups in acute inpatient care, and for pharmaceutical and device prices. Payment is made to the facility and not to individual physicians. In hospital settings, physicians are employed and usually paid fixed salaries that reflect their seniority, not their clinical specialty or the revenue they generate. In clinics, most are solo-practices so that the earning would effectively be the physician's income less expenses.

The Fee Schedule manual is over 1500 pages in fine print. There are more than 4000 items listed together with their conditions of billing. For example, an initial consultation (which is four times the repeat consultation fee) may only be billed if the patient had either not made a visit within the last 29 days or has not been told by the physician when to make the next visit. To bill rehabilitation therapy for a patient who has had a stroke, the facility must employ three or more full-time therapists and the patient must have had the stroke within the last 180 days. Compliance to these conditions is inspected when claims are reviewed, and when the regional offices of the MHLW make on-site visits. If the latter finds that claims have been purposely falsified, then both the physician and hospital could be delisted from a SHI contracted service provider, which would de facto mean not being able to operate in Japan.

The fee is the same for the same item throughout Japan. Paying the same amount has contributed to a more equitable distribution of physicians and nurses. Although big city hospitals have higher operating costs and must pay their nurses higher wages to cover the higher cost of living, the wages of their physicians are lower because they are able to offer more non-monetary rewards in the form of peer prestige, access to high-tech equipment and support of trained staff. In the public hospitals established by big cities (over 700 000 inhabitants), annual wages were ¥13.6 million for physicians and ¥5.1 million for nurses. In the public hospitals established by towns and villages (less than 30 000 inhabitants), they were 30% higher at ¥17.9 million for physicians and 10% lower at ¥4.6 million for nurses (MIAC 2017). Although there are no data for private sector hospitals, these differences are likely to be greater because their wages tend to be less seniority based.

The restrictions on balance billing and extra billing were specifically stipulated in 1984. The payment from delivering services based on the fees set in the Fee Schedule composes

more than 95% of the providers' revenue. Balance billing (charging more) is mostly restricted to beds with more amenity that compose about one fifth of all hospital beds; extra billing (charging for items not included in the benefits package) to new technology being tested for its efficacy and safety (Ikegami 2006). Direct subsidies from the government to public hospitals compose about 2% of total medical expenditures (Koushi Byoren News 2019). Thus, the Fee Schedule effectively controls the flow of money in the Japanese health care system.

4.2 Revision process

The Fee Schedule is revised every two years. The revision is divided into the following processes. The first is deciding the global revision rate, which is the cumulative volume-weighted revision rate of all services and pharmaceuticals listed in the Fee Schedule. In setting the rate, increases in costs from population ageing (per capita costs increase as the age group becomes older) and increases due to shifts to higher-priced items resulting from advances in technology (such as from CT scan to MRI) are projected from the past three years' trends. Since these two factors have increased health expenditures by 2.4% per year in the past ten years (Asahi Shinbun 2019), if health expenditures are to remain budget neutral for the next two years, the global rate must be set at −5%.

The second step is setting the revision rate of pharmaceutical and device prices. For established products, prices are reduced based on the results of the market survey conducted by the MHLW. Market prices are almost always found to be lower than their Fee Schedule price because providers are able to negotiate discounts from wholesalers. The extent of these discounts is surveyed by the MHLW's Survey of Pharmaceutical Prices. The price of each product will then be revised so that it would be 2% higher than its volume-weighted average market price. For newly launched products, the price is reduced if its sales volume is more than the amount predicted by the manufacturer. The rationale for lowering the price lies in the fact that the manufacturer would then be able to recover R&D costs from the increase in sales.

The third step is setting the overall revision rate of medical service fees. A survey of the providers' revenue and expenditure is conducted by the MHLW in the year before the revision. If their profits have increased or are stable, there would be pressure to decrease the rate. On the other hand, if their profits have decreased or they have deficits, there would be pressure to increase the rate. However, the results are seldom clear cut, because margins differ by the type of provider. Large public hospitals tend to operate at a deficit, and small private hospitals at a small profit. The revenue of the clinic, which is de facto the income of the physician, tends to be stable. Thus, the revision rate is basically a political decision made by the prime minister who must balance the need to contain costs with the need to maintain services and to retain the political support of the providers. This decision can only be

made by the prime minister, because it has a major impact on the general expenditure budgeted amount allocated to health care composing one tenth of the total. This one-tenth, in turn, composes one quarter of total health expenditures. These proportions have been stable.

Figure 4
Annual increase rate of national medical expenditures, medical service expenditures, and fee schedule revision rates (in %)

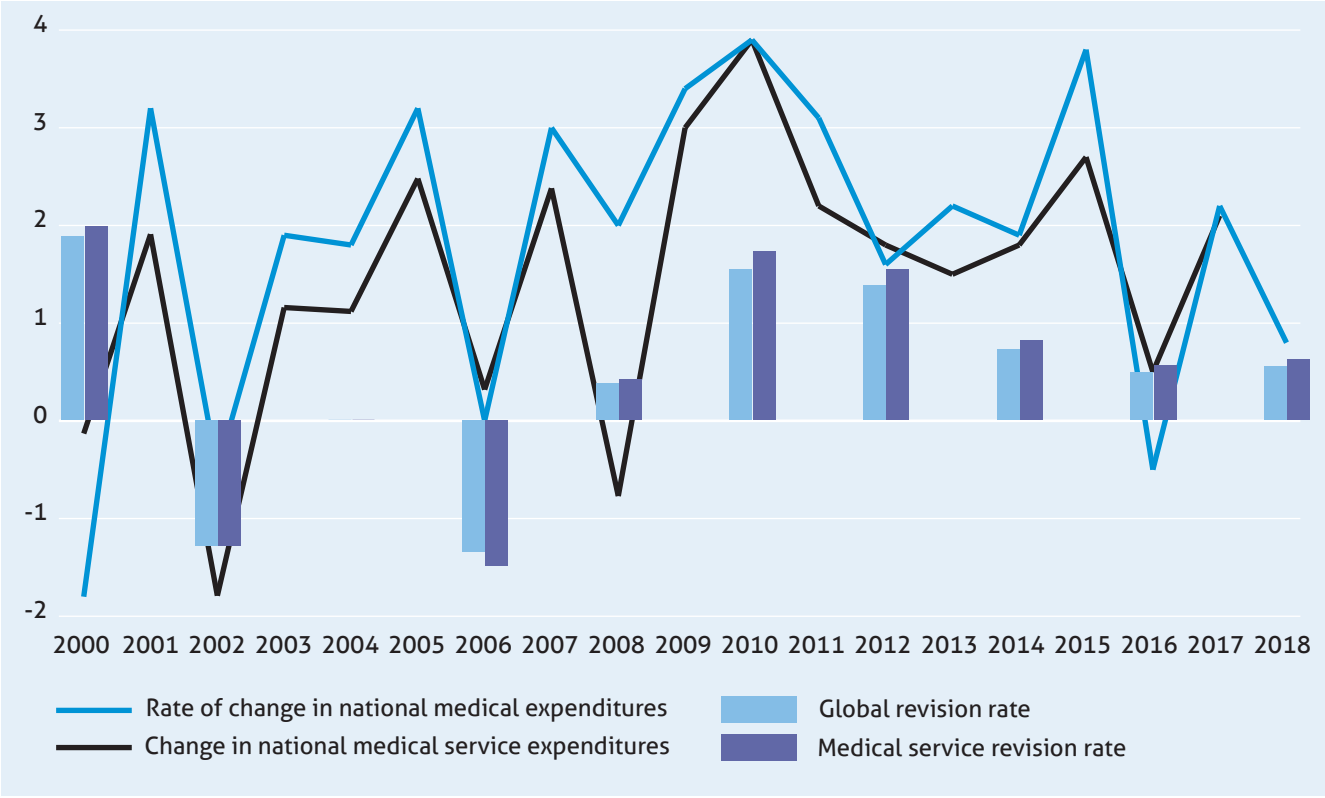


Figure 4 shows how the global revision rate and the medical services revision rate have impacted national medical expenditures and medical service expenditures (MHLW 2019e)[16]. In general, revision rates are reflected in changes in expenditures. However, the estimates for the next year's government's expenditures are not necessarily 100% accurate. For example, in the 2016 revision, the global revision rate was set at −1.45%, which would have increased expenditures by 0.55% in 2017 if expenditures had increased by 2.0% as they had in the past three years. However, the actual increase from increases in volume and shifts to higher priced items was only 0.95% (MHLW 2018), which led to national medical expenditures decreasing by 0.5%.

Finally, the fees and conditions of billing are revised on an item-by-item basis. In some items, the fees are increased, while in others they are decreased. The conditions of billing are tightened in some, which would decrease volume, and relaxed in others, which would increase volume. The impact of revising

16 The MHLW's national medical expenditures (NME; Kokumin Iryouhi in Japanese) are composed of medical service expenditures (Ika Iryouhi), pharmacy dispensing expenditures and dental expenditures. Medical service expenditures compose about 80% of the total. The method for calculating the expenditures was revised in 2008, which was why the expenditures appeared to decline despite the increase in the global revision rate.

each item on medical service expenditures is calculated from the National Claims Database, which lists the volume of every item in the Fee Schedule. The cumulative effect of these revisions must be made equal to the amount set by the global budget.

The item revisions are deliberated in the MHLW's Central Council on SHI, which is composed of representatives from payers, providers and public interest. Based on its decisions, the minister of the MHLW formally revises the Fee Schedule. However, because the details are very complicated, the actual negotiations are made by the MHLW officials in charge and provider organizations. Among the latter, the JMA (Japan Medical Association) has played a dominant role because it is well organized and has been a major contributor to the Liberal Democratic Party. This party has been in almost continuous power for the past 65 years. Moreover, the JMA's interests are generally in line with the MHLW because its main constituents, the private practitioners delivering primary care, are in a better position to meet the needs of Japan's ageing society than hospital specialists. As a result, private practitioners generally have higher incomes compared with specialists in tertiary hospitals, who tend to have fixed salaries based on their seniority. Monetary rewards and professional rewards tend to balance each other in Japan.

4.3 Outpatient care and home care

This sector has been of paramount importance to the JMA, because it directly impacts the income of private practitioners. The overriding goals of the JMA have been to maintain "free (uncontrolled) access" of patients to all providers and for providers to be paid "fee-for-service". It has opposed gate-keeping and capitation payment, because these would violate the principle of physicians being compensated for all medically necessary services they deliver and the principle of being able to open practice should they wish to do so. Only a fee-for-service would allow physicians to earn income on the day they opened practice. Because of their opposition, the basic form of payment has remained fee-for-service. However, fees have been contained, and the conditions of billing have restricted increases in volume. The below shows some examples.

- Fees to promote home care were first introduced to provide guidance for diabetic patients to self-inject insulin in the 1981 Fee Schedule revision. These instructions fees have been expanded to oxygen therapy, total parental therapy, elimination (from artificial bladder or anus), injections (opioids) and peritoneal dialysis.
- A "comprehensive consultation fee for bed-bound elders at home" was listed in the 1998 Fee Schedule revision for physicians to make scheduled and on demand visits. As of 2018, the physician must visit the patient two or more times for a monthly fee of ¥8330. Should the patient die at home, the physician would receive an additional fee of ¥55 000.

- A fee to provide comprehensive primary care services was listed in the 2014 Fee Schedule revision. To bill the fee, the physician must monitor all pharmaceuticals prescribed (including those prescribed by other physicians), and the patients must have two or more of the following conditions: hypertension, diabetes, hyperlipidemia and dementia. The fee is ¥250 (¥350 if dementia is included) per month. If billed as a bundled fee including pharmaceuticals and laboratory tests, it would be ¥15 600 (¥15 800 if dementia is included). If the facility meets these conditions, it will be able to bill an additional ¥800 to the first consultation fee.

The conditions of billing have become more complicated. For example, to bill the scheduled home visit fee, the clinic now must have had three or more patients who have transferred from outpatient care to home care in the past year and have two or more full time equivalent physicians (among which one must be full time). To reflect the shorter travel time for the physician if the patients were to live in congregated housing for frail elders, the visit fee is reduced by 80% if more than 80% of the patients visited by the physician on the same day reside in the same building. To bill the bonus payment for providing EOL care to a patient dying at home, the physician must have visited the patient two or more times within the past 14 days. There is an additional bonus fee of ¥10 000 if the visit is made from a designated "palliative care facility".

Physicians who make scheduled visits must arrange for and give instructions to visiting nurses. The fee for visiting nurse services was first listed in the 1992 Fee Schedule for Elders for bedridden elders 65 and over. The objective was to provide support and advice to the patient and family[17]. The visits became available to non-elders in the 1994 Fee Schedule revision, but they continue to be focused on chronic patients and not on post-acute patients discharged from acute hospitals. Seventy one percent of visiting nurses' patients are financed for by LTCI and not by SHI (Japan Visiting Nurse Foundation 2018). SHI financed services are for patients with cancer and other designated diseases such as Parkinson's.

4.4 Inpatient care

Two policy goals have been consistently pursued. The first is to improve the level of basic inpatient services. As noted, before the post-World War II reforms, the family had provided care. Bonus fees were first introduced in 1951 for hospitals that met basic standards in nursing, bedding and meals. Since then, conditions have become increasingly complex. For example, in order to bill higher rates, registered nurses must compose more than 70% of the total, and the night shifts must compose less than 72 hours per month. These conditions have been promoted by the Japan Nursing Association. The second policy goal has been to shorten lengths of hospital stays and

17 There was another Fee Schedule for all elders 70 and over (and elders 65~69 with disabilities) from 1984 to 2009, which differed in minor details. https://www.mhlw.go.jp/file/06-Seisakujouhou-12200000-Shakaiengokyokushougaihokenfukushibu/0000123638.pdf

functionally differentiate hospital beds into acute care and LTC. In order to bill the higher hospitalization fees, the hospital must not only have higher staffing levels, but the average length of stay must be 18 days or less.

The conditions of billing for LTC have become increasingly complex. As noted, the demand for inpatient care increased dramatically after "free" (no coinsurance) inpatient care was introduced in 1973. The fee-for-service payment led to over-medication and the excessive ordering of diagnostic tests. There were also not enough nurses. Care was mainly delivered by private attendants who were hired 24x7 by the patients. Their presence exacerbated the over-crowding in the units: most hospitals had only the minimum floor space per patient that was set at 4.3m^2 (this level was set in 1948, reflecting housing conditions at that time).

In response, a new type of facility, the HFE, was established in 1986. The ostensive purpose was to deliver intermediate, step-down care after the patient had been discharged from the hospital. Admissions were initially restricted to those who were expected to be discharged home within three months. However, this restriction came to be flexibly interpreted. Payment was a flat per diem amount inclusive of medications and diagnostic tests. The staffing level was set relatively high, and the hiring of private attendants was prohibited. The floor space per bed had to be 8m^2 or more, which made it difficult for hospitals to convert to HFE, even though this had been the intention of the government.

This was why the government decided to introduce a new form of inclusive payment for hospital LTC units from 1990 (Nishiyama 2019). The payment was inclusive of all services and similar to that of the HFE, but without the physical facility requirements. This form of payment was widely adopted by hospital LTC units. Parenthetically, physical facilities have since been improved by introducing a bonus payment in 1992 if the unit met the standards for "convalescent" (ryoyougata) beds. These units must have a floor space of more than 6.4m^2 per bed, a dining room attached to the unit and so forth. Most hospitals delivering LTC eventually converted to this type of unit by 2003.

However, the flat per diem payment quickly led to a new problem: hospitals were given a perverse incentive not to admit patients with high medical needs. To rectify this situation, case-mix-based payment was introduced in 2006 that was based on the patient's medical acuity and the activities in daily living (ADL) level (Ikegami 2009). The fees for patients with the lowest medical acuity level were set below costs. The MHLW thought that this would force hospitals to discharge patients and close some of their chronic care units. However, a survey made one year after the introduction revealed that hospitals appeared to have up-coded their patients to higher medical acuity levels. Problems in the quality of care and data were also revealed: in one hospital, over 80% of patients had been

checked for urinary infection that would have grouped patients into a high medical acuity level.

Some of these issues have been resolved by on-site audits of patient records. The conditions of billing have also been made more complex. In the 2012 Fee Schedule revision, to bill higher fees, the hospital must have a higher nurse staffing level and more than 80% of the patients in Medical Acuity level 2 or higher. The pressure on hospitals not meeting these conditions to convert to LTCI facilities has increased.

There have also been reforms in post-acute care with the Kaifukuki (recovery) Rehabilitation Units, which were first designated in 2000. The conditions of billing were as follows: the number of therapists per patient must be more than the prescribed level; the patients receiving therapy must have had a stroke within the past 180 days or an injury within the past 90 days. Pay for performance (P4P) was introduced in 2012 using FIM (Functional Independence Measure) scores. Targets for measuring improvements have since been refined.

Next was acute care. Inclusive per diem rates were introduced by the DPC for the 82 Special Function Hospitals (university main hospitals and two national centers) in 2003. A per diem rate was set for each DPC group that differed according to the four hospitalization periods. Following its introduction, many hospitals opted to be paid by DPC rather than fee-for-service because it gave them more status (to be recognized as an acute facility), and because it also generally enabled them to earn more revenue. Hospitals paid by DPC transferred services such as MRI to before and/or after admission (from which they can be billed fee-for-service). Moreover, each hospital was given a specific conversion factor that compensated for the difference in the amount paid by DPC and the amount paid by fee-for-service. This factor began to be phased out from 2012 and was completely eliminated in 2018. About 80% of acute care units are now paid by DPC.

Lastly, Akyuseiki (sub-acute) beds were introduced in the 2004 Fee Schedule revision. The policy goal was to reduce the number of patients in acute care DPC units by transferring them to these units and by directly admitting patients from the community requiring less care to these units. However, the latter function has not developed because the hospitals feared there would be a deficit if the patient needed more resources than the amount paid per diem. The sub-acute units have been renamed "Chiki Houkatsu Kea" (Comprehensive Community Care) beds in 2016, having basically the same functions. In the 2018 Fee Schedule revision, bonus fees were introduced if 10% or more of their patients had been directly admitted from the community and had not been transferred from acute units.

The MHLW has made these revisions to functionally differentiate hospital units so that patients would be transferred from acute to more cost-effective units. However, hospitals have lobbied for more flexibility on the conditions of billing on the grounds that each patient is unique and

physicians must have professional autonomy. The heated negotiations have made the Fee Schedule increasingly more complex.

5
LTCI Fee Schedule

5.1 Basic structure

The Fee Schedule of LTCI has basically the same structure as that of health insurance. The fees and the conditions of billing are precisely defined. When first set, the services covered by SHI such as most visiting nurse services, LTC hospital units and HFE were transferred at the same amount and with the same conditions of billing. For the services transferred from social welfare, the fees were newly set based on their unit costs in the social service budget.

The LTCI Fee Schedule differs from the SHI Fee Schedule in the following aspects. First, unlike health care, providers are, in principle, allowed to extra bill and balance bill. However, in community care, they seldom do so. Only 1.3% of users have purchased services beyond the amount set by their eligibility level (Niki 2016). The proportion of those who pay more for services of better quality probably compose even less. In contrast, in institutional care, "hotel" costs are in principle not covered, and most quasi-institutional care facilities balance-bill for amenities.

Second, the conversion factor of units to yen differs according to the geographical area. Metropolitan Tokyo is highest: up to 11.4% (the extent differs according to the type of service) than the national base rate, reflecting the higher cost of living and wage levels. Note that, unlike health care, the higher wages of nursed and staff in big cities cannot be compensated by the lower wages of physicians in LTC. Thus, fees must reflect the local labor market.

Third, users are more cost conscious in LTCI services, because they are much more tangible and easier to evaluate than in health care. For example, the fee for a home-helper visit is higher in agencies that have a higher proportion of experienced home-helpers (to provide incentives for agencies to hire them so as to improve quality), but users may prefer an agency that has a lower proportion, because they would pay less as coinsurance. Thus, the bonus incentives on providers are likely to be less effective than in health insurance.

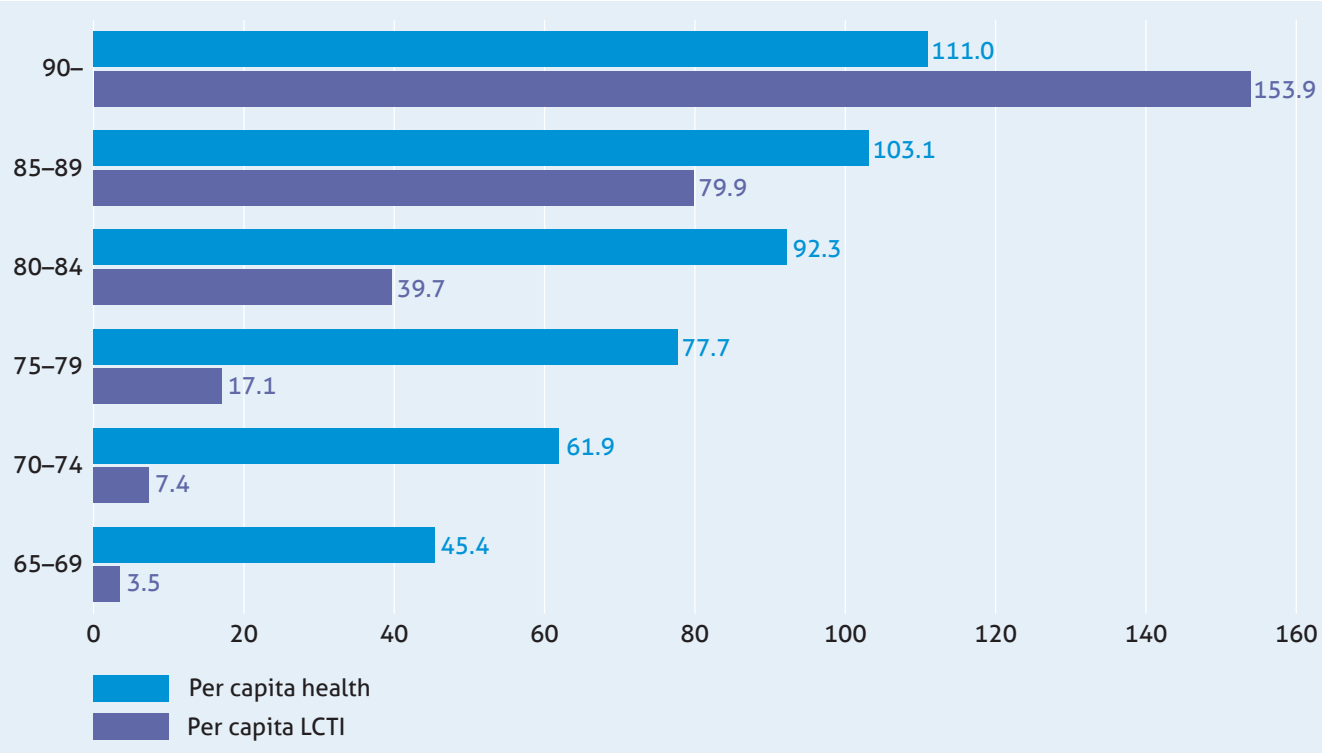
The LTCI Fee Schedule has become increasingly complex. When first implemented in 2000, it had only about one hundred pages. The current 2018 version has 1000 pages in fine print. For example, in home and community services, day care fees differ according to the number of hours spent at the facility, the type of facility and the number of users coming to the facility (bigger facilities are paid less because they have lower costs).

The user's care managers should offer them the best option, but they may steer users to purchase services from their affiliated providers. In institutional care, as noted, it is difficult to evaluate the cost and benefits among the various types of facilities that are available.

5.2 Revisions: process and impact

The revision process is similar to that of SHI except that the LTCI Fee Schedule is revised every three years, and not two years as in SHI. As in SHI, the prime minister first sets the global budget by deciding the global revision rate. Future expenditures are estimated based on the average increase rate in the past three years and the increases that would arise from population ageing. In making his decision, the financial condition of the providers is surveyed. If profit margins have declined, then it is likely to lead to a positive revision. In 2003, 2006 and 2015, the global revision rate was negative, but expenditures declined only in 2006, which was due more to the decision made in October 2005 to basically stop covering hotel costs. In 2003, expenditures increased because services were rapidly expanding as new providers entered LTC. In 2015, the negative revision was compensated by subsidies from general revenues to providers so that they could pay higher wages to the care staff in order to mitigate their shortage.

Figure 5
Per capita expenditure by age groups: Health Insurance and LTC Insurance (in ten thousand yen)



Source: Per capita health and LTCI expenditures by age groups. (jeiu.or.jp, 2017)

LTCI expenditures have increased at a faster pace than SHI because the ageing of the population has had a greater effect. Figure 5 shows that per capita expenditures are higher for the older age groups in LTCI: whereas SHI expenditures for those 90 and over are only 2.4 times that of those between 65 and 69, in LTCI, expenditures are 44 times more (Cabinet Office 2016; MHLW 2016; Statistics Office 2016). Parenthetically, although there are no increases due to advances in technology in LTCI, there are also no savings from the reduction of pharmaceutical prices.

Next, the global budget is allocated to service items. As in health care, fees are individually increased or decreased, and/or their conditions of billing tightened or relaxed. The impact of making these revisions is calculated from the national LTCI claims database. The revisions are deliberated in the MHLW's Committee on LTCI Fee Schedule, which has members from providers, payers and independent academics. As in health insurance, the details are negotiated between the MHLW officials in charge and the provider organizations. The LTCI Fee Schedule has rapidly become as complex as that of health insurance, mainly because both the MHLW and the provider organizations have the same mentality. They have also become complex because revisions are a convenient way of dealing with questions raised in the Diet by showing that the MHLW has responded by taking due actions.

To illustrate the complexity of the LTCI Fee Schedule, the following example describes how bonus fees were set in 2006 to promote EOL care in SPHE facilities (Ikegami and Ikezaki 2012). The fee was ¥800 from 4 to 30 days before the date of death (2018 fee revised to ¥1220), ¥6800 for 1-3 days before the date of death, and ¥12 800 at the date of death on top of the daily rate of about ¥8000 (standard rate). The conditions for billing this fee were, first, SPHE must meet the standards of a designated EOL care facility: employing a full-time registered nurse, having a 24 hour on-call service for nurses employed either by the nursing home or contracted to hospitals or visiting nurse agencies, having a policy on EOL care that is explained to the resident and the family on admission, holding seminars on EOL care for the staff, and having a private room available for EOL care. Following its introduction in 2006, two-thirds of SPHE have met these conditions (MHLW 2009).

Second, the resident must be in an unrecoverable condition and have an EOL care plan that is drawn after discussion among the nursing home staff, physician and, whenever possible, the resident and family. This bonus can be retrospectively billed for the 30 days prior to death if the resident was physically in the SPHE (death could have occurred at a hospital). Additional bonuses to augment the EOL care bonus were introduced in 2009: a bonus for having a nurse always on duty during night shifts and a bonus for having more care staff than the prescribed minimum level (MHLW 2009). These bonuses are billed across-the-board for all residents if the facility meets the standards. This focus on the structural aspects of quality,

especially on the staffing level of nurses, has long been the government's policy for assuring quality in Japan (Ikegami, Ishibashi and Amano 2014).

These bonuses appear to have had the desired effect. The number dying in SPHE doubled from 16 788 in 1999 to 36 814 in 2009. This is more than the 50% increase in the number of SPHE beds from 291 631 to 432 284. When the annual number of deaths in nursing homes is divided by the number of nursing home beds, the annual rate of increase was 0.2% between 1999 and 2005, and 0.7% after the introduction of the EOL care bonus in 2006. The latest data show that the number of deaths in SPHE has doubled to 100 523 in 2017[18]. A similar bonus payment to provide EOL care has been introduced to other LTCI facilities.

Other bonus incentives have been introduced to encourage and pay for the additional costs of having more staff on night duty, more therapists, and more staff trained to care for residents with dementia, to deliver enhanced dietary management, to promote oral feeding, to improve dietary patterns, to treat pressure ulcers and to support improvement in elimination and transitions into home care. It is difficult to evaluate their impact, because government data are limited to claims and eligibility levels.

6 Challenges in SHI and LTCI

The greatest challenge is fiscal sustainability. Health and LTC expenditures compose 10.9% of the GDP, the sixth highest among OECD countries (OECD 2019)[19]. The number of elders 65 and over has been increasing while the working age population has been decreasing. In SHI, increases in expenditures are due to advances in technology and ageing of the population. The impact of the former has been balanced by reducing the Fee Schedule price of pharmaceuticals and devices. In LTCI, expenditures have increased 1.5 times faster than SHI, because the ageing of the population has had a greater impact. These trends will not change. Containing public expenditures by increasing the proportion paid by elders would not be a practical solution, because their income is usually low and limited to public pensions.

The fiscal problems have been aggravated by the way SHI and LTCI are structured. In SHI, there are over 3000 SHI plans. About half are employment-based and enroll those who are currently employed and their dependents. The remaining half are community-based and enroll the self-employed, the irregularly employed and elders retired from the workforce. From the start, the latter had difficulties in financing the health care costs of

18 The Vital Statistics do not differentiate deaths in SPHE from those in Homes for Elders with Charge, but they exclude deaths in HFE.

19 OECD's Total Health Expenditures (THE) include both health and LTC. Japan's THE percentage to GDP jumped from 9.2% to 10.6% in 2011, when LTC expenditures came to be fully included in the THE.

the enrolled. Population coverage in 1961 was achieved by the government increasing subsidies to community-based plans. However, these subsidies were not enough to cover the costs of elders when "free" medical care was implemented in 1973. To mitigate the burden on the government, employment-based plans were ordered to contribute towards the costs of elders from 1983. Since then, their contributions have steadily increased so that they now amount to nearly half their premium revenue. Employment-based plans have protested that contributions of this magnitude are unfair and argued that funding should be increased from taxes. However, the government is unwilling/unable to do so, because the national debt has increased and now composes twice the GDP. Financing health care for elders has become the source of intergenerational conflict.

In LTCI, since all insurers are the municipalities, the cross-subsidization across plans is not a problem. However, it is difficult to increase premiums of those 65 and over who live in the municipality. One solution would be to expand coverage to all ages and levy premiums from all ages. However, expenditures for those between the ages of 40 to 64 currently compose only 3% of LTCI expenditures. This percentage is not likely to increase significantly even if the current rules that restrict benefits to those caused by age-related diseases were to be removed. Moreover, those 64 and younger who are currently receiving benefits from disability programs would oppose the transfer to LTCI, because the level would be less generous.

As the above illustrates, there are no easy solutions. Currently, the government has focused on the non-controversial policy of promoting prevention. In health insurance, penalties are imposed on health insurance plans in the form of contributing more towards the health care costs of elders if the percentage of their enrollees who undergo annual check-ups is below 45% (MHLW 2012). In LTCI, from 2020, bonuses will be given to municipalities (insurers) that show improvement in the eligibility levels of their beneficiaries (Cabinet Office 2019). However, the effect of these preventive measures is likely to be at best marginal.

7
Lessons for other countries

The first lesson is that, in SHI, providers must strictly adhere to the fees and conditions of billing set by the government. In Japan, it took more than twenty years after population coverage had been achieved to impose explicit restrictions on balance billing and extra billing. These rules are pre-conditions for the Fee Schedule to function effectively because unless they are strictly adhered, patients would continue to be at risk of being impoverished from health care costs. As a quid pro quo, the government must guarantee that all services and pharmaceuticals that have been demonstrated to be effective and safe are covered by SHI.

The second lesson is that fee-for-service payment does not necessary escalate costs. Costs can be contained by setting a global budget and by regulating fees and setting conditions of billing. In Japan, the prime minister decides the Fee Schedule's global revision rate after evaluating the fiscal space and political situation. In making his decision, the extent to which increases in costs from population ageing and advances in technology would be mitigated by reducing pharmaceutical and device prices are estimated. Next, within the global budget, the fees and the conditions of billing are revised on an item-by-item basis. The impact of revising the fee and the conditions of billing each item on the global budget is calculated from the claims database.

The third lesson is that fees can be set and revised so that providers would be nudged to deliver services that are in line with policy goals. In Japan, physicians have clinical autonomy, but they will be paid only if they adhere to the fees and the conditions of billing in the Fee Schedule. The revisions have made physicians more focused on monitoring and advising patients who have lifestyle diseases such as diabetes and on providing home care, including EOL, to frail elders. Hospitals have developed services to provide post-acute rehabilitation care and sub-acute care for frail elders. The coordination of services between clinics and hospitals has been promoted by establishing fees for providing information to the hospital referred and from the referred hospital back to the clinic. However, in LTC, incentives have worked less well because services are chosen basically by the user and not by the physician. This basic fact has not been fully recognized in Japan. Some of the incentives introduced have led to only making the LTCI Fee Schedule excessively complex.

In SHI, Japan's regulated fee-for-service payment offers an alternate method to the dichotomized model of DRG for acute inpatient care and capitation for primary care. This classic model might be appropriate if patients were to be discharged as "cured" and not requiring further treatment. However, it is not appropriate for frail elders who will compose an increasingly larger share of patients and who need seamless

care from acute to post-acute and from post-acute care to LTC. In Japan, their needs have been mainly met by small to medium sized private sector hospitals that deliver both SHI and LTCI services. These hospitals have quickly responded to the revisions made in the Fee Schedules to pursue policy goals.

The last lesson is that public LTCI should be established separately from health insurance because their basic principles fundamentally differ. In health insurance, all effective services must be made available, with strict restrictions on balance billing and extra billing. In contrast, in LTCI, the government is only responsible for providing services up to the amount set by the eligibility level. The dividing line between institutional care and community care also differs between the two sectors. In health insurance, patients are admitted to the hospital by the physician based on their medical need. In LTCI, it is the person needing care who decides whether to opt for community care or institutional care, and, moreover, the dividing line between the two has become blurred as special housing has developed. It would be better to establish LTCI earlier than later to avoid creating ad hoc pockets of entitlement and resulting cost escalation.

In health care, the behavior of physicians and the expectations of patients are difficult to alter. Physicians have professional autonomy and patients tend not to be proactive consumers. Thus, payment reform must be made incrementally. In LTC, the market has a greater role because users, as consumers, are able to choose services and the government's responsibility is limited to providing a basic level of services. Once established, LTC is likely to develop more rapidly than health care because population ageing will have a greater effect.

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Case study

Republic of Korea

Soonman Kwon
Seoul National University
Seoul, Republic of Korea

Abstract

This study aims to provide a case study of the Republic of Korea for the price setting and price regulation for the care of older persons. This case study will first examine the coverage, financing and organization of long-term care (LTC) systems, focusing on long-term care insurance (LTCI) in the Republic of Korea. Then it will examine the pricing and price regulation of various types of LTC or care of older persons provided by different types of providers, such as nursing facilities (LTC facilities), home-based care, and long-term care hospitals in the Republic of Korea.

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1
Population coverage of LTCI

Long-term care insurance (LTCI), introduced in 2008, is the key institution for LTC in the Republic of Korea. As in the case of national health insurance (NHI), pricing and price regulation is a key policy instrument for financial sustainability and affordability in LTCI. LTCI is separate from NHI, although both are administered by the National Health Insurance Service (NHIS) to save administrative costs, i.e. managed by a single agency with two different funding pools.

Different from European countries (e.g. Germany, Netherlands) where LTC systems have been developed for people with disabilities including older people, LTCI in Korea was introduced in the context of population ageing. As a result, people aged 65 years or older are eligible for all types of LTC, but eligibility of those under 65 is restricted to aged-related LTC need, such as individuals with geriatric diseases, e.g. dementia, cerebrovascular disease. The design of LTCI to which younger people pay contribution but their eligibility for benefits is restricted has resulted in a big inter-generational transfer and to some extent contributed to the financial sustainability of LTCI. As of December 2018, LTCI covered 8.4% of older people over 65 (Table 1). For 10 years since the introduction of LTCI, the population coverage in terms of the percentage of the population aged 65 and over has doubled.

Table 1
Long-term care insurance (LTCI)-eligible people in 2008-2018, Republic of Korea

(Unit: thousand persons)

	2008	2010	2012	2014	2016	2018
a. Total population	50 001	50 581	51 169	51 757	52 273	52 557
b. Older population (aged 65+)	5086	5449	5922	6463	6940	7612
c. LTCI eligible population	214	270	342	425	520	671
c-1. aged 65 and over	200	251	318	400	493	640
(% of older people 65+)	(3.9)	(4.6)	(5.4)	(6.2)	(7.1)	(8.4)
c-2. aged under 65	14	19	24	25	27	31

Source: NHIS (various years).

To become eligible for LTCI, individuals who have disability for more than 6 months can apply for needs assessment. Needs assessment examines functional status in physical, cognitive, behavior, and rehabilitative characteristics based on 52 items[1]. The eligible group is classified into six levels/grades. As of 2018, the distribution of severity levels 1-5 are 7%, 13%, 32%, 40%, and 8%, respectively (Table 2). With the increase in the number of severity categories, the proportion of the most severe level (i.e. level 1) has declined.

Table 2
Distribution of LTC grades/levels among LTCI-eligible people in 2008-2018, Republic of Korea

(Unit: thousand persons, %)

	2008	2010	2012	2014	2016	2018
Grade I	57 (26.8)	31 (11.6)	38 (11.2)	38 (8.9)	41 (7.9)	45 (6.7)
Grade II	58 (27.2)	64 (23.6)	71 (20.7)	72 (17.0)	74 (14.3)	85 (12.6)
Grade III	99 (46.0)	175 (64.8)	233 (68.1)	170 (40.1)	186 (35.7)	211 (31.5)
Grade IV	-	-	-	134 (31.6)	189 (36.3)	265 (39.5)
Grade V	-	-	-	10 (2.5)	30 (5.8)	54 (8.0)
Grade for cognitive support	-	-	-	-	-	11 (1.7)
Total	214 (100)	270 (100)	342 (100)	425 (100)	520 (100)	671(100)

Source: NHIS (various years).

1 Need assessment examines physical functions (dressing, face washing, tooth brushing, bathing, dining, changing positions, sitting, moving, control of excrement, shampooing, level of self-reliance), social functions (housing, preparing for meals, laundry, financial management, shopping, using telephones, using transportation, going out for short distances, dressing, taking pills), cognitive functions (recall of stories, dates, places, ages and birthdays, difficulties in understanding directions, lack of judgment, difficulties in communication, difficulties in calculations, difficulties in understanding daily schedules, difficulties in recognizing family or relatives), change of behavior (newly occurred psychological symptoms related to dementia, delusion, anxiety, etc.), nursing necessity, rehabilitation necessity, willingness to use welfare equipment, main source of care, residential environment (evaluating whether environments are harsh or detrimental to health), vision and hearing ability and morbidity. The assessment of each item is based on 2 or 3 scales.

2
Benefits and expenditures of LTCI

LTCI provides in-kind benefits for institutional and home-based care, and cash benefits are available only in exceptional cases, e.g. when no service providers are accessible in the region. Meals are not covered by LTCI, and extra charge is applied for private wards. People with severity levels 1-2 can use all types of care whereas those with lower levels of severity are not eligible for institutional care.

The amount of benefits depends on the eligibility/severity level, and the ceiling on benefit coverage is different by the level. For example, the maximum monthly benefits range from ₩1 007 200 for level 5 to ₩1 498 300 for level 1 in the case of home-based care (Table 3). The benefit ceiling for institutional care is higher than that for home-based care. The ceiling for welfare equipment is ₩1 600 000 (about US$ 1400) per year. In most cases, benefits to the insured/beneficiaries and payment to providers do not depend on individual services because provider payment is based on the visit (e.g. home-based care) or day (e.g. institutional care).

Table 3
Monthly ceilings on the benefits in LTCI, 2020, Republic of Korea

(Unit: Korean won)

Severity Level	Level 1 (most severe)	Level 2	Level 3	Level 4	Level 5	Cognitive
Home-based Care	1 498 300	1 331 800	1 276 300	1 173 200	1 007 200	566 600
LTC facility	2 129 700	1 976 100	1 822 200			

Source: NHIS (2019).

1 US dollar = about 1100 Korean won.

Note: average monthly salary of a nurse is around 4 000 000 won.

The proportion of institutional care in total expenditure for LTCI was 45.5% and for home-based care, it was 54.5% (Table 4). The proportion of institutional care in total LTCI expenditure has been declining slightly over the years. The home-based care consists of visiting care, visiting bathing, visiting nursing, day and night care, short-term care and welfare equipment. Home-visit care and day/night care account for 71% and 21% of home-based care expenditure of LTCI, respectively. The number of users of different types of LTCI benefits is presented in the Appendix.

Table 4
LTCI expenditure by service types, 2012-2018, Republic of Korea

(Unit: billion Korean won, %)

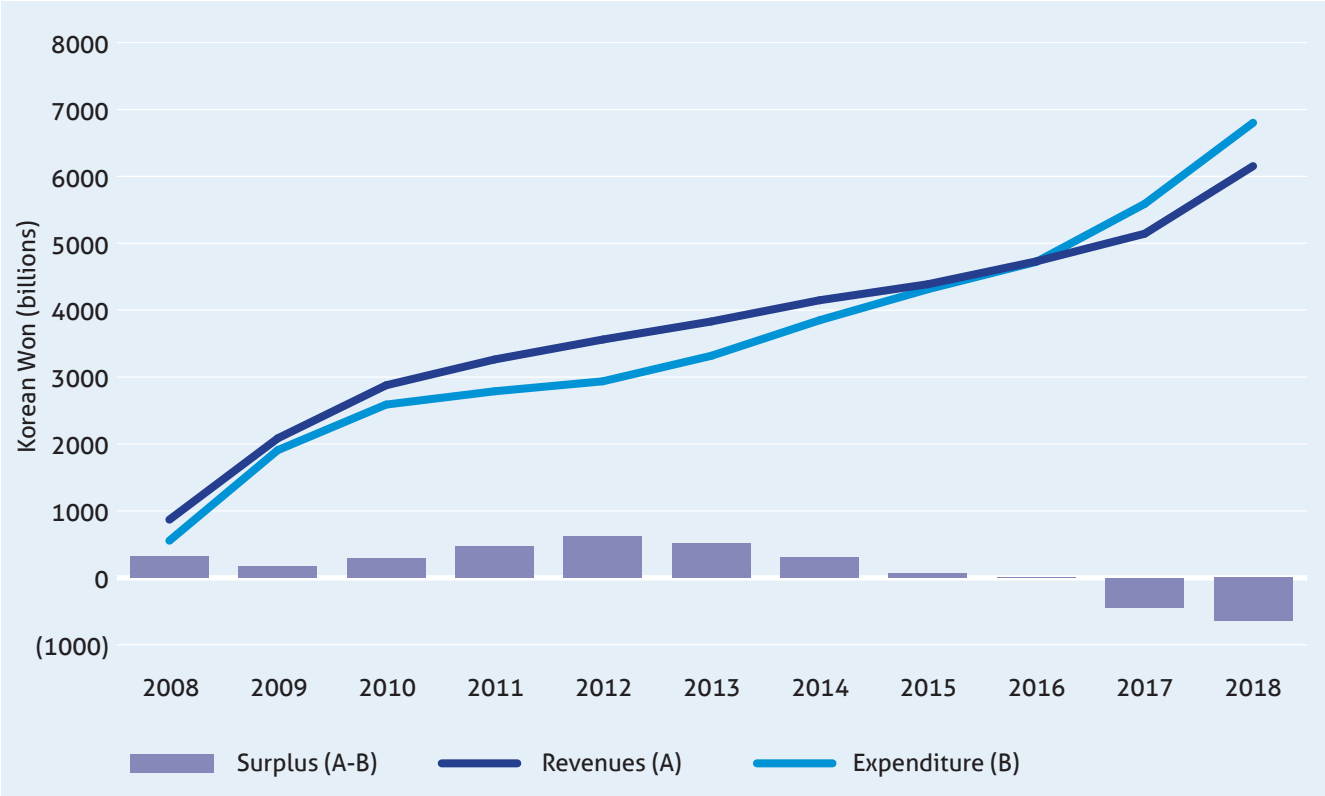
	2012	2013	2014	2015	2016	2017	2018
Total LTCI expenditure	2718	3083	3498	3982	4418	5094	6299
(%)	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Institutional care	51.1	51.8	52.1	51.3	50.7	48.1	45.5
Home-based care	48.9	48.2	47.9	48.7	49.3	51.9	54.5
Within home-based care							
Home-visit care	80.6	79.0	78.3	76.4	73.8	71.6	70.9
Home-visit bathing	5.3	4.9	4.2	3.7	3.5	3.4	2.9
Home-visit nursing	0.5	0.5	0.5	0.5	0.4	0.5	0.5
Day and night care	7.2	8.6	10.4	13.2	16.6	19.4	21.4
Short-term care	0.7	1.0	1.0	0.8	0.6	0.5	0.4
Welfare equipment	5.7	6.0	5.6	5.4	5.2	4.6	3.8

1 US dollar = about 1100 Korean won.

Source: NHIS (2019).

The contribution rate for LTCI is 8.51% of health insurance premiums in 2019 (increased from 7.38% in 2018). In other words, anyone who pays NHI contribution pays LTCI contribution. The contribution is exempted for the poor. Because the NHI contribution is 6.46% of wage, the contribution for LTCI was about 0.55% of wage (6.46 X 8.51) in 2019. The contribution rate started at 4.05% of the health insurance contribution in 2008, increased to 4.78% in 2009, and to 6.55% in 2010-2017. Since 2017, LTCI has experienced an annual increasing deficit (Figure 1). As a result, the financial sustainability of LTCI is a serious concern.

Figure 1
Fiscal status of LTCI, 2008-2018, Republic of Korea



Source: NHIS (various years).

The financing mix of LTCI consists of contributions (60-65%), tax subsidies (20%), and copayment by service users, which is 20% for institutional services, 15% for home-based services, and 15% for welfare equipment. The coinsurance rate for institutional care is higher than that for home-based care in order to promote de-institutionalization and community-based care. There is a 40% copayment discount for those in the 25-50% income quartile and 60% discount for those in the lowest (0-25%) income quartile. Copayment is exempted for the beneficiaries of the Medical Aid program, which is a public assistance program for the poor.

3
LTC provision

After the introduction of LTCI, the number of LTC providers rapidly expanded from 1700 to 5320 facilities/institutions and 6618 to 15 970 home-based care agencies from 2008 to 2018 (Table 5). An over-supply seems to result in severe competition among LTC providers. The number of care workers and nurse aides increased dramatically, as they need a shorter period of education and training than registered nurses.

Table 5
Number of LTC providers, Republic of Korea

Institution (number)	2008	2010	2012	2014	2016	2018
a. Home-based care agency	6618	11 228	10 730	11 672	14 211	15 970
b. Institution/Facility	1700	3751	4326	4871	5187	5320
b-1. Aged Care Facility	1379	2408	2588	2714	3137	3389
b-2. Senior Congregate Housing	321	1343	1739	2157	2050	1931

Source: NHIS (various years).

The increase in quasi-professional staffing seems driven by small-sized institutions, e.g. capacity of less than 30 residents or group homes (less than 10 residents), where the entry to market is relatively easy for private sector providers. About 70-80% of providers are from the private sector, and the majority of home care providers are concentrated in urban areas. To assure the quality of care in the LTC sector, the NHIS has implemented a quality evaluation system since 2009. The number of quality indicators varies by the type of service providers, e.g. 88 items for institutional care and 32-59 items for home-based care, and they are grouped by five domains of quality measurement, namely, management of institutions, environment and safety, rights and responsibilities, process of services and outcome of services (Jeon and Kwon 2017).

The result of the evaluation score (A-E) has been publicly disseminated through an official LTCI website (Table 6 for the results of the year 2018), and high-performance institutions have received incentives of 1-2% additional reimbursement of LTCI. Based on the provider assessment report, the NHIS gives 2% extra payment to the top decile of facilities and 1% extra payment to the next decile. Facilities that employ more human resources than required by law (social worker, nurse, night watch) also receive extra payments.

Table 6
Results of the assessment of LTC facilities, 2018

A (Highest)		B		C		D		E	
%	Score	%	Score	%	Score	%	Score	%	Score
13.5	94.1	21.7	85.3	24.4	76.7	19.8	68.3	20.6	55.7

Note: 4287 facilities were assessed with a mean score of 74.9.

Source: http://news.healthi.kr/news_view.asp?articleid=190424110016&CatrCode=1201

Inadequate collaboration between local governments and the NHIS has been criticized because local governments are not active in controlling the quality of LTC providers even though they have the authority to approve or close the operation of providers (Jung et al. 2014). LTCI is a centralized system with a single pool and has a concern of a lack of coordination between the NHIS and LTC delivery by local governments. The central government, i.e. MoHW (Ministry of Health and Welfare), formulates policy and provides overall guidance on LTC policy implementation but does not have direct control over local governments. Although the centralized single pool has the benefit of equity in financing and efficiency of risk pooling, it has not been so far effective in organizing LTC delivery at the local level. This coordination problem is prominent in the Republic of Korea, as the majority of LTC providers are private, the role of gate-keeping by general practitioners is minimal, and consumers are used to the freedom of choosing their providers.

Informal care is not covered by LTCI, in other words, LTCI covers LTC only when LTC is provided by formal care providers. According to a national survey of community-dwelling older people (65 years and older) by the Korea Institute of Health and Social Affairs (KIHASA) in 2017, about 25% of those surveyed needed some type of care/support when care need was defined as at least one limitation among the 17 items of ADL (Activities of Daily Living) and IADL (Instrumental Activities of Daily Living) (Chung et al. 2017). 71% of those who needed support received care from many sources (multiple sources could be chosen in the survey). Among those who received some care, 19% relied on LTCI and 89% received some support from family members, mainly the spouse.

4
Payment and price setting in LTCI

The payment method varies by severity level and service type, such as pay per visit (service hours) for home-visit care and pay per day for institutional care (Table 7). Payment per visit is higher for visiting nurses and visiting baths than that for visiting homes. In contrast to the collective price negotiation between the provider association and the NHIS in the case of the national health insurance system, there is no price negotiation process in the case of LTCI. This lack of negotiation seems related to the weak professional power of LTC providers relative to health care providers.

Table 7
Per-diem payment for LTC facilities, 2019, Republic of Korea

	Severity Level	Amount (won)
Aged Care Facility	Level 1	69 150
	Level 2	64 170
	Levels 3	59 170
Senior Congregate Housing	Level 1	60 590
	Level 2	58 220
	Levels 3	51 820

Source: NHIS (2019).

1 US dollar = about 1100 Korean won.

The LTC committee plays a key role in the pricing of LTC. It discusses and makes final decisions on various aspects of LTC insurance, such as premium, benefits, pricing for providers, etc. It consists of 21 members, with the Deputy MoHW as the Chair: 7 from payers (employer associations, labour unions, civic groups), 7 from providers (4 associations of LTC facilities and home-care providers, 2 medical associations, nursing association), and 7 representing public interests (MoHW, MoF (Ministry of Finance), NHIS, and 4 experts). Because providers account for only a third of the committee membership, they complain that the annual increase in price is lower than it should be.

The pricing of LTC is based on the costing of a standard practice model. Standard models are based on the operation with the following numbers of older persons being cared: 70 persons for LTC facilities, 9 for senior congregate housing (group homes), 26 for day and night care and 17 for short-term care. Standard models for home-visit providers are based on 6450 visits per year. It is an important issue whether the standard models well represent the real practice or standard of care with optimal

operation. A recent study of cost function estimation of LTC facilities shows that the optimal scale is larger than 100 beds (Kwon et al. 2019). However, the sample size in the study is small, and it is controversial if the study fully controlled the quality of care due to measurement and data issues.

Standard models of each provider type are based on the different number of personnel and include depreciation. The minimum number of care workers is 28, 3, 3.7, and 4.3 for the above four types of providers, and 15 for home-based care, respectively. The minimum number of nurses or nurse aids is 2.8, 1, 1, and 1 for the above four types of providers (facilities), respectively. At least one social worker is required for standard models of LTC facilities, short-term care and day/night care. The estimate of personnel cost depends on various data, such as a survey of LTC providers, the minimum wage and its increase, etc. Payment for each of the five levels of severity is determined by considering resource needs (amount of hours needed to provide care for each severity level), personnel cost for care workers, administrative cost, etc. For the decision on pricing by the LTC committee, NHIS provides information on the costing based on standard models of practice.

In addition to the lower professional bargaining power of LTC providers, there are some differences among NHI and LTCI in terms of costing (Table 8). NHI has fee-for-service (FFS) payment for a large number of medical services, from relatively simple to complicated cases, relying a lot on medicines and technology services. Health services paid by NHI often use heterogeneous resources and inputs provided by various health professionals, and indirect costs to be allocated to services are often very high especially in the case of big hospitals. As a result, how to allocate indirect costs to individual services has a big effect on the price of individual medical services under FFS payment. To the contrary, LTC services rely heavily on the direct labor input of care workers, with a much smaller number and type of simple homogeneous inputs, mostly in a smaller scale of practice.

Table 8
Costing approach in NHI and LTCI, Republic of Korea

	NHI	LTCI
Costing unit	Numerous services	7 Service/provider types
Payment system	Fee for Service	Lump sum per day or visit
Diversity of products	Numerous products	Limited types of products
Role of medicines and technology	High	Low
Role of indirect cost	Relatively high	Relatively low
Complexity/diversity of inputs	Relatively complex/diverse	Relatively simple
Homogeneity of inputs	Heterogeneous	Homogeneous
Operating scale	Big	Small

Since 2016, the NHIS has collected panel data consisting of about 550 LTC providers based on the seven major types of care, size of providers, region and ownership type. Although they are valuable data, the reliability of the data is still controversial, as they are based on self-reporting. Especially when providers are engaged in both LTC and other types of social welfare services, joint cost allocation between LTC and other welfare services can be biased following the strategic motive of providers to maximize reimbursement from LTCI. The NHIS is considering the construction of its own LTC facilities, which can provide reliable data on the costing and standard practice of LTC.

5
Coordination between NHI and LTCI

Medical or nursing care for older persons is provided by long-term care (or geriatric) hospitals, which are paid by NHI, not by LTCI. The minimum requirement for medical doctors and nurses is lower in LTC hospitals than acute care hospitals. The boundary or division of labor between LTC hospitals (reimbursed by NHI) and LTC facilities (reimbursed by LTCI) is a serious concern in the Republic of Korea. The pricing of services provided by LTC hospitals are governed by the NHI system, i.e. through price negotiation between NHI and the Korean Hospital Association (KHA). Although LTC hospitals (LTCH) are somewhat different in nature from acute care hospitals, there is a negotiation between the NHIS and KHA, covering all types of hospitals, including LTCH. LTCH think it is better for them to be included in the bargaining between the NHIS and KHA, rather than separately bargaining with the NHIS.

Policy challenges remain regarding the lack of coordination between health care and LTC. For example, overlapped inpatient services are provided by LTC facilities/institutions (under LTCI) and LTCH (under NHI) for older people with similar

health and functional status. LTCH are required to have physicians, whereas the minimum requirement for medical personnel in LTC institutions/facilities is a nurse aide. Some older people, even without the need for medical treatment, want to stay in LTCH, because they worry that the medical capacity of LTC institutions is very limited and referrals to hospitals are not well arranged (Kim, Jung and Kwon 2015).

The lack of effective coordination between LTC facilities and LTCH resulted in the persistent medically unjustified social admissions of older people with lower medical care needs in LTCH (Jeon, Kim and Kwon 2016). On the other hand, a significant portion of older people with clinical care needs stay in LTC facilities where health care is not provided. Based on a national representative sample of 52 LTCH (1364 patients) and 91 LTC facilities (1472 residents), which are 6% of LTCH and 4.4% of LTC facilities nationwide, Kwon et al. (2013) showed about 35% of patients in LTCH are in the categories of Cognitive Impairment, Behavior Problem, and Physical Function. They do not really need medical care and are better to stay in LTC facilities (Table 9). At the same time, about 35% of residents in LTC facilities need medical care and are better to stay in hospitals.

Table 9
Distribution of resource utilization groups in LTCH and LTC facilities, the Republic of Korea

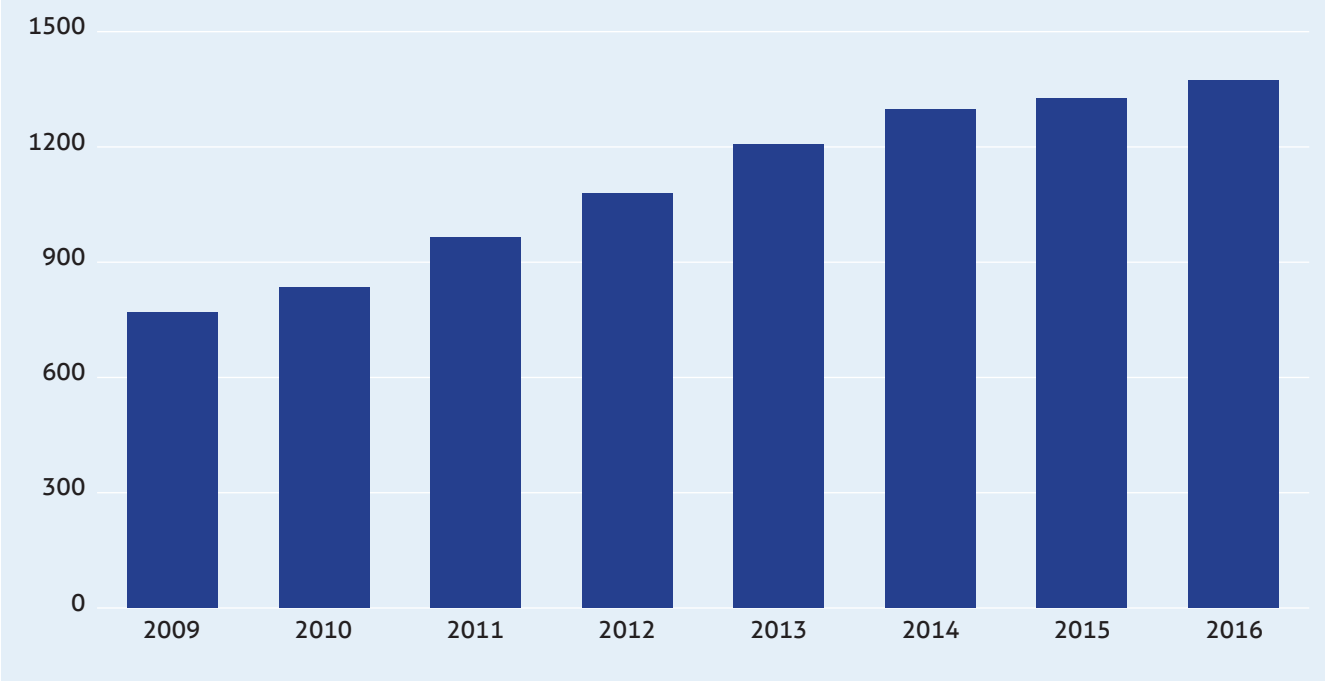
	LTC Hospital (%)	LTC Facility (%)
Rehabilitation	44.20	19.77
Extensive Special Care	5.45	1.36
Special Care	2.68	2.92
Clinical Complex	13.35	11.28
Cognitive Impairment	4.23	9.44
Behavior Problem	1.97	4.62
Physical Function	28.23	50.61

Source: Kwon et al. (2013).

The coordination failure between health insurance and LTCI has to do with the history and path dependency in the development of the LTC system for older people in the Republic of Korea (Jeon and Kwon 2017). With population ageing and the increased need for LTC of older people, the government introduced LTCH with lower requirements for medical personnel than acute care hospitals. LTCH were reimbursed by NHI (there was no LTCI then). When there was no public funding for LTC, many older patients in LTCH were reluctant to be discharged to LTC facilities because they had to pay for LTC facilities while the majority of the cost of LTCH was funded by NHI. As a result, social admissions were prevalent in LTCH

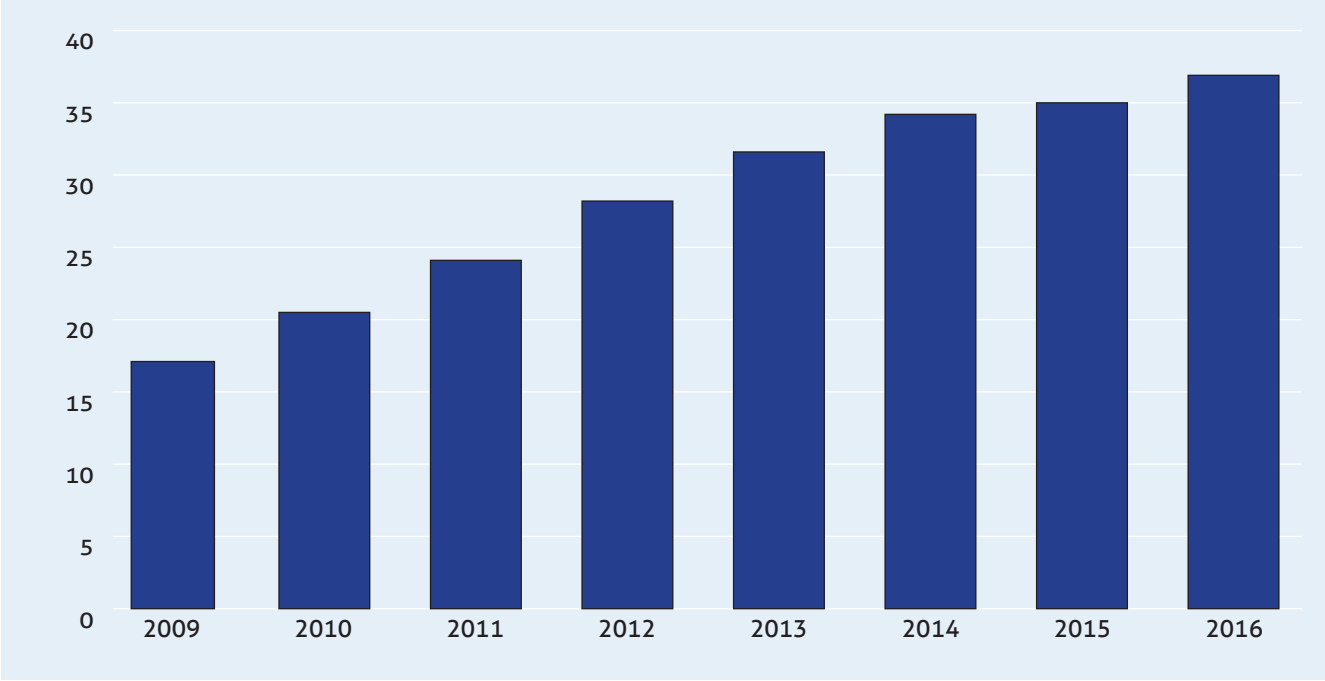
before LCTI was introduced, but inefficient social admissions unfortunately have continued even after the introduction of LTCI. LTCH have mushroomed over the last ten years (Figure 2), and competition to attract patients has been fierce. The number of LTCH beds per 1000 persons aged 65 or older has increased from 5.9 in 2005 to more than 35 in 2016 (Figure 3).

Figure 2
Number of LTCH in the Republic of Korea in 2009-2016



Source: KOSIS (Korean Statistical Information Service) (2020).

Figure 3
Number of LTCH beds per 1000 older people aged 65 and over in 2009-2016



Source: KOSIS (2020).

There are several institutional factors contributing to the persistent social admissions in LTCH. The majority of LTCH and LTC facilities are private, and more patients/residents mean profits for them. The benefits packages of NHI tend to be more generous than LTCI, e.g. the ceiling on cumulative copayment every six months in NHI. As a result, after a few months of stay in LTCH, copayment can be exempted. Then it becomes less costly for patients to stay in LTCH than in LTC facilities. There is a financial penalty, i.e. reduced fees, for LTCH when patients stay for more than 6 months. However, the lower fee (for a given copayment rate for patients) means lower total copayment or OOP (out-of-pocket) pay for patients, resulting in a financial incentive for patients to stay longer in LTCH.

In 2018, 38% of the funds for copayment exemption under NHI were paid to patients in LTCH (NHIS 2019). As of 2018, 64% of patients in LTCH got financial support from the above policy of copayment exemption. Government plans to merge the three patient groups with lower need for medical care in LTCH (Cognitive Impairment, Behavior Problem, and Physical Function) into one category and raise the copayment rate from 20% to 40%. However, the increase in copayment is likely to have a limited impact on the reduction in long-term stay in LTCH, because many patients will get benefits from the copayment exemption. In other words, the increase in copayment rate can result in reaching the ceiling of copayment earlier than present.

Coordination problems between health care and LTC are also associated with weak primary care, dominant private providers, and separate insurance (with separate payment) for health care and LTC, all of which are chronic challenges facing the Republic of Korea. An effective approach would be to change the policy of copayment exemption in the case of LTCH. A policy can consider that copayment is not exempted for long-term stay, e.g. if patients stay for more than 6 months, in LTCH. Government can mandate a strict discharge planning and patient assessment for LTCH, and the above policy of no exemption of copayment can be applied to patients with minor severity or those who can be transferred to LTC facilities. Although the above policies have been discussed, they have not been implemented mainly due to opposition by LTCH and older people, because many older people still tend to prefer LTCH to LTC facilities.

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Appendix
LTCI beneficiaries by service type, 2012-2018, Republic of Korea

(Unit: No. of recipients)

	2012	2013	2014	2015	2016	2017	2018
Total LTCI benefit recipients*	**369 587**	**399 591**	**433 779**	**475 382**	**520 043**	**578 867**	**648 792**
Institutional care*	**104 023**	**156 999**	**168 924**	**180 157**	**189 374**	**200 475**	**213 775**
LTC facility	83 538	130 750	142 382	153 840	164 221	176 041	189 615
LTC Congregate housing	20 485	26 249	26 542	26 317	25 153	24 434	24 160
Within Home-based care*	**447 785**	**487 574**	**522 075**	**574 731**	**634 955**	**723 732**	**821 630**
Home-visit care	210 508	224 233	240 392	260 252	284 232	317 195	357 575
Home-visit bathing	67 035	65 509	62 017	60 285	61 812	68 590	74 801
Home-visit nursing	7 866	7634	7660	8613	9 077	11 485	14 270
Day and night care	24 014	28 051	35 089	45 006	57 165	74 081	94 399
Short-term care	4867	7264	7021	6436	5866	5421	4685
Welfare equipment	133 495	154 883	169 896	194 139	216803	246 960	275 900

Source: KOSIS (http://kosis.kr/statisticsList/statisticsListIndex.do?menuId=M_01_01&vwcd=MT_ZTITLE&parmTabId=M_01_01#SelectStatsBoxDiv).

Note: Totals do not always add to 100% because people can use more than one type of benefit.

Case study

Netherlands

Pieter Bakx, Erik Schut and Bram Wouterse
Erasmus School of Health Policy and Management, Erasmus University Rotterdam
Rotterdam, Netherlands

Abstract

The Netherlands has a long tradition of public long-term care provision. The Dutch system is known for its broad access to a wide range of long-term care services, which not only includes good quality nursing home care, but also extensive home care and social assistance. At the same time, this long tradition has led to a complicated mix of three financing schemes – social long-term care insurance, social health insurance, and tax-financed social support – each of which pays for other types of long-term care. In all three schemes, the national government has delegated the contracting of private care providers to a different party (regional purchasing offices, health insurers, municipalities). The extent and kind of (price) regulation, the way of contracting and pricing, and the distribution of financial risk between the national government, the contractor, and the private providers differ across schemes.

In this report, we describe the pricing and contracting in these three financing schemes. We identify two common best practices. First, care is highly accessible, and the distribution is equitable. Second, integrated prices, which play a role in all schemes, give room to providers to tailor care to the specific needs of a patient. We also identify three challenges: ensuring the coordination and sharing of responsibilities *within* each financing scheme, improving the coordination of care provision *across* the three financing schemes, and modifying price setting and contracting to improve quality, efficiency, innovation and prevention.

Lessons learnt

If the incentives to achieve system goals and financial risk and decision-making power are delegated, this is best done in tandem and to the same organization or organizations.

Financing long-term care through multiple schemes means coordination problems. Even if incentives of all agents are aligned within one scheme, this may not need to be the case across schemes.

Integrated prices give providers opportunities to provide long-term care that is tailored to the needs of their patients, yet it does not provide them with the incentives to actually do so.

Ensuring universal access requires that there is ample budget and that providers are paid a price that ensures that they can at least recover their costs. Ensuring efficiency and quality requires several additional preconditions.

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1 Introduction

The Dutch health care system aims to provide affordable care of good quality to all its citizens. Universal health coverage has existed in the Netherlands for decades and has included long-term care as early as 1968 (Schut and van den Berg 2010). Currently, this universal health coverage is achieved through three complementary public financing schemes that each pay for specific types of care. Social long-term care insurance pays for care in nursing homes (about 217 000 users in 2019), social health insurance pays for nursing and personal care provided at home (about 222 000 users in 2019), and the Social Support Act makes municipalities responsible for organizing and financing assistance and social support for elderly living in the community (1.1 million users in 2019). Each of these public schemes pays for care for the full population, and enrolment in the social insurance schemes is mandatory. The two social insurance schemes are primarily funded through earmarked insurance premiums[1], and the Social Support Act is fully financed through general taxation. In addition, co-payments amount to 8% of the social long-term care insurance spending, and a deductible pays for 4.3%[2] of the expenditures paid for through the Social Support Act, but there is no cost sharing for home care paid for through social health insurance (Staat van Volksgezondheid en Zorg 2019; Statistics Netherlands 2019a, 2019b).

This universal and comprehensive coverage of long-term care expenditures comes at a cost, however. According to the most recent estimates (OECD 2020), the Netherlands spends 3.7% of its Gross Domestic Product on long-term care, which is more than any other country. Because the share of the oldest-old in the Dutch population will grow fast over the next two decades and the government strongly increased long-term care spending in recent years, growing health care expenditures – long-term care expenditures, in particular – are a major threat to the sustainability of public finance in the long run (Adema and Van Tilburg 2019). Reforming the organization and financing of long-term care, including the price setting, may be part of the effort to deal with growth in demand for (high-quality) long-term care and increased budgetary pressures.

While virtually all long-term care is publicly funded, all providers are private organizations. Therefore, prices are not merely for administrative reasons but are used to pay these private providers. Prices for most types of long-term care are regulated, but this regulation offers room for price negotiations

1 16% of social long-term care insurance revenues come from general taxation; 6.6% of the social health insurance revenue comes from general taxation: primarily for health insurance for children (5.6%), and the remaining 1% is for home care expenditures (Staat van Volksgezondheid en Zorg 2019). These revenues are not earmarked, however.

2 This estimate is for 2018. In 2019, the co-payment schedule was reformed. Preliminary estimates for the first 9 months suggest that the revenue from co-payments was about 27% lower in 2019 than in 2018 (Statistics Netherlands 2019a).

between payers and providers. The regulation of prices, among other things, differs strongly between the three financing schemes. This has implications for the incentives and the financial risks that payers and providers face, and hence for the outcomes of the negotiations, not only in terms of prices and volumes but possibly also for other outcomes, including the quality of life of the elderly who need care and relatives who are potential caregivers.

The outline of the remainder of this report is as follows. Section 2 describes the structure of the long-term care sector in more detail and argues how this structure determines the incentives for providers and payers. Section 3 discusses how the prices are determined. We distinguish two steps in this process: (i) the administrative process that sets the boundaries for the negotiations between payers and providers ,and (ii) the negotiations themselves. In the conclusion (Section 4), we review the evidence on the contribution of price setting and price regulation on the system objectives and describe the best practices for other countries.

2
Background on the Dutch long-term care system

2.1 Historical perspective and recent reforms

In 1968, the Netherlands was the first country to implement a universal social long-term care insurance scheme (AWBZ) alongside a social health insurance scheme for curative health services (e.g. hospital care, primary health care, prescription drugs). Initially, social long-term care insurance covered primarily nursing home care and institutionalized care for the mentally handicapped, but in due course coverage was expanded to home care (1980), ambulatory mental health care (1982), social assistance in case of frailty and psychosocial problems and assistance after childbirth (1989) and elderly homes (1997) (Schut and van den Berg 2010). In comparison to other European countries, the resulting public financing scheme for long-term care was very generous and comprehensive. Provider contracts were negotiated by 32 regional procurement offices within a regional budget constraint set by the government. In almost all 32 regions, the health insurer with the largest market share has been designated as the regional procurement office[3]. The central government was the single risk-bearing entity, implying that regional procurement offices were not at risk for long-term care expenses covered by the social long-term care insurance scheme.

3 Hence, although the social long-term care insurance and the social health insurance schemes were separate, the functioning of social long-term care insurance relied on insurers operating in the health insurance system. In contrast to the social health insurance scheme, however, in the context of social long-term care insurance, health insurers were – and are – not at risk and not competing for customers.

The comprehensive and generous social long-term care insurance scheme has resulted in a high share of older people receiving formal care within long-term care institutions relative to most other OECD countries (Colombo et al. 2011). From 2000 to 2013, the average annual growth of public expenditure on long-term care was 4.3% in real terms (Ministry of Health, Welfare and Sport 2013). The broad entitlements, heavy reliance on formal (institutionalized) care, and limited incentives for efficiency resulted in increasing political concerns about the financial sustainability of the system. However, the large role of public financing of professional home care and institutional care has created strong vested interests in maintaining this way of long-term care provision, which made it difficult to reform the system. Nevertheless, after years of discussion and several minor reforms to curb the growing public long-term care expenditure, in 2015, the growing concerns about the sustainability of the long-term care system resulted in a radical reform. The former comprehensive social long-term care insurance scheme was split up, and its benefits were allocated to three different financing regimes: (i) a new social long-term care insurance scheme replacing the previous one (Long-term Care Act - WLZ)) covers institutional care and substitute care at home or in other assisted-living facilities (hereafter, we simply refer to this as institutional care, since most people covered under this scheme use this type of care); (ii) the existing social health insurance scheme (Health Insurance Act - ZVW) now covers nursing and personal care provided at home; and (iii) the existing Social Support Act (WMO) covers assistance and social support for elderly living in the community and assistance for people with chronic psychic or psychosocial problems.

The reform had three interrelated goals: (i) improve the quality of long-term care provision by encouraging 'tailor made' care and facilitating self-reliance; (ii) increase the role of the person's social network in providing informal care; and (iii) improve the financial sustainability of the public long-term care system (Alders and Schut 2019). The idea behind the split-up of the former comprehensive social long-term care insurance scheme was two-fold. First, its aim was to improve the coordination between the provision of nursing and personal care on one hand and medical care (e.g. primary care and hospital care) on the other hand by financing all this care through social health insurance. Second, it was expected to foster coordination between all types of social care (e.g. social care, domestic help, social welfare and housing) by financing them all through the Social Support Act. Moreover, the aim was to make people more self-reliant and less dependent on formal care by explicitly making their social network responsible for providing social assistance and support and only providing publicly-funded care if this social network is not capable of providing all the care that an individual needs. Finally, by making risk-bearing health insurers and municipalities responsible for procurement, the reform aimed to reinforce incentives for an efficient provision of care.

2.2 Main features of current long-term care financing

The main features of the organization and financing of long-term care for the three different financing schemes are discussed below. Key figures about the various types of long-term care covered by these finance schemes are summarized in Table 1.

Table 1
Type of long-term care by source of finance, number of users and total expenditures in 2018.

Financing source	Type of long-term care	Number of users (in thousands)	Expenditure (in million EUR)
Long-term Care Act (WLZ)	Nursing home care[a]	217	10 720[b]
Health Insurance Act (ZVW)	Nursing and personal care	222	3637
Social Support Act (WMO)	Assistance in daily living	1106[c]	4918

Notes: [a] Including intensive (around the clock) care in other settings; [b] Excluding cash benefits; [c] Users of tailor-made services only. **Sources:** Ministry of Health, Welfare and Sport (2019a, 2019f, 2019g), Statistics Netherlands (2019d, 2019e).

2.2.1 Long-term Care Act

The Long-Term Care Act covers around the clock intensive care for vulnerable elderly and individuals with severe disabilities in the full Dutch population: enrolment is automatic and mandatory[4]. The long-term care insurance scheme is financed by earmarked, income-dependent insurance premiums and has a standardized benefits package (including care for elderly people in an institutional setting, care for people with mental and physical and sensory limitations, and care for people with long-term severe psychiatric conditions). The benefits people are eligible for depend on the type and severity of an individual's disability. Individuals apply for eligibility at the independent central assessment agency (CIZ), where an assessor determines whether an individual meets the set of eligible criteria, and, if so, which amount of care is appropriate. Because the Long-Term Care Act is a social insurance scheme, access to care is a legal right: eligibility should solely be based on formal criteria regarding someone's health status and disabilities. That is, the availability of care (e.g. concerns about waiting lists and the regional care budgets) does not play a role in the eligibility decision.

Most care for the elderly that is financed through this scheme is provided in-kind in a nursing home. The basic costs of living, such as housing, are also covered by this scheme. Instead of an in-kind provision of nursing home care, beneficiaries can also choose to receive in-kind care in another setting, such as their own home, an assisted-living facility or a partly privately

4 From 2021 onwards, care for adults with chronic psychiatric conditions will also be covered by the Long-Term Care Act.

funded nursing home[5] – in which cases only the care components are covered – or they can choose to receive cash benefits. When people opt for cash benefits, they organize the provision of care themselves[6]. Individuals are free to go to a nursing home or provider of their choice, as long as the providers has been contracted and the capacity of the provider permits.

Procurement of in-kind services is carried out by 32 regional procurement offices, each within a separate geographic region. Typically, the role of the regional purchasing office is entrusted to the largest health insurer in the region, though this task is carried out by a separate legal entity. The regional purchasing offices are not at risk, because it is believed that the financial responsibility for the provision of care for the most vulnerable people, requiring very intensive care is best borne by the central government. However, the regional offices must comply with a regional budget constraint – set by the national government – when contracting care.

2.2.2. Health Insurance Act

The Dutch social health insurance scheme is carried out by competing private health insurers. The benefits package is defined by law and includes hospital and medical specialist care, primary care, prescription drugs and – since 2015 – nursing and personal care. Health insurers are at risk for the medical expenses of their enrolees and no selection of applicants is allowed. People have an annual free choice of health plans offered by the insurers at community-rated premiums (i.e. insurers are not allowed to differentiate health plan premiums based on personal characteristics), yet signing up for health insurance is mandatory.

Benefits are financed from three sources: (i) an income-related contribution that is set by the government (which has to cover 50% of total expenditure), (ii) a community-rated premium that is set by the insurer, and (iii) mandatory and voluntary deductibles paid directly by the consumers. Because premiums are community-rated, insurers are compensated for differences in the expected costs of their insured population by risk-adjusted capitation payments. These payments come from a national health insurance fund that is financed by the income-related contributions. General practitioner (GP) care, maternity care and nursing and personal care are free for users, because these benefits are exempted from the deductibles.

Health insurers may selectively contract with health care providers, which may be for-profit or non-profit entities. Moreover, in line with common practice in medical care, the

5 All nursing homes are private entities. Fully publicly funded nursing homes (i.e. in which case total costs are reimbursed by social long-term care insurance) are not allowed to be for-profit (i.e. not allowed to distribute profits to owners or stockholders). By contrast, partly privately funded nursing homes (i.e. where the costs of room and board are privately paid) are allowed to be for-profit.

6 In 2018, there were 216 780 eligible persons for nursing care covered by the Long-Term Care Act, of which 12 975 (6%) opted for cash-benefits (sometimes in combination with in-kind services) (Ministry of Health, Welfare and Sport 2019fe).

need for nursing and personal care is assessed by providers themselves. Instead of care that is provided in kind, elderly may opt for a cash benefit and may contract and organize the care that they need by themselves[7].

2.2.3. Social Support Act

In 2015, the Social Support Act[8] was revised to expand the responsibility of municipalities for assisting citizens who need support in performing activities of daily living (ADL) from domestic help to assistance and social support. The Social Support Act is not a social insurance scheme and hence individuals do not have a formal right to care. Instead, municipalities have to provide assistance and social support that is tailored to the individual's needs, but only when someone's social network is not capable of arranging sufficient support. Municipalities have considerable freedom in setting the eligibility criteria and the way in which individual cases are assessed and how the care is provided, but they are required to specify this. Eligibility decisions are formal government decisions that may be appealed.

Municipalities receive a non-earmarked block grant from the national government to provide care, which is financed from general taxation[9]. This block grant means that municipalities bear the full financial risk for organizing this home care. Until 2019, they were allowed to charge co-payments that depended on the amount of care that was used and the user's income and means (up to a legal maximum amount), but, since 2019, municipalities have to charge a fixed deductible for providing individual-specific ('tailor-made') social support and assistance (maximum €19 per month in 2020).

Like health insurers, municipalities may selectively contract with providers, which are for-profit or non-profit private entities. Instead of care that is provided in kind, elderly may opt for a cash benefit and contract and organize the care that they need by themselves[10].

2.3 Incentives for ensuring financial sustainability

Since health insurers are at risk for nursing and personal care and compete for customers, they are expected to have incentives to contract good quality care at the lowest possible price. In addition, since health insurers are also responsible for

7 In 2018, 222 435 persons used nursing and personal care covered by the Health Insurance Act, of which 15 725 persons (7%) opted for cash benefits instead of in-kind benefits (Ministry of Health, Welfare and Sport 2019g).

8 The Social Support Act regulates the responsibilities of municipalities for providing support to two groups: (i) citizens who need assistance in daily living and (ii) informal caregivers. A distinction is made between general support available to all citizens (e.g. meals on wheels, activities in community centres) and tailor-made support for specific persons (e.g. house cleaning, support in administrative tasks, home adjustments, providing mobility scooters).

9 Dutch municipalities have a limited ability to raise their own taxes and are mostly dependent on grants from the national government.

10 In 2018 about 1.11 million people made use of tailor-made care services provided by municipalities, of which 313 880 (28%) used support at home and 51 220 (5%) opted for cash benefits (Statistics Netherlands 2019c, 2019d).

covering the cost of hospital care and primary care, they have an incentive to coordinate care provided by different providers, for instance by organizing good home health care or rehabilitation care for frail elderly after hospitalization to prevent unnecessarily long hospital admissions. Similarly, since municipalities are fully at risk for the expenses of providing social support and assistance, they are expected to put pressure on providers to offer care at competitive prices. In addition, municipalities are expected to put pressure on people's social network to provide informal care and to foster an efficient coordination of the provision of social support and assistance and social welfare.

However, the system also creates a number of potentially important incentive problems that are resulting from: (i) the way long-term care benefits are allocated to the three financing regimes; (ii) the way the various third-party purchasers are financially compensated; and (iii) the way co-payments for the beneficiaries are designed (Alders and Schut 2019). As will be explained below, these incentive problems may result in cost shifting, a lack of coordination between various long-term care providers, and inefficient use or provision of long-term care.

Cost shifting

The distribution of long-term care benefits across three different financing schemes creates opportunities for cost shifting from one scheme to another. The boundaries between social support and assistance provided by municipalities, personal care and nursing covered by social health insurance, and nursing home care covered by the Long-Term Care Act are not clear-cut and frail elderly sometimes may be simultaneously meet the eligibility criteria for all of these services.

Municipalities have particularly strong incentives for cost shifting, since they are fully at risk for providing care, while the block grant they receive does not depend on whether someone uses social support services from the municipality or care from home healthcare agencies or nursing homes covered by health insurers or the public long-term care scheme. Therefore, municipalities have few financial incentives to prevent frail elderly from being institutionalized by investing in social support and assistance, home adaptations and other facilities that enable people to stay at home if possible. Moreover, if the municipality suspects that someone is eligible for nursing home care financed through the Long-Term Care Act, it may urge this person to request eligibility at the independent assessment agency. If someone is considered to be eligible for this care or does not cooperate with this assessment, the municipality can deny paying for social support and assistance.

Although health insurers also are at risk for the cost of personal care and nursing, their incentives for cost-shifting are much weaker than for municipalities. This is because their financial risk is substantially reduced by the system of risk equalization. Due to a lack of data on exogenous risk adjusters for predicting

individual expenses on community nursing, the risk equalization is currently based on the individual's prior cost of community nursing. People with the highest expenses on nursing and personal care in the preceding three years are classified in 8 categories, and the risk-adjusted capitation payment to the health insurer is increased by the mean spending in this category up to a maximum (about €31 000 per adult per year in 2020). This provides health insurers with incentives for shifting costs to the Long-Term Care Act for only the subgroup of enrolees with expected costs exceeding €30 000 a year (i.e. those needing on average more than 13 hours of community nursing per week), e.g. by urging advanced care planning and an application for admission to a nursing home or substitute care covered by the Long-Term Care Act.

Hence, municipalities and health insurers financially benefit from nudging independently living people to apply for care financed through the Long-Term Care Act. These incentives are opposite to the reform goal of financial sustainability, because they may result in avoidable use of home care and nursing home care.

Coordination problems

The separate financing of institutional care, nursing and personal care and social support and assistance also generates coordination problems, because these services are now purchased by different entities serving different populations and having different incentives. Cooperation and coordination between regional purchasing offices, health insurers and municipalities are very difficult to organize, which is perceived as a major problem (Kromhout, Kornalijnslijper and de Klerk 2018), especially because incentives for cooperation are not well-aligned. Furthermore, none of these entities are clearly responsible for the coordination of medical and social care, there is no financial reward for coordination tasks with uncertain outcomes, and there is no mechanism for sharing savings.

Efficiency problems

A first problem is that both the purchasers of institutional care (i.e. regional purchasing offices) and of personal and nursing care (i.e. health insurers) have limited financial incentives for the procurement of efficient care (i.e. good quality care at the lowest possible price). This is because regional purchasing offices are not at risk for the cost of institutional care, and health insurers are largely compensated by the risk equalization scheme for the cost of nursing and personal care.

A second efficiency problem is caused by the way co-payments of the three financing schemes are structured. Because these are not aligned, the cheapest way to obtain appropriate care for the user may not be the most efficient way to provide this care for society. Co-payments in the Long-Term Care Act are related to the user's income and wealth and may be up to a maximum of about €2300 per month for nursing home care for users with a high income. By contrast, there are no co-payments for

nursing and personal care. This makes these types of care financially more attractive for users and may encourage people to age-in-place rather than enter a nursing home. However, the lack of any incentive for cost-conscious use of nursing and personal may result in moral hazard. This incentive may be reinforced by the fact that the needs assessment for these services is no longer entrusted to an independent agency (as in the former AWBZ scheme) but to the providers themselves, who may also have incentives for overprovision if they are paid a fee-for-service. For social care and assistance, the new deductible introduced in 2019 may provide similar incentives: the deductible (€19 per month) is very low and means that the marginal cost of using an additional hour of care is zero for existing users. This may encourage people to age-in-place but may also result in moral hazard (Onstenk et al. 2019). The replacement of income-related co-payment by a small deductible in 2019 has resulted in a relatively strong growth of the use of municipal housekeeping assistance, particularly among middle- and high-income groups (De Koster 2019). Hence, the introduction of the deductible in 2019 may be at odds with the goals of increasing self-reliance and improving financial sustainability.

3 Price Setting

The process for price setting differs across the three schemes that pay for long-term care. Hence, this section will be divided into three subsections, one for each of the financing schemes: social long-term care insurance, social health insurance and the Social Support Act. In each of these subsections, we discuss how prices (and volume and quality) are determined through a combination of (i) administrative processes that set the boundaries for the negotiations and (ii) the negotiations between payers and providers.

3.1 Social long-term care insurance

The contracting of care providers is delegated by the national government to the regional purchasing offices. Three important boundaries limit the room for negotiations between the regional purchasing offices and providers. First, purchasing offices have to comply with a regional budget constraint set by the national government. Second, the Dutch Health Care Authority (NZa) sets maximum prices. Third, the purchasing offices and providers have only limited control over the total amount of care required within their region. In addition, the Dutch Health Care Institute puts legally binding requirements for the quality of nursing home care (ZIN 2017) into place. These requirements directly impact the price setting and delivery of nursing home care.

3.1.1 The regional budget

The national government sets a macro budget for all care financed through social long-term care insurance for the coming year based on forecasts by the NZa (NZa 2018c). These forecasts try to take wages and price changes, demographic changes, and policy changes into account. The macro budget is then divided across the regional purchasing offices. The allocation of funds across regions is based on historical grounds, although a model based on indicators of care demand is being developed. The regional purchasing offices are responsible for the procurement of care within their region. In doing so, they have to comply with the lump-sum regional budget set by the government. A part of the budget is specifically earmarked for quality improvements in nursing homes.

Because the regional purchasing offices are not allowed to exceed the assigned budget, unexpected budgetary setbacks (e.g. caused by additional volume growth) should be financed by adjustments within the region in which they occur. The financial risks of exceeding the budget thus lie in principal with the providers. However, there are two ways to increase the budget. First, the purchasing offices can redistribute funds from one region to another. Second, the national government can increase the macro budget during the year based on updates of the expenditure forecasts by the NZa. In the past few years, upward adjustments of the forecast have been a reason for the government to increase the macro-level budget. This has made the financing system somewhat open-ended in practice, shifting the financial risk of excess volume growth from the providers to the national government.

3.1.2 Maximum prices

The care an individual is entitled to is determined by his or her care profile, which is assigned by the independent assessment agency. For elderly care, there are 10 care profiles (see Table 2). These care profiles give a broad description of the health problems, limitations and the care category to which clients with that profile are legally entitled to. The exact type of care and the number of hours are not specified in detail. Care providers are required to make a care plan together with each client and are responsible for maintaining good quality care and provide enough hours of care.

Each year, the NZa sets maximum prices for each care package, which are based on the care profiles (NZa 2019c, 2019d). The maximum prices are shown in Table 2. As the care profiles do not describe the exact type and hours of care required, these prices are integrated: there is one (per diem) price for a care package that should cover all the care needed for a certain health profile. The maximum prices for each package are differentiated based on whether treatment is provided by the nursing home or outside a nursing home. Moreover, the NZa sets separate maximum prices for a substantial number of additional activities, including additional care for patients with

specific diseases, such as Huntington's, or additional services like transport. On top of the payment for care, the price of a care package contains payments for two types of capital: housing and inventory.

The maximum prices are based on empirical costing research on the actual costs related to each care package across providers (KPMG 2018). A survey among all providers delivering care financed by social long-term care insurance was conducted in 2017[11]. Based on this data, costs for each care package per provider were estimated. The care package-specific average price is used as the main input for the regulated maximum price. Depending on the statistical validity and plausibility of the estimates or policy changes that might impact costs, the maximum set by the NZa can deviate from the estimated prices (NZa 2018a). Empirical cost calculations are only conducted occasionally, but the NZa does update the regulated prices each year.

Table 2
Care packages, number of users, regulated maximum price.

Care package	Description	Users[a] (in-kind)	Users[a] (cash benefit)	Price per day in EUR[b]
1	Assisted living with some support	350[c]	0	100
2	Assisted living with support or personal care	1015[c]	0	128
3	Assisted living with intensive support and extensive nursing	2110[c]	0	183
4	Assisted living with intensive support and extensive nursing	26 445	2235	197
5	Nursing home care with extensive dementia care	60 290	5400	250
6	Nursing home care with extensive personal care and nursing	27 885	1750	251
7	Nursing home care with intensive care, with focus on supervision (often behavioural problems)	10 635	290	293
8	Nursing home care with intensive care, with focus on personal care / nursing (problems with ADL and cognitive)	2150	355	331
9b[d]	Rehabilitative treatment	825	55	300
10	Protected living and palliative care	255	25	354

Notes: [a] Number of users on reference date (2018, 2nd Friday of November). [b] Regulated maximum price for 2019. Prices for intramural care packages including day care and treatment. **Source:** NZA (2019c). [c] Access to care packages 1-3 was abolished in 2012; only cases prior to 2012 remain. [d] Rehabilitative treatment for individuals already living in a nursing home. Rehabilitative treatment for community dwelling elderly (ZZP 9a) was transferred to the social health insurance in 2013. **Source:** NZa (2019c).

11 In the end, data from 56% of all providers were used in the analysis (KPMG 2018).

There are two recently introduced exceptions to the idea that the NZa only sets maximum integrated prices. The first is an additional payout to compensate care providers in relatively expensive regions (for instance, because of high turnover in personnel in urban regions). To ensure a fair price compensation for these providers, the NZa sets a bandwidth: the negotiated price between the regional purchasing office and the provider for this component should stay between the minimum and maximum price set by the NZa.

The second is additional funding for quality improvements of nursing homes to fulfil the quality requirements introduced in 2017. Based on a cost impact assessment of the quality framework by the NZa, the macro-level budget for nursing home care was increased substantially (€2.1 billion per year, or about 10% of the total budget). In 2021, this extra budget will be added to the regular prices for care activities. Until then, the distribution of the quality budget is based on lump-sum funding. The regional purchasing offices have to distribute the quality funds across care providers. The providers are required to make a quality plan. The regional purchasing offices and providers then have to agree on the additional budget for quality improvements based on this plan, while the NZa ensures that the negotiated budgets stay within the macro-level budget. Although the regional purchasing offices and providers have considerable freedom on how to spend these funds, agreements and expectations at the national level are that 85% of these funds are spent on additional nursing staff.

3.1.3 The demand for care

Because eligibility for care is determined by the independent central assessment agency and not by the regional purchasing offices themselves, the purchasing offices have no influence on the overall amount of care demanded in their region. Because demand for care has increased relatively strongly during the last few years, the supply of care has become tight: between 2017 and 2019, the waiting list for nursing homes increased from 9000 to 18 000 people[12] (Ministry of Health, Welfare and Sport 2019d). The number of individuals that apply for eligibility for nursing home care may be affected by the availability and the quality of home care and social support. As these types of care are provided by health insurers and municipalities, the purchasing offices cannot directly influence the demand for care financed through the Long-Term Care Act through this channel either. Purchasing offices do try to cooperate and align care provision with health insurers and municipalities within their region, but they are, for example, not (yet) allowed to use financing through the Long-Term Care Act to pay for social support that may help elderly postpone a nursing home admission.

12 The majority of these persons (16 000 in 2019) are individuals for whom a place is available but who are waiting for a place at their preferred provider.

3.1.4 Contract negotiations

The regional purchasing offices negotiate the volumes and prices with each individual provider on an annual basis. The negotiated prices are generally lower than the maximum prices set by the NZa, in part so that the regional purchasing offices are able to adhere to the regional budget. The regional purchasing offices often apply the same rebate (a few percentage points) to the maximum prices to all providers. The regional purchasing offices have to comply with procurement rules regarding transparency and non-discrimination (VGN 2018), which might restrict their ability to negotiate different prices for each provider. In addition to negotiating prices, regional purchasing offices and providers negotiate budgets. One way such a negotiated agreement can look is as a fixed ex-ante budget (for instance, 90% of a provider's revenue), with a smaller flexible part based on the number of clients the nursing home is able to attract.

The contract also contains agreements on the quality of care. These agreements seem to be mostly enforced through the informal power of the purchasing offices, as they only have limited formal means to enforce quality agreements within the contracts. The information on the quality of the care that is provided by providers to the purchasing offices is limited. Purchasing offices use the report by the Health Care Inspectorate (who is responsible for enforcing basic levels of quality of care), client satisfaction data, data on employees' sick leave, and the quality of the administrative and management processes. In some instances, the purchasing offices carry out file examinations. The providers gather quality information themselves, but there is no uniform quality measurement system, making it difficult to compare this information across providers. Specific agreements are made for the budget that is earmarked for quality improvements.

3.1.5 Conclusion

The price setting and contracting of care in social long-term care insurance is based on shared responsibilities. The budget is set by the national government, which also bears the financial risk. The maximum prices are set by the NZa, and the eligibility for care is determined by the independent central assessment agency. Within these boundaries of regulated prices and a regulated budget, the regional purchasing offices are responsible for ensuring access to good quality care by contracting providers and containing costs by negotiating prices below the maximum and staying within the budget.

There are two main challenges. The first is ensuring the quality of care. A public debate about the quality of Dutch nursing homes has been ongoing for some years now. The additional, legally binding quality framework that has been put into place in 2017 (ZIN 2017) suggests that the limited requirements about quality of care in the care profiles and individual care plans are no longer considered to ensure that the quality of care is sufficient. To fulfil the additional requirements that

follow from this quality framework, substantial additional funds have been made available. Currently, these quality improvements are financed through a separate budget. In 2021, they will become an integral part of a new system to set the regulated prices being developed by the NZa. Policy efforts and funding are now mostly directed at increasing staffing ratios, but whether this will also result in improvements in other quality dimensions is unclear, in part because the ability of the regional purchasing offices to incentivize providers to increase the quality of care is limited by the lack of uniformly measured quality indicators.

The second challenge is to ensure enough supply of nursing home care for an ageing population. Waiting lists for nursing homes are increasing in all regions, and waiting times are particularly long for individuals who want to go to the nursing home of their first choice (e.g. a home in their own neighbourhood). These capacity constraints can decrease the incentives for providers to deliver good quality care, as they limit consumer choice. In light of the ageing of the population, both acquiring enough personnel and building enough nursing home beds is a challenge. Organizing price setting and the contracting of care such that they stimulate capacity growth, e.g. by facilitating the entrance of new providers, is an important challenge.

Apart from these two specific challenges, there seems to be a tension between the desire for a tailor-made approach to care, which means that decisions are delegated to the regional level or even the level of the individual provider and client, and a desire to control spending and quality of care at the national level, which means that the room for lower-level decision making is limited. One example of this tension is the new benchmark-based system to regulate prices that is currently being developed (Ministry of Health, Welfare and Sport 2019c). In this new system, which is planned for 2022, the regulated maximum prices of the care packages will be replaced by a specific bandwidth for each nursing home. This nursing-home specific bandwidth is based on a costing method that takes circumstances out of the control of the nursing home into account. The additional payments to nursing homes in relatively expensive regions are an example of this move towards price regulation at the level of the individual providers. The idea is that the bandwidth set by the NZa will be wide enough for the regional purchasing offices to still be able to engage in meaningful price negotiations with the providers, but how much room will be left for them to do so is still unclear.

3.2 Social health insurance

Nursing and personal care are covered by the social health insurance scheme. The contracting of care providers is delegated by the national government to competing risk-bearing health insurers. Three regulatory boundaries restrict the room for negotiations between the health insurers and providers: (i) health insurers and care providers have to comply

with an overall budget constraint set by the national government; (ii) prices are partly regulated by the Dutch Health Care Authority (NZa); and (iii) insurers have to reimburse part of the prices charged by non-contracted providers.

3.2.1 The overall budget constraint

Within the social health insurance scheme, health insurers are responsible for the procurement or reimbursement of nursing and personal care. To that end, health insurers conclude contracts with providers of care about the conditions of care delivery or reimburse (part of) the cost of non-contracted providers. The government sets an overall budget for nursing and personal care based on a national agreement with the representative associations of providers and insurers.

For the period 2019-2022, the agreed-upon growth of the overall budget has been 2.4% per year in real terms. Typically, health insurers and care providers take this overall growth limit into account when negotiating contracts. Still, this does not guarantee that total expenditures satisfy the ex-ante overall budget constraint. When total expenditures exceed the overall budget, the government will consult the representative stakeholders to investigate and discuss the reasons for the budget overrun. The government has the legal power (known as the "macro control instrument") to recoup the budget overrun by requiring providers to pay back a share of the excess expenditure in proportion to their market share.

3.2.2 Maximum prices and freely negotiable prices

Prices for nursing and personal care are set in two different ways.

Regulated maximum prices
First, regulated maximum prices for legally defined types of activities have been traditionally set by the NZa based on calculated average costs per activity (Table 3).

Table 3
Regulated maximum prices per hour (in EUR) for legally specified care activities in 2019.

Care activity	Regulated maximum price per hour (in EUR)
Personal care	55.56
Nursing	72.25
Personal care (on call 24 hours)	59.51
Nursing (on call 24 hours)	77.40
Specialized nursing	90.63
Advice, instruction and counseling	88.71

Source: NZa (2018a).

Since 2019, maximum prices have been based on a detailed cost analysis by PricewaterhouseCoopers (PwC 2017) using data from 2015 and 2016 of a representative sample of 80 home care organizations and 40 self-employed providers (together, these account for 51.8% of total spending on nursing and personal care)[13]. According to PwC (2017), 95% of the total number of hours of care activities consists of personal care (68%) and nursing care (27%). In consultation with the associations of care providers and health insurers, the cost calculation model developed by PwC was supplemented by the Dutch Healthcare Authority with several normative elements about skills mix, job rating, and productivity to safeguard sufficient quality of care (NZa 2018a, 2018b).

Health insurers and care providers negotiate prices for these activities up to the regulated maximum price. If they sign a contract, the negotiated prices are fully reimbursed by the insurer. If no contract is concluded, care providers may charge a price up to the regulated maximum level directly to consumers. Depending on the insurance contract between the health insurer and the consumer, health insurers then reimburse 70-100% of the average price paid to contracted providers.

Freely negotiable prices

Second, instead of paying regulated maximum prices or negotiating lower prices for legally defined types of activities, providers and insurers may also opt for negotiating a single integrated price for a bundle of agreed-upon activities. In this case, a contract between the provider and insurer is required. The option of integrated prices was introduced in 2016 as an experiment for a period of 5 years (i.e. until 2021).

Despite being officially still an experiment, insurer-provider negotiations about integrated prices for nursing and personal care have rapidly become the standard way of price setting. Since 2016, the share of contracted providers opting for integrated prices steadily increased to nearly 100% in 2019. Hence, the regulated price per type of activity is now only used by non-contracted providers, which in 2018 accounted for about 9% of public expenditures on nursing and personal care (Ministry of Health, Welfare and Sport 2019b). The experiment on integrated prices was recently evaluated by the Dutch Healthcare Authority (NZa 2019b). According to the evaluation, the main reason for the increasing popularity of integrated pricing was the substantial reduction of the administrative burden[14] and the larger room and stronger incentives for providing tailor-made care, innovation and prevention. Providers and insurers also mentioned a number of downsides: the providers and insurers commented on a lack of relevant

13 From 2002 to 2019, maximum prices were based on a detailed cost analysis that was performed in the year 2000. During this period, prices were annually adjusted for changes in personal, material and capital costs.

14 About half of the providers switched from a 5-minute registration of activities to only registering a "care plan" including the planned activities for the specific patient, from which the number of hours is derived (based on the supposition that realized activities are equal to planned activities, unless there are reasons why this is not likely to be the case). In 2020, all providers should be switched to this new way of registration (NZa 2019a).

information for about which specific care activities were performed, on incentives for underprovision and risk selection, and on less comprehensible prices for clients. Nevertheless, based on the overall positive assessment of the experiment, the Dutch Healthcare Authority recommended to retain the system of integrated pricing as the standard way of price setting for nursing and personal care (NZa 2019b).

Integrated prices are typically set per hour, although an increasing number of providers and insurers switched to monthly prices[15]. As shown in Table 4, in 2019, the average price per hour was about €54, but prices varied considerably across providers from about €46-84.

Table 4
Integrated prices for a bundle of care activities per hour in 2019.

	Average	Lowest	Highest
Negotiated price per hour (in EUR)	54.42	46.20	83.88

Source: NZa (2019a).

The substantial variation in prices can at least partly be explained by differences in the type and mix of activities performed by the provider. As shown in Table 5, almost all providers in the sample (97%) provide regular personal and nursing care, about two-thirds (64%) also provide nursing palliative care, about half (48%) provides specialized nursing care, 39% provides case management of dementia care, whereas (regional) coordination of unplannable care and complex wound care is typically provided by a minority of large home care organizations[16]. Other potential sources of price variation are differences in the type and mix of personnel and differences in productivity.

Large providers (i.e. with an annual turnover exceeding €10 million) charge substantially higher prices than smaller ones (NZa 2019a). This is presumably because they perform a broader range and more complex activities (e.g. providing unplannable acute care and complex wound care) to a group of patients with more severe and complex needs. Small providers often restrict themselves to a niche of less severe patients, but some small providers focus on very specialized care activities. Large providers may also be able to negotiate higher prices because of more market power. To date, however, empirical research is lacking about the sources of provider price variation.

15 In 2019, monthly prices were negotiated by 7 care providers with most health insurers (at an average price of €808), accounting for about 5% of total expenditures on nursing and personal care (NZa 2019b). However, the actual number of providers and insurers using monthly prices is likely to be considerably higher, since several providers agree upon a monthly price but are still paid on an hourly basis, while at the end of the month the difference between the amount that is billed and the fixed monthly price is compensated. Next to monthly prices, a small minority of integrated prices are set on daily or weekly basis.

16 On top of this, providers of elderly care may also provide home care to children and the handicapped.

Table 5
Overview of the type of activities included in the bundle of care activities with integrated provider prices, by percentage of a sample[a] of providers in 2019 for which this activity is included in the bundle.

Activity included in integrated price	# of providers	% of providers for which this activity is included in the bundle
Personal care	206	97
Nursing	205	97
Personal care on call	154	73
Nursing on call	150	71
Palliative nursing	135	64
Advice, instruction and counseling	115	54
Specialized nursing	101	48
Case management of dementia care	82	39
Regional availability for unplannable care	33	16
Other activities	23	11
Pay for performance	20	9
Coordination of complex wound care	13	6
Personal and nursing care for children (< 18 years)	13	6
Daycare nursing for intensive childcare	3	1
Residential care for intensive childcare	1	0
Total response to survey	212	100

[a] The sample includes 212 providers, which is about 10% of all providers of personal and nursing care.

Source: NZa (2019a).

3.2.3 Budget ceilings, renegotiations and waiting times

In most cases, health insurers and care providers do not only negotiate an integrated price (per hour, day, week or month) but also a budget ceiling (or expenditure cap) per provider. According to the Dutch Healthcare Authority (NZa 2019a), most insurer-provider contracts include a clause that providers have a "duty to deliver care" in case the budget ceiling has been reached, which delegates all responsibilities for limiting use and the financial risk from the health insurer to the provider. However, in practice this responsibility and this risk are shared: in 2018, about one-third of the providers who reached the budget ceiling during the year were able to renegotiate a higher budget during the year. Another 19% announced a temporary "patient stop" when reaching the budget ceiling (NZa 2019a), which means that the consumer or the health insurer has to find another provider (as the health insurer has a legal responsibility to ensure timely access to care)[17]. Despite these temporary patient stops, research shows that most people were able to receive care within reasonable time: in 2018 the average waiting time was 2.6 days after providers were notified that care is needed, and 37% of patients received care the same day as the notification (Meijer, van

17 In addition, 14% of providers announced a patient stop because of a shortage of personnel.

Plaggenhoef and Reitsma 2019)[18]. For only 1% of patients, waiting times exceeded 6 weeks, which is considered the maximum acceptable waiting time by the Dutch Healthcare Authority[19]. Due to the growing shortage of personnel and ageing of the population, however, timely access is expected to become under increasing pressure in the near future (Meijer, van Plaggenhoef and Reitsma 2019; NZa 2019a).

3.2.4 Non-contracted care

Care providers and insurers are not obliged to conclude a contract. Non-contracted providers directly charge consumers a price for their services. As explained in section 3.2.2, the maximum price they can charge for a specified set of activities is determined by the NZa. Health insurers may reimburse users for the full or part of the price. Legally, it is stipulated that in the case of incomplete reimbursement, this should not hinder people from consulting a non-contracted provider. Court decisions do not provide a clear-cut minimum level for the reimbursement of non-contracted providers, but in practice the minimum reimbursement level used by insurers is set at 70% of the average price paid to contracted providers (NZa 2019a).

A growing number of care providers does not have a contract with a health insurer, either because they do not agree with the contract conditions offered by the insurer, or because the insurer does not want to conclude a contract with the provider[20]. The share of non-contracted care in total public expenditure on nursing and personal care increased from 4.3% in 2016 to 9.0% in 2018 (Ministry of Health, Welfare and Sport 2019b). The increase in non-contracted care is primarily due to the unrestricted entry of new providers[21].

As mentioned above, if no contract is concluded, care providers may charge a price up to the regulated maximum level directly to the consumers. Since insurers often reimburse only 70-80% of non-contracted care, this may create financial barriers to the use of non-contracted care. Frequently, however, non-contracted providers do not require patients to pay the non-reimbursed part of the price. Instead, they claim reimbursement from insurers for substantially more hours per patient than contracted providers. In 2018, non-contracted providers offered on average 2.7 more hours per patient than contracted providers, despite their patients being younger and not having more chronic conditions (Ministry of Health Welfare and Sport 2019a). Although health insurers increasingly use preauthorization requirements to counteract excessive provision of care by non-contracted providers, the ratio of the average

18 There is regional variation in waiting times of 0.8 and 6.1 days. Health insurers offer waiting list mediation services, which are frequently used (Meijer, van Plaggenhoef and Reitsma 2019).

19 An exception is case management of dementia care, for which waiting times in several regions are substantial (NZa 2019a).

20 For instance, in 2016 the largest health insurer (Zilveren Kruis) started a pilot to grant contracts through a tendering process to only four preferred providers in the city of Utrecht.

21 Some insurers only contract new providers when their turnover exceeds a certain threshold (e.g. the largest health insurer requires a minimal annual turnover of €100 000).

number of hours of care per patient offered (or claimed) by non-contracted providers to the average for contracted providers increased from 1.9 in 2016 to 2.7 in 2018. To curb the growth in non-contracted care, the Ministry of Health is considering introducing a legal notification and licensing requirement for providers of nursing and personal care.

3.2.5 Quality and other performance targets

Both contracted and non-contracted providers have to comply with the legally required standards for quality and safety as specified by the Health Care Inspectorate (IGJ)[22]. In 2018 a quality framework for nursing and personal care was formally registered by the National Health Care Institute (ZIN 2018), which was developed by the associations of patients, providers and insurers. This framework describes the professional and organizational requirements for providers of nursing and personal care. In addition, about half of providers make specific contractual agreements about performance with the largest insurer in their region (NZa 2019a). Typically, these agreements are about realizing a certain (maximum) number of hours of care per patient and a certain level of average cost per patient in return for extra payment or a higher budget ceiling. In a recent evaluation of the provider-insurer contracts, the Dutch Healthcare Authority concluded that there are hardly any specific agreements about quality, innovation, or prevention (NZa 2019b). One reason for this is that health insurers do not gather data on these topics and do not possess a set of relevant, reliable and comparable quality indicators about nursing and personal care. In the recently adopted quality framework for nursing and personal care, however, providers and insurers have committed themselves to developing, measuring and implementing indicators for patient experiences[23] and other indicators for quality, which should be used to provide patients and insurers with relevant quality information and providers with relevant feedback information (ZIN 2018).

3.2.6 Towards case-mix adjusted monthly payments per patient

In its evaluation of the experiment with integrated prices, the Dutch Healthcare Authority argues that most of the insurer-provider contracts are based on integrated prices per hour, which provides incentives for overprovision and disincentives for prevention and adopting labor- and cost-saving innovations such as e-health (NZa 2019b). For this reason, the Dutch Healthcare Authority is in favor of integrated payments per month instead of per hour. In 2019 only seven care providers agreed upon an integrated monthly payment per patient with most health insurers, accounting for about 5% of total expenditures on nursing and personal care. Fixed monthly

22 In addition, contracted providers also need a legal licence to operate, which implies that they have to meet requirements about governance and financial administration, as specified in the Act on Admission of Health Care Providers.

23 In 2019, providers started to measure a Patient Reported Experience Measure (PREM) for nursing and personal care based on a standardized questionnaire among patients.

payments per patient offer incentives for prevention and cost-saving innovations. However, they may also provide incentives for underprovision and risk selection and may obscure which care activities are actually performed. Hence, the Dutch Healthcare Authority stipulates a number of preconditions – including appropriate case mix adjustment, transparent registration of activities and adequation patient information – that should be fulfilled before expanding the role of monthly payments per patient (NZa 2019b).

3.3 Social Support Act

3.3.1 Boundaries for contract negotiations

The Social Support Act states that the 355 Dutch municipalities are responsible for organizing and financing assistance that enables residents who live in the community to live independently and participate in society. To this end, municipalities contract providers[24]. There are two main sets of rules that set the boundaries for the negotiations about these contracts.

The first set is about the process of awarding contracts. As the value of these contracts usually exceeds the threshold set by the European Union (EU) above which EU regulation applies, the process through which the contracts are awarded needs to be public and transparent. The vast majority of the contracts are awarded either through public procurement or through a so-called open house procedure. Public procurement means that the municipality sets evaluation criteria and awards a pre-specified contract to the bidding organization or organizations who score highest on these criteria. The open house procedure means that the municipality sets criteria for reimbursement and that all providers who meet these criteria are reimbursed for the care that they provide[25]. These criteria may include, but are not limited to, criteria about the price and about meeting quality standards. Both public procurement and the open house procedure are governed by EU regulation.

The second set of rules governs how prices are determined. Municipalities are required to ensure that the price they pay is sufficiently high for providers to cover their costs (Rijksoverheid 2017). The national government has set rules that state the types of costs that municipalities need to account for when calculating the price. The types of costs that the municipality must include are at least: (i) the salary and related costs for the workers providing the care (including non-billable hours because of paid time off, illness, education, and work meetings), (ii) reasonable overhead costs, (iii) travel costs, (iv) training costs, (v) inflation, and (vi) costs for the provider resulting from requirements that the municipality sets for providers (e.g. about reporting and administration). These rules were set in 2017 as

24 Municipalities may choose to hire health care workers themselves to provide this care, but currently none of them does this (PPRC 2018).

25 In addition, some support services may be provided by organizations who receive subsidies for this. In 2018, this occurred for 4% of the services (PPRC 2018).

decreasing prices were causing concern about the quality of care, service disruptions and poor working conditions. The rules were set after consulting representatives of all stakeholders: municipalities, providers, labour unions and patients.

In addition to rules about the process of awarding contracts and about price setting, there are additional boundaries that have an influence on the contract negotiations. First, the Social Support Act requires that municipalities set rules to (i) determine which citizens are eligible for care[26] and (ii) how high the deductible is. Second, municipalities need to ensure that the quality of care that is provided is monitored in a transparent and independent manner (Health Care Inspectorate 2019). Unlike in the case of social long-term care insurance and social health insurance, there are no rules for providers about public reporting of quality measures. Third, while municipalities receive a block grant for financing social support and assistance (section 2), they may increase expenditures by re-allocating budget from other expenditure categories towards assistance and social support. In practice, however, changes in the block grant have a large effect on expenditures on these types of care (Kattenberg and Vermeulen 2018). This finding suggests that municipalities are generally reluctant to re-allocate money away from other expenditure categories to increase spending on assistance and social support.

3.3.2 Contract negotiations

From subsection 3.3.1, it follows that municipalities have freedom regarding the prices that they set and several other aspects of the contracts.

Regarding prices, municipalities may decide how they define the product that providers are being paid for. Most municipalities pay per hour of care that is delivered. In these cases, a very limited number of contracts contains a reimbursement cap (0-17% of the new contracts in 2018 and 2019, respectively; PPRC 2020), unlike in social health insurance, where such caps are very common when contracting providers.

Some municipalities choose alternative ways to remunerate providers. The most commonly used alternative is to define the desired results or intermediate results, e.g. that the house of the recipient of assistance is always clean (PPRC 2020). This may take the form of longer-term care trajectories. Contracts about these care trajectories may contain expectations about achieving certain outcomes at the end of the trajectory, e.g. about functional limitations or the ability of the care recipients to care for themselves, but achieving these targets is generally not rewarded financially (PPRC 2020). Two other alternative ways of defining the product are (i) care bundles, which mean that care recipients receive all types of assistance from the same provider in order to ensure the continuity of care and to

26 A recent court ruling limits the freedom that municipalities have when specifying the care that a person is eligible for. Specifically, it rules that decisions in which the aim of the care is specified without specifying the amount of care that someone should receive to achieve this goal are not providing patients with a sufficient level of safeguards against arbitrariness in the allocation of means (Ministry of Health 2019h).

limit transaction costs, and (ii) prospective payments, which mean that providers are being paid a fixed sum for providing all assistance that a specified subpopulation (e.g. by neighbourhood) is entitled to[27]. There are currently no studies that document the differences in outcomes between these ways of remunerating providers.

Moreover, municipalities have the freedom to decide how much weight they place on the quality of care versus other goals such as access or cost containment and how they define and measure the quality of care. Generally, the role of quality of care in price setting and contracting is limited. If quality plays any role, then this is usually limited to setting minimum criteria regarding the quality of inputs (e.g. the level of qualification of employees) or the process (e.g. by requiring ISO certification) when awarding the contracts (Berenschot 2019). Prices are generally not directly adjusted for quality[28].

Regarding other aspects of the contracts, municipalities have freedom regarding which services are contracted out. All municipalities contract out the delivery of care; some municipalities also outsource the eligibility assessments that determine which citizens are eligible for assistance. Alternatively, they do these assessments together with providers in multidisciplinary teams consisting of providers of assistance and civil servants (Van Eijkel 2018)[29].

Moreover, municipalities are free to decide whether to limit the number of providers or to contract all providers that are interested in providing care. It is unclear what the optimal number of providers is. On one hand, contracting many providers has the advantage that it may stimulate competition for clients. If quality is observed by care recipients, contracting many provides may mean that recipients can choose their provider based on quality and hence that providers have incentives to provide high-quality care (Van Eijkel 2018)[30]. On the other hand, a smaller number of providers might facilitate better relationships between the municipality and providers and hence discussions about longer-term goals such as cost reduction and improvements in the quality of care.

27 In addition, municipalities have the freedom to offer services as general provisions or as tailor-made services. The rules, such as awarding contracts and setting co-payments, are less strict in the former case, which means more room to manoeuvre for municipalities. However, general provisions are by definition available to all residents whereas tailor-made services are only provided to residents who are eligible for this specific service. This means that if municipalities offer a service as a general provision, they give up one important way to target services to those individuals who need them most and limit the demand for care.

28 Indirectly, higher quality of inputs, e.g. higher-educated staff, may influence prices, because higher-quality input may be more expensive, which means that the costs for the provider are higher. In turn, municipalities need to set prices such that providers may cover reasonable costs.

29 In some municipalities, a provider who is contracted by health insurers to provide personal care or nursing that is paid for through social health insurance is also part of such a team. Many elderly who require personal care and nursing paid for through social health insurance also need assistance paid through the Social Support Act. This means that these care recipients receive care from multiple long-term care providers (Van Eijkel 2018). In these cases, the full need for home care and support may be assessed at the same time.

30 The open house procedure rules out that municipalities engage in favouring some contracted providers over others. This includes steering care recipients towards providers who provide higher-quality care (Pianoo 2020).

Both public procurement and the open house procedure provide opportunities for municipalities to influence the number of providers, as in both cases municipalities may set standards that limit the number of providers that are able to meet these standards. Municipalities that use public procurement may also explicitly limit the number of providers that they contract. The open house procedure was used to award 90% of the contracts that municipalities had in 2018 (PPRC 2018). Whether public procurement or open house in practice achieves superior results is unclear, nor is there direct evidence regarding the relationship between the number of providers that is contracted and the choice between open house and public procurement[31,32]. While the process of awarding contracts through public procurement is administratively much more complex than the open house process, the administrative burden *after the contracts* have been awarded depends on the number of providers that is contracted.

3.3.3 Conclusion

The Social Support Act and other relevant legislation leave municipalities with ample freedom to determine how prices are set and providers are contracted. Most municipalities opt for an open house procedure, which means that all providers who meet some set of criteria may provide care and get reimbursed. In most cases, providers are paid per hour, although a minority of the municipalities opts for prospective payments or for partly tying payments to achieving outcomes or intermediate outcomes. Unlike contracts for nursing and personal care between health insurers and providers (section 3.2), municipalities usually do not cap total payments in these fee-for-service contracts.

These contracts mean that the incentives of providers are often not fully in line with the goals of municipalities: the contracts give providers incentives to deliver more services, which helps to ensure access but also increases expenditures. Moreover, since the deductible is low and not related to the amount of care that is used, potential care users do not have strong incentives for efficient care use either.

The contract design and the limited ability to increase revenues together mean that many municipalities face substantial financial risks. The risk that a municipality exceeds its budget is particularly important because the block grant from the national government is fixed and municipalities have very limited room to increase revenues.

31 In general, it is not known if there is a relationship between characteristics of the municipalities (e.g. with respect to their budget situation or population composition) and whether they choose public procurement or the open house procedure. However, municipalities that choose to pay providers through prospective payments must opt for public procurement.

32 KPMG (2020) states that in adolescent care, which is also organized and financed by municipalities, the number of providers is higher in municipalities that use the open house procedure, yet it does not reveal the magnitude of this difference.

Hence, the main way to limit this financial risk is to contain the expenditures, by either limiting prices or limiting the quantity of care that is provided. Municipalities have some room to set prices low, yet this room is limited by the requirement to ensure that the prices are sufficiently high such that providers can at least recover their production costs (Rijksoverheid 2017). Municipalities may keep the quantity of care in check in two ways. First, by tightening the criteria that determine which citizens are eligible for assistance. Second, if municipalities pay providers for achieving an intermediate outcome (e.g. a clean house) rather than per hour, municipalities may reduce spending by reducing the estimate of the number of hours that is used to calculate how much providers are being paid for this outcome[33].

Generally, it is unclear whether the system-level goals – access, high-quality care and efficient provision – are achieved for social support and assistance, because there is limited information on how municipalities spend the budget, on waiting lists, and on outcomes such as care-related quality of life of the care recipients and other dimensions of quality of care.

4 Conclusion

4.1 Key characteristics of the Dutch system

The Netherlands has a long tradition of public long-term care provision. The Dutch system is known for its broad access to a wide range of long-term care services, which not only includes good quality nursing home care, but also extensive home care and social assistance. At the same time, this long tradition has led to a complicated mix of three financing schemes. Within each of these three schemes the responsibilities and incentives for achieving the system goals are with different parties. The three financing schemes have different pricing schemes for the different types of long-term care.

A key characteristic of the Dutch system is the partial delegation of responsibilities: in the three financing schemes, the procurement of care and, to some extent, the financial risk, are delegated by the national government to regional purchasing offices, health insurers, and municipalities, while the budget for each type of care is determined at the national level. This delegation to the decentral level can enable tailor-made solutions that take personal and regional circumstances into account. At the same time, this delegation of responsibilities is only partial. In practice, a substantial share of the (perceived) political responsibility, decision-making power and financial risk remains centralized because the national government issues

33 In addition, municipalities may limit the information that is available to residents about the possibilities to apply for tailor-made care, or they may nudge people to apply for nursing and personal care covered by health insurers or to apply for nursing home care (see also chapter 2).

regulations that set important boundaries to what the contracting organization negotiates with providers. This partial delegation results in a system where no single party bears sole responsibility for ensuring that the goals of the health and long-term care systems are achieved.

4.2 Best practices

Across the three main financing schemes we have discussed, two common best practices can be identified. First, care is highly accessible, and the distribution is equitable. Second, integrated prices, which play a role in all schemes, give room to providers to tailor care to the specific needs of a patient.

Equitable access

Equitable access to care is supported by separating the price setting and contracting from eligibility decisions and from the way co-payments are set. The social long-term care insurance is the strongest example of a completely separated eligibility decision: the entitlement to care is based on national rules, and eligibility is determined by an independent assessment agency. Hence, although the regional purchasing offices are bound to a budget and negotiate on volumes with providers, this should not affect the access to care for individuals. In the Social Support Act, the eligibility decision is made by the municipality and not by the providers. The requirement for municipalities to specify eligibility rules and regulate the assessment procedure means that access is likely to be equitable within each municipality. However, municipalities may set different eligibility rules, for reasons such as different political preferences and different budget constraints, and hence there may be differences in access between municipalities. In social health insurance, eligibility decisions and contracting are less separated, as providers are responsible for determining eligibility and their contracts with the health insurers tend to include volume caps. In practice, however, access to nursing and personal care is not an issue, possibly in part because of the lack of incentives and ability of the health insurers to actually control volume that we describe below. Moreover, volume caps are set at the provider level rather than on the patient level, which leaves providers with enough room to tailor the amount of care to patients' needs[34].

In all three schemes, co-payments are determined at the national level and are considerably lower than the real price of care. This way, low-income people are protected against the financial risk of substantial out-of-pocket costs and are ensured access to care. For nursing home care co-payments are income-related, for nursing and personal care, co-payments are zero, and for social assistance, the deductible is very low (€19 per month).

34 Although volume caps can also induce risk-selection, there is no evidence that this happens in practice.

Integrated pricing

Integrated pricing plays an important and increasing role in the price setting of long-term care in the Netherlands. Instead of specifying and pricing the exact hours and types of care that must be provided, one price is set for an integrated, broadly defined package of care that suits a particular type of patient. Integrated pricing can reduce the administrative burden for providers and gives more room for providing tailor-made care. However, without appropriate risk adjustment and appropriate publicly available information about the quality of care providers, integrated pricing may also incentivize providers to engage in risk selection, underprovision of care and quality skimping (NZa 2019b).

The price setting in social long-term care insurance is almost fully based on integrated pricing. The eligibility is based on care profiles that describe the nature of the health problems and the type of limitations, clients with certain health profile, and the type of care needed (e.g. around the clock supervision and intensive nursing). Maximum prices for the care packages are set at the national level, and providers and regional purchasing offices negotiate the actual price. These integrated prices seem to function well and are generally accepted. However, the fact that new requirements about the quality of nursing home care have been introduced in 2017 (along with additional, earmarked funding to fulfil these requirements) seems to indicate that the integrated pricing mechanism, which leaves major decisions regarding the allocation of the care budget to nursing homes, did not lead to the quality of care that was desired by the general public. Moreover, these integrated prices might be less suitable to stimulate investments in more capacity or the entrance of new providers.

Integrated pricing has also been introduced for nursing and personal care activities. These prices can be freely negotiated between health insurers and care providers. In most cases negotiated prices are set per hour, providing incentives for overprovision of care. However, several large providers and insurers have concluded monthly prices, which provide incentives for prevention, efficiency and innovation. Providers and insurers report that monthly prices are often accompanied with specific agreements about improving quality and innovation, and professionals report having more room for providing tailor-made care resulting in higher job satisfaction (NZa 2019b). For social support and assistance funded through the Social Support Act, integrated pricing is used by a minority of municipalities and may take the form of paying providers for achieving a pre-defined result or intermediate result.

4.3 Challenges

Based on our analysis, we identify three challenges: the coordination and sharing of responsibilities *within* each financing scheme, the coordination of care provision *across* the three financing schemes, and the use of pricing and contracting to improve quality, efficiency, innovation and prevention.

Appropriate incentives and tools for procurement of care within each financing scheme

In each financing scheme, the partial delegation of responsibilities from the national government to other entities has led to a situation in which not all parties have the right incentives to achieve the system-level policy goals of good access, high quality and efficiency. This is at least partly because decisions about pricing and overall budget constraints are often not made by the party that bears the financial risks.

In social long-term care insurance, regional purchasing offices are responsible for distributing the budget set by the national government by negotiating prices and volumes of care with providers. The purchasing offices are not allowed to spend more than the budget, but since they do not face any financial risk, they also have little incentive to spend less. In theory, the financial risk lies with the providers, who would be faced with budget cuts by the purchasing offices in order to stay within the budget. In practice, however, the macro-level budget has been adjusted upwards by the national government during the year whenever this was needed, essentially making the system become open-ended and shifting the financial risk from providers to the national government. Further, the negotiating room for the purchasing offices might be limited because of the fixed maximum prices and by the fact that they have no direct impact on the volume of care required.

Like regional purchasing offices in social long-term care insurance, health insurers have limited incentives for the procurement of efficient nursing and personal care (i.e. good quality care at the lowest possible price), because higher prior individual expenditures for nursing and personal care automatically result in higher risk-adjusted capitation payments in the next year. Hence, the way risk-adjusted capitation payments are calculated should be improved. However, improving the risk equalization method is far from easy, because there are no individual-level data on characteristics that can accurately predict someone's expenditures on nursing and personal care. Providing appropriate incentives for insurers to purchase efficient care is therefore a major challenge. In addition, health insurers have no instruments to counteract the provision of inefficient care by non-contracted providers (9% of all expenditures), because they are legally obliged to reimburse at least 70% of the prices charged by these providers. Municipalities are responsible for providing adequate social support and assistance and bear the financial risk for this. Their ability to contain the costs of care is in practice limited by national-level requirements on the level

of care that needs to be provided and by the nationally determined maximum on co-payments, which limits their potential effect on demand-side moral hazard. Moreover, their space to set prices is limited by recently introduced requirements that stipulate that prices should be set such that providers may recover their costs.

Lack of incentives and tools to coordinate care across financing schemes

The payers and providers in each of the three financing schemes of the long-term care system lack incentives to ensure that patients receive appropriate care in the appropriate setting, because each of the providers and payers is responsible for allocating only a subset of services. An optimal allocation is further hampered by the fact that incentives for patients (co-payments) are not set such that they choose the type and the amount of care that is optimal for them. This lack of coordination is most pressing for those elderly who are about to move from home (while receiving home care) to a nursing home: these individuals can face important changes in the amount of care they receive and how much they pay for it themselves. Also, the lack of coordination seems to hamper the ability to provide temporary institutional care for individuals who still live at home and the ability to provide and build residential care settings, because it is unclear through which financing scheme these types of care that are in between home care and nursing home care would have to be financed.

At the local level, several initiatives have been employed to streamline the provision of care within neighbourhoods. Some municipalities form neighbourhood teams, consisting of professionals financed through the Social Assistance Act as well as by social health insurance (e.g. nurses, GPs). At the national level, an effort is being made to enable the regional purchasing offices to use some of the budget for nursing home care to cooperate with health insurers and municipalities to stimulate living longer at home (Ministry of Health, Welfare and Sport 2019e).

Paying for quality and efficiency

Contracting of providers, including price setting, is currently mainly used as an instrument to ensure universal access to long-term care, which is one of the goals of the Dutch health care system was achieved. However, the contracting is currently used to a lesser extent to work towards achieving the two other health care system goals: efficiency and high-quality care. Instead, the national government aims to achieve the goal of high-quality care through a fully separate set of policy measures.

Quality of care and related outcomes currently do not play a role in contracting and paying for long-term care: while integrated prices are used in each of the three schemes, there are only a few cases in which payments are explicitly tied to achieving pre-defined outcomes such as care-related quality of life or preventing nursing home admissions or hospitalizations.

Until very recently, neither the regional purchasing offices nor the health insurers or the municipalities made efforts to collect good and uniform information on the quality of care and related outcomes. This may be due to the intrinsic difficulty to define good quality of long-term care and disagreement about the value of each of the dimensions of quality of care. However, in 2017 (nursing home care) and 2018 (nursing and personal care), the government and associations of patients, providers and insurers agreed upon the development and implementation of quality indicators based on patient reports and other quality measures. This information would help to not only understand if the policy goals of high-quality care and efficiency are currently achieved, but also to enable payers to use the contract negotiations as an instrument to incentivize providers to work towards achieving these goals.

To incentivize providers to provide high-quality care in an efficient way, payers do not only need information on outcomes, however. In addition, several other preconditions must be met, such as appropriate case-mix correction (or risk adjustment), an appropriate registration of activities, and an appropriate communication to users of care to prevent providers from engaging in risk selection, underprovision of care and quality skimping (NZa 2019b). Only when these preconditions can be fulfilled may prices provide appropriate incentives for efficiency, prevention and innovation.

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Case study

Spain

Manuel Flores

Research Institute for Evaluation and Public Policies (IRAPP), Universitat Internacional de Catalunya

Barcelona, Spain

Abstract

The public long-term care system in Spain, known as System for Autonomy and Care for Dependency (*Sistema para la Autonomía y Atención a la Dependencia*, SAAD), was introduced in January 2007. The system is universal and financed mainly through taxes, with funds from the central and regional governments (Autonomous Communities, ACs), and to a lesser extent through co-payments. Long-term care is coordinated within the Territorial Council of the SAAD – a cooperation body where the central government, the ACs and the local governments are represented. Managing the SAAD is a responsibility of the ACs, which can decide whether to allocate funding to provide additional services.

Chronic underfunding of the system has been a major problem of the SAAD. The Great Recession hit Spain particularly hard in 2008, just after the implementation of the SAAD, causing important budget cuts. The subsequent benefit and coverage adjustments in the SAAD resulted in long waiting lists for those who had been formally recognized as dependants (and were thus eligible for such benefits). Budget constraints in public financing for long-term care benefits combined with the demand for care have resulted in low benefits in addition to low prices paid to providers; thereby ensuring quality of care is a challenge. Moreover, large discrepancies exist between the Spanish regions (ACs) in benefit generosity, coverage and co-payments.

Spain is ageing rapidly, second only to the Republic of Korea among OECD countries. It will rank among the oldest among OECD countries by 2050. In the long term, rapid population ageing will put more pressure on the financial sustainability of the public long-term care system and place pressure on adequate provision of care for older persons in Spain. Moreover, differences in population ageing across Spanish regions are striking. Under the current financing scheme, ageing will exacerbate the current inequalities in the provision of long-term care services and benefits among regions in Spain.

The Spanish public long-term care system has taken significant steps in providing coverage and care for the recipient population, but it faces important challenges. These include long waiting lists for those formally recognized as dependants; large inequalities among regions in the provision of long-term care services, benefits and co-payments; lack of transparency of the system; and insufficient funding and inadequate financing arrangements. These factors result in low prices paid to providers and possibly low quality long-term care services for recipients.

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Glossary and abbreviations

Term	Abbreviation	Definition
Autonomous Communities	ACs	The Spanish regions. There are 17 in Spain, and they correspond to the OECD's Territorial Level 2 administrative jurisdictions or the EU's NUTS 2.
Base for payment	-	The base or unit of activity on which prices are set. Common base for payments is FFS, diagnosis related groups, per diem, and capitation.
Capitation	-	A prospective fixed lump-sum payment per person enrolled for care with a provider within a given period (typically one year) covering a defined set of services, independent of whether the services are provided.
Co-payment	-	A fixed payment paid by an individual for health or long-term care services that is not covered by insurance, regardless of the kind of services provided.
Diagnosis Related Group	DRG	Payment paid to hospitals per admission or discharge, whereby patients are classified into groups (DRGs) based on diagnosis and procedures.
General State Administration (*Administración General del Estado*)	AGE	Refers to the Spanish central government.
Fee-for-service	FFS	A fixed payment for each unit of service without regard to outcomes. It is typically paid retrospectively by billing for each individual service or patient contact.
Global budget	-	A prospective lump-sum payment to a health care provider to cover aggregate costs over a specific period for a set of services independent of the actual volume provided.
Gross Domestic Product	GDP	The standard measure of the value added created through the production of goods and services in a country during a certain period. As such, it also measures the income earned from that production or the total amount spent on final goods and services (less imports).
Individual care program	-	Once an applicant is recognized as dependant, an individual care program is prepared by the AC's Social Services, which includes a list of appropriate services for the degree of dependency, as well as the corresponding entitlement to allowances. This program is established with the participation of the beneficiary through consultation and opinion seeking and, where applicable, with the beneficiary's family.
Institute for Older People and Social Services (*Instituto de Mayores y Servicios Sociales*)	IMSERSO	A public body of the Ministry of Social Affairs (since 2020, the Ministry of Social Rights and 2030 Agenda) that coordinates and manages the AGE's long-term care policies and programmes, amongst others.

Term	Abbreviation	Definition
Official State Gazette (*Boletín Oficial del Estado*)	BOE	It enables the central government to publish mandatory laws, regulations and other acts approved by the parliament.
Pay for performance	-	Payments to health care providers for meeting specific performance targets, such as process quality or efficiency measures, or penalties for poor outcomes, such as medical errors or avoidable readmissions.
Per diem	-	A fixed amount per day for inpatient stay, which may vary by department, patient, clinical characteristics, or other factors.
Public Income Indicator of Multiple Effects (*Indicador Público de Renta de Efectos Múltiples*)	IPREM	A reference index for social assistance benefits in Spain. Its monthly amount has been at €537.84 since 2017.
Spanish National Health System	NHS	The statutory quasi-universal health care system in Spain, which is mainly funded from taxes and where care is predominantly provided within the public sector. Provision is free of charge at the point of delivery, with the exception of outpatient prescriptions of pharmaceuticals and some ancillary goods.
Scale of Dependency (*Baremo de Valoración de Dependencia*)	BVD	A scale used for measuring limitations with various (instrumental) activities of daily living and for evaluating the degree of dependency that determines the eligibility for dependency benefits.
System for Autonomy and Care for Dependency (*Sistema para la Autonomía y Atención a la Dependencia*)	SAAD	The public long-term care system in Spain, which was introduced in January 2007 with the passage of the 39/2006 Act. The system is universal and financed mainly through taxes, with funds from the central government (AGE) and regional governments (ACs), and to a lesser extent, through co-payments.
Information System of the SAAD (*Sistema de Información del SAAD*)	SISAAD	A database where the ACs introduce information concerning the management of the SAAD in their territory. The central government is responsible for the SISAAD.
Territorial Council of the SAAD	-	A co-operation body where the AGE, ACs and local governments are represented and where long-term care is coordinated. Based on the recommendations from this Council, the AGE sets the basic legislation that is common to all ACs and serves as a framework for their own legislation.

Sources: Barber, Lorenzoni and Ong (2019), Bernal-Delgado et al. (2018), IMSERSO (2020), OECD (2019).

1
Overview

The public long-term care system in Spain, known as the System for Autonomy and Care for Dependency (*Sistema para la Autonomía y Atención a la Dependencia*, abbreviated as SAAD), was introduced in January 2007, with the promulgation of the 39/2006 Act (BOE 2006) or the "Dependency Act". The system is universal and financed mainly through taxes, with funds from the central and regional governments (Autonomous Communities; ACs), and to a lesser extent through co-payments (see section 3).

Prior to this Act, care for older persons was provided through the basic social services of the ACs and municipalities, and through specific programmes for people with disabilities. These services met the long-term care needs of the population only partially. It is estimated that just about 12% of elderly dependants received any kind of publicly financed support in 2000 (compared to about 72%-80% today, depending on whether applicants on wait lists are included or not; see below). The role of the public sector was secondary, provided only in cases where informal care was not possible or insufficient and the level of support linked to the economic capacity of the recipient. Furthermore, as responsibilities for social services were decentralized to the ACs and municipalities, geographical differences widened (European Commission 2019).

The purpose of the Act was twofold. First, to promote personal autonomy and ensure sufficient attention and protection of *all* dependants in Spain through adequate collaboration of all public administration levels. Second, to reduce the burden of family members who were primary (informal) caregivers and to formalize the employment status of these non-professional carers, most of whom are women.[1] Informal carers received special pension rights, and their contributions to Social Security were financed by the State's General Budget.

The initial demand for care was overwhelming, but most needs were covered with the different cash and in-kind benefits that were included in the SAAD (see section 2). By early 2012, close to 1 million applications were accepted (70% of the assessed applications). However, about half of the benefits granted were cash benefits for informal care (Territorial Council of SAAD 2012), which were intended to be used under special circumstances only (see section 2). The SAAD thus rather unexpectedly consolidated informal care. Attempts have been made to reverse this situation in recent years by promoting the use of service benefits over cash benefits for informal care (see section 5).

Chronic underfunding of the system has been a major problem of the SAAD. The Great Recession hit Spain particularly hard in

1 By the end of January 2020, close to 90% of these non-professional carers were women (IMSERSO 2020a).

2008, just after the implementation of the SAAD, resulting in important budget cuts. In 2012, the central government - in agreement with the regional governments (ACs) - introduced adjustments to the SAAD to meet public deficit objectives. For instance, the inclusion of people with moderate levels of dependency (Degree I) was postponed until July 2015. In addition, the ceiling of financial benefits for dependants and informal carers were reduced, and co-payments were increased (BOE 2012a).

These benefit and coverage adjustments resulted in long waiting lists for those who had been formally recognized as dependants (and were thus eligible for such benefits). By mid-2013, the benefit coverage for dependants was reduced to 63%. Effective coverage has remained low. According to official SAAD statistics, by the end of 2016, just 71% of the 1.23 million dependants entitled to benefits were actually receiving them (IMSERSO 2017a). Public expenditures on long-term care increased with the introduction of the SAAD from 0.5% of GDP in 2005 to 0.7% in 2007 and have stayed constant since then (OECD 2020a).

Budget constraints in public financing for long-term care benefits combined with the demand for care have resulted in low levels of benefits and low prices paid to providers, undermining the provision of high-quality care (see section 8). Moreover, large discrepancies exist among the Spanish regions (ACs) in benefit generosity, coverage and co-payments.

Spain is ageing rapidly, second only to the Republic of Korea among OECD countries. By 2050, Spain will rank among the oldest countries in OECD. For instance, the share of people 80 years or older is projected to more than double by 2050 to 9.5% of the total population on average in comparison with 16% in Japan and Spain (OECD 2017). Approximately 75% of the total applications received by the SAAD come from individuals aged 65 and older; nearly one out of four applicants are high dependant (Degree III); and over half of the beneficiaries in SAAD (54%) are 80 years or older (IMSERSO 2020b).

In the long term, rapid population ageing will put more pressure on the financial sustainability of the public long-term care system and further challenge the adequate provision of care for older persons in Spain. The projected public expenditure on long-term care as a percentage of GDP is steadily increasing in Spain and approaching to the EU average. It is projected to increase 1.4 times as much as the EU average, to about 2.2% by 2070 (European Commission 2018).

Differences in population ageing across Spanish regions are striking. For instance, in 2014 the percentage-point difference between Territorial Level 3 (TL3) regions with the lowest and highest shares of people 65 years and older across all OECD countries was widest in Spain, ranging from 9% in the region of

Fuerteventura to 30% in Ourense (Figure 6.2 in OECD (2017))[2]. Older regions have a lower potential for economic growth in the long run. Under the current financing scheme (see section 3), this will tend to exacerbate the current inequalities in the provision of long-term care services and benefits among regions in Spain.

The Spanish public long-term care system has taken significant steps in providing coverage and care for the dependent population, but it faces important challenges. These include long waiting lists for those formally recognized as dependants; large inequalities among regions in the provision of long-term care services, benefits and co-payments; low transparency of the system; and insufficient funding and inadequate financing arrangements, resulting in low prices paid to providers and possibly low quality long-term care services for dependants.

2
Providers of care for older persons

2.1 Definition, scope and components

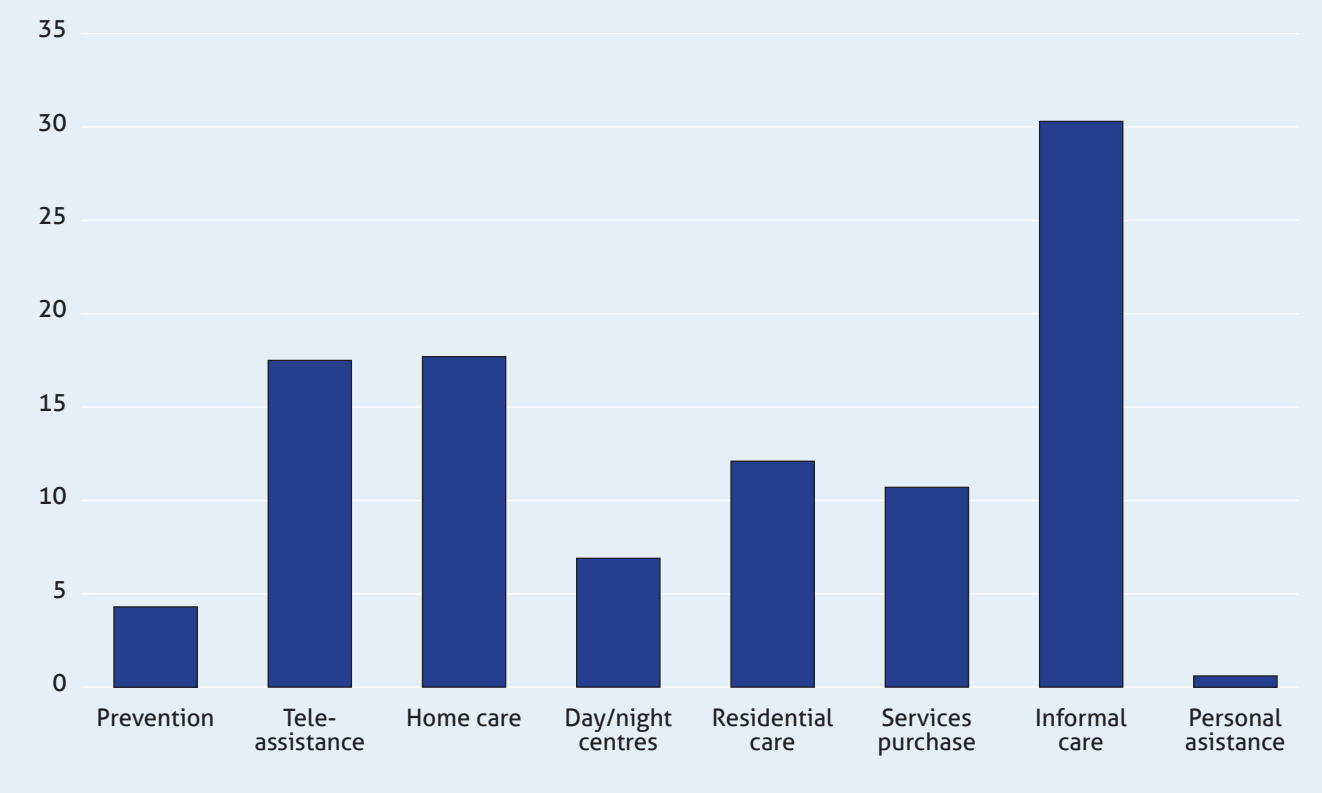
Long-term care in Spain is provided mainly within the SAAD. According to SAAD statistics, in December 2019 there were 1.9 million applicants to SAAD benefits. Close to 92% of them (1.74 million) had been examined, and 80% (1.39 million) of those examined were eligible for benefits from the SAAD based on their degree of dependency. In particular, 23% were recognized as high dependants (Degree III), 30% as severe dependants (Degree II) and 27% as moderate dependants (Degree I) (see section 3 for a definition of the degrees of dependency). However, only 1.12 million were receiving benefits. The remaining 0.27 million (20%) were on a waiting list (IMSERSO 2020b).

The SAAD includes different type of services and financial benefits. The service benefits include prevention, tele-assistance, home care, day/night centres and residential care. There are cash benefits for informal care, personal assistance, and an allowance linked to the purchase of services (see later in this section for more details). Figure 1 shows the distribution of these benefits in the SAAD by 31 December 2019. Three out of 10 benefits in SAAD are cash benefits for informal care, which continues to be the most widely used benefit. Next in order of importance are two service benefits, tele-assistance and home care, each with a share close to 18% of all benefits. Residential care and cash benefits for the purchase of services are also important, with a share of 12% and 11%, respectively. Less than one in 10 benefits correspond to day/night centre services (7%). Prevention services and cash benefits for

2 TL3 are small regions. The OECD divides subnational regions in its 35 member countries into two territorial levels that match administrative jurisdictions. Territorial Level 2 (TL2) denotes the upper administrative tier of subnational government, and Territorial Level 3 (TL3) the lower tier. Across the OECD, there are 391 large TL2 regions, which contain 2197 TL3 (or small) regions.

personal assistance are the least used, with a share of 4% and 1% of all benefits, respectively.

Figure 1
Distribution of service and financial benefits in the SAAD by 31 December 2019 (in %)



Source: Author's elaboration based on IMSERSO (2020b).

Services in the SAAD are provided through its own network (the "SAAD network"). Providers from this network must be accredited by the regions (ACs). The central government, by means of the Territorial Council of the SAAD (described in section 3), sets state-wide criteria with respect to staff qualifications, minimum care worker per beneficiary ratios, and requirements of material resources, equipment and documentation (BOE 2012a). The SAAD network includes public centres and services in the ACs and municipalities, as well as national reference centres for the "promotion of personal autonomy and care for dependent persons" and accredited private partner centres. ACs have total freedom to set up this network of providers where non-governmental organizations and not-for-profit institutions are considered priority partners compared with for-profit providers (Bernal-Delgado et al. 2018).

The provision and minimum content of services in the SAAD is regulated by law. For instance, some services have stipulated the minimum intensity for each of the three degrees of dependency (BOE 2012a, 2013, 2015). Priority in access to services is determined by the applicant's degree of dependency and economic capacity. Services are co-paid according to the type of service required and the ability to pay (see section 3). The numbers of coverage for tele-assistance,

home care, residential care centres and day care centres (which are the main long-term care services in the SAAD, see Figure 1) refer to users of social services 65 years and older in Spain. It is important to note that not all of these users are included in the SAAD[3].

- **Tele-assistance:**
  The main goal is to provide safety and support to dependants to promote their autonomy and facilitate their stay in their home environment. For instance, the technical equipment allows the user to press an emergency alert to contact a service centre, which enables an emergency response to situations such as falls.

  This service has the highest number of users. By 31 December 2019 there were 937 990 users 65 years and older, which implies a coverage rate of 10.2% (IMSERSO 2020c)[4]. This coverage rate varies substantially across regions, from 1.0% in Extremadura to 15.6% in Andalucía, but has been steadily increasing since the early 2000s. For instance, the coverage rate was 4.4% in 2006, just before the introduction of the SAAD in Spain.

- **Home care:**
  Home care comprises personal (health) care and assistance (social) services. The intensity of home care varies with the beneficiary's degree of dependence from up to 20 hours/month for those with moderate dependence (Degree I) to 21-45 hours/month for those with severe dependence (Degree II) and up to 46-70 hours/month for those with high dependence (Degree III). The intensity of care and the amount of hours devoted to personal care and assistance services is determined within the beneficiary's individual care program by the ACs based on a dependency assessment. Assistance services are normally provided along with personal care services. The provision of these services separately needs to be justified in the individual care program (BOE 2013).

  By 31 December 2019, there were 454 068 users aged 65+ in Spain, which implies a coverage rate of 4.9% (IMSERSO 2020c). This coverage rate increased steadily during the 2000s, reaching a maximum of almost 5.0% in 2009, decreased afterwards until 3.6% in 2014, but has recovered since then. As for tele-assistance, the coverage rate varies substantially across regions from about 1.7% in Murcia and País Vasco to 9.3% in Madrid[5].

  In addition to coverage, the quality of the service matters. In terms of hours of care by the user, on average, 20.6 hours

3 The data are taken from IMSERSO (2020c), the latest annual report of the Institute for Older People and Social Services (*Instituto de Mayores y Servicios Sociales*), which is a public body of the new the Ministry of Social Rights and 2030 Agenda; formerly the Ministry of Social Affairs.

4 The coverage rate is defined as: (number of users aged 65+ / population aged 65+) x 100.

5 For País Vasco, however, this coverage is inaccurate, as it assumes zero users in one of its three provinces for which there is no information available (see IMSERSO 2020c).

per month are provided, of which 64% are devoted to personal care services, 34% to assistance services and the remaining 2% to other duties. Across regions, the intensity of hours of care is highest in Galicia, with 39.0 monthly hours per user.

- **Residential care centres:**
  These services are provided only for severe and high dependants with Degrees II and III, respectively (BOE 2013). Residential care centres offer comprehensive and continuous personal, social and health care, adapted to the beneficiary's type and degree of dependence, on a temporary or permanent basis. The intensity of these services is specified in the dependant's individual care program. Institutional long-term care service providers include regional and municipal centres, as well as private accredited sector institutions.

  As of 31 December 2019, there was a supply of 389 031 places distributed along 5542 residential care centres, which implies a coverage rate of 4.2% (IMSERSO 2020c)[6]. This coverage rate was above 5% in six ACs, with the highest value corresponding to Castilla y León (7.8%) and the lowest one to Murcia (2.3%).

  The majority of offered places by December 2019 were publicly funded (62%), but a large majority of centres were private (74%). In 2001, the share of private centres was even larger (86%) and that of publicly financed places was substantially smaller (26%). There has been a large increase in the supply of places, in particular of publicly funded ones. 155 723 new places were created between 2001 and 2015, of which 116 941 corresponded to publicly funded ones (IMSERSO 2017b). The coverage rate increased from 3.1% in 2001 to 4.6% in 2010, decreased then slightly to 4.3% in 2014 and has remained stable since[7].

- **Day care centres:**
  Day care centres offer full- or part-time psychosocial support during the daytime to elderly dependants. These services are meant to improve or maintain the best possible level of personal autonomy of the dependants and to provide support to their families or caregivers. They are adjusted to the specific needs of the dependants, and their intensity is specified in the dependant's individual care program. However, for moderate dependants (Degree I), the intensity of day-centre services is set at a minimum of 15 hours per week (BOE 2013).

  As of 31 December 2019, there was a supply of 99 163 places distributed along 3674 centres, which implies a

6 The coverage rate is defined as: (number of places / population aged 65+) x 100.

7 This is consistent with data from OECD (2020b) on the number of beds in residential long-term care facilities per 1000 people aged 65 and over. These numbers show that in Spain this ratio declined from 47 in 2011 to 44 in 2017, remaining just above the OECD average, which was 43 in 2017, but well below that of countries such as France (51) and Germany (54).

coverage rate of 1.1% (IMSERSO 2020c)[8]. This coverage rate varies substantially across regions, from 0.6% in Aragón to 2.8% in Extremadura.

By December 2019, the majority of offered places were publicly funded (60%), but the majority of centres were private (57%). In 2001, the share of private centres was larger (65%) and that of publicly financed places was smaller (55%). There has been a large increase in the supply of places, in particular of publicly funded ones. 71 758 new places in day care centres were created between 2001 and 2015 in Spain, which corresponds to an average of 5126 new places per year (IMSERSO 2017b). As a result, the coverage rate has been steadily increasing since the early 2000s (it was, for instance, 0.3% in 2001 and 0.7% in 2006).

- **Night care centres:**
  Night care centres are intended to support dependants in need of care during the night. As for day care, these services are meant to improve or maintain the best possible level of personal autonomy of the dependants and to provide support to the dependants' families or caregivers. They are adjusted to the specific needs of the dependants and their intensity is specified in the dependant's individual care program.

- **Promotion of personal autonomy:**
  This service is aimed at promoting and maintaining the dependant's personal capacity. Its intensity in terms of hours per month is set at a minimum of 12 for moderate and severe dependants (Degrees I and II) and at a minimum of 8 for high dependants (Degree III). This service includes, amongst others, the following sub-types whose minimum hours of care per month are also stipulated by law and indicated in brackets: early attention (6 for Degrees I, II and III), and promotion, maintenance and recovery of functional autonomy (15 for Degree I, 12 for Degree II, and 8 for Degree III) (BOE 2013, 2015).

- **Prevention of dependency:**
  This service includes different programs to prevent situations of dependency or to avoid a worsening in dependency status. It is offered to all dependants, but it is a priority service for those with moderate dependency levels (Degree I). Prevention services are included in tele-assistance, home care, day care centres and residential care (BOEs 2013).

8 The coverage rate is defined as: (number of places / population aged 65+) x 100.

Hospitals also provide care for older persons. In particular, long-term care can take the form of inpatient care in dedicated long-term hospital beds, in addition to services provided in the SAAD, as discussed above. The Spanish National Health System (NHS) has 10 899 long-term care beds that represent 9% of public beds and 77% of long-term care beds in the country, according to 2014 data. Additionally, private hospitals (usually not-for-profit) hold 3102 beds that might be used to complement public supply. Typically, hospital long-term beds cover palliative care needs, either in chronic patients or patients with cancer (MSSSI 2014).

Skilled nursing facilities offer intermediate socio-health care to patients that are transitioning from an episode of acute hospitalization to their homes or residence. These patients are characterized by a medical and social dependence and, importantly, by a possibility of functional recovery. Older persons are the main recipients of this type of care, which is typically provided in medium- and long-term beds. The average stay care ranges between 2 and 6 weeks (IDIS 2016). This type of care releases resources from acute hospitals, generating savings to the overall health care system.

There were 14 884 medium- and long-term beds in Spain in 2014[9], resulting in a coverage rate of 0.32 beds per 1000 inhabitants. Between regions, this coverage rate varied from 0.02-0.03 in Andalucía and Galicia to 1.11 in Catalunya[10]. The majority of beds were privately funded (60%) and about equally distributed along for-profit and not-for-profit places.

Primary care provides preventive services to elderly patients and other population groups. It is mainly delivered by public health care centres within the statutory NHS with specialized family doctors and staff nurses. Care for older people includes programmes for early detection of frailty, as well as follow up of terminally ill patients. This latter service is provided in close coordination with other specialized services. Moreover, as an effort to increase care continuity and coordination between primary and secondary health care levels, some ACs are enhancing the role of primary health care in the implementation of case-management programmes meant to deal with more fragile patients (Bernal-Delgado et al. 2018).

No specific care programmes for older persons were found in outpatient care in the Spanish NHS.

Besides service benefits, the SAAD includes financial benefits based on the beneficiary's degree of dependency and economic capacity, which are discussed here for completeness (BOE, 2012a, 2013). These are mainly linked to supporting the provision of services outside the SAAD network. Three types of allowances are available:

9 This number is obtained from *Catálogo Nacional de Hospitales* 2014 (MSSSI 2014) by selecting centres that are classified within the categories of "Rehabilitation" and "Geriatrics and long stays" (see IDIS (2016) for more details).

10 Defining the coverage rate as the number of places per 1000 persons aged 65+ results in a similar ranking, with the highest value being 6.03 in Catalunya and the lowest ones being 0.11-0.13 in Andalucía and Galicia.

- **Financial benefits for care recipients to purchase services:**
  This allowance is meant for care recipients to purchase a service outside the SAAD network when no public or private partner centre is available. Benefit levels for new recipients from August 2012 range from €300 per month for degree I, to €426.12 per month for degree II and €715.07 per month for degree III. For those with an earlier recognised degree and level, they range from €400 per month for degree II, level 1, to €831 per month for degree III, level 2, in 2012 (sub-levels within each grade were eliminated in 2012; see section 3).

- **Financial benefits for care recipients receiving informal care:**
  This allowance is for care provision within the family when a relative is acting as the principal informal carer. It would only apply when the recipient is being cared for at home if physical and living conditions for care are met (see section 5 for more details). Benefit levels for new recipients from August 2012 range from €153 per month for degree I, to €268.79 per month for degree II and €387.64 per month for degree III. For those with an earlier assessed degree and level, they range from €255.77 per month for degree II, level 1, to €442.49 per month for degree III, level 2, in 2012.

- **Financial benefits for paid personal assistance:**
  This allowance is to support the hiring of professional services in order to promote the care recipient's personal autonomy, access to work and education, and help with activities of daily living (ADL). Hiring expenses for the carer must be documented and the carer needs to have appropriate professional qualifications (state certifications). Benefit levels for new recipients from August 2012 range from €300 per month for degree I, to €426.12 per month for degree II and €715.07 per month for degree III. For those with an earlier recognised degree and level, they range from €609 per month for degree III, level 1, to €812 per month for degree III, level 2, in 2012.

There are limitations to combining the different benefits covered by SAAD (BOE 2012a). Service benefits cannot be combined. The exception is tele-assistance, which can be combined with all service benefits apart from residential care or its equivalent financial benefit to get this service. The ACs can allow specific benefits for the promotion of personal autonomy and home care to be combined as long as their sum of hours of care is within the dependency degree-specific limit of maximum home care hours (BOE 2012b). The ACs can further establish the compatibility between service benefits for home care, day and night centres, and financial benefits for informal care and personal assistance (BOE 2013). Tele-assistance can be provided as a single benefit for moderate dependants only. For severe and high dependants, it has to be provided along with other benefits, except if the beneficiaries were receiving this service already in an earlier stage as moderate dependants (BOE 2018a). Finally, financial benefits cannot be combined or

with service benefits, except those for the prevention of dependency, promotion of personal autonomy and tele-assistance.

2.2 Link to Universal Health Coverage entitlements

Coverage in the statutory Spanish NHS is virtually universal, mainly funded from taxes, and care is predominantly provided within the public sector. Provision is free of charge at the point of delivery, with the exception of outpatient prescriptions of pharmaceuticals and some ancillary goods, where co-payment is set considering a maximum ceiling of monthly payment and fixed according to annual household income (Bernal-Delgado et al. 2018). Long-term care services in the form of inpatient care or primary care services for older persons (as discussed earlier in this section) are thus free of charge in the Spanish NHS.

Benefits from the SAAD are universal but means-tested for both service and financial benefits. While the central and regional government budgets cover most of the costs of the SAAD, co-payments have become increasingly important over the last years and equalled 18% of the total cost of the SAAD in 2018 (see section 3). Co-payment is progressive up to a maximum of 90% of the cost of service and financial benefits, depending on the beneficiary's economic capacity (and degree of dependency or cost of the service for some benefits). ACs can increase further these co-payments (see section 8).

3
Financing and systems issues

The system is funded through taxation and financed with resources from the central government and ACs. The central government allocates funds to each AC based on the number of dependants and their degree of disability and the proportion of service benefits over financial benefits for informal carers[11]. As explained below, the ACs can decide whether to allocate additional funding to provide additional services.

3.1 Care coordination

Long-term care is coordinated within the Territorial Council of the SAAD. This is a cooperation body where the central government, the ACs and the local governments are represented. By means of this council, the central government and the ACs agree on a framework for intergovernmental cooperation, the intensity of services, the terms and amounts of financial benefits, the criteria for co-payments by the beneficiaries, and the scale of dependency that is used for the recognition of dependency. Based on the recommendations from the Territorial Council, the AGE sets the basic legislation that is common to all ACs and serves as a framework for their own legislation. Local authorities take part in the Territorial Council of the SAAD and can also complement the set of benefits, mainly by financing community services. In practice, though, they play a subordinate role in the system (Rodríguez-Cabrero et al. 2018).

Managing the SAAD is a competence of the ACs. Long-term care services are fully operated by the ACs, which includes planning, accreditation, quality assurance, financing and pricing. The Spanish long-term care system is thus highly decentralized and is often considered a "system of regional long-term care services". Many differences in its application can be observed across the different ACs. For instance, whereas 2.4% of the population in Spain has been recognized a degree of dependency and receives a benefit from the SAAD, this share varies between ACs from 4.4% in Castilla y León, to about 3% in Castilla-La Mancha, País Vasco and Cantabria, 1.8% in Illes Balears and C. Valenciana, and only 1.1% in Canarias (IMSERSO 2020b).

11 The ratio of service benefits over financial benefits for informal care was introduced as an additional criterion for funding allocation in 2012 to promote the use of service benefits, as they have a higher potential than financial benefits for informal care for creating jobs and developing a "sector" of long-term care (see section 5).

3.2 Source of financing

Long-term care in Spain is financed mainly through taxes and, to a lesser extent, through co-payments and charges (BOE 2008a). Tax contributions are paid by the AGE and by the ACs.

There are three levels of protection in the SAAD. The basic level corresponds to a minimum level of care and is entirely financed by the AGE. The ACs receive funding from the AGE depending on 1) the number of dependants and their degree of disability, and 2) the proportion of service benefits over financial benefits for informal carers. The second criterion was introduced in 2012 to promote the use of service benefits with an initial weight of 10% in the AGE's funding allocation that was increased to 50% after five years. There is a guaranteed minimum level of protection per SAAD beneficiary that results from this basic level of protection which varies from €190.13 per month for high dependants (Degree III) to €84.49 per month for severe dependants (Degree II) and €47.38 per month for moderate dependants (Degree I) (BOE 2017). The agreed level tops up the basic level and is financed with matched contributions from the AGE and the ACs. This level takes into account factors such as the geographical dispersion of the dependants and the number of returned emigrants who return usually after retirement to their AC of origin and are therefore potential dependants. The additional level is entirely financed with additional and voluntary contribution from the ACs to provide additional protection.

In 2018, contributions from the ACs and AGE covered respectively 66% and 16% of the total cost of the dependency system in Spain, with co-payments covering the remaining 18% (see Table 1). There are, though, important differences across regions in these shares. For instance, the share of co-payments vary from 11% in the region of C. Valenciana to 22% in Madrid. The regions' contributions vary from 61% in Castilla y León to 74% in C. Valenciana. In addition, the AGE's budget contribution varies from 11% in Cantabria to 20% in Castilla y León, Extremadura and Galicia.

The total costs of the system per person 65 years and older (which is the main group of applicants to the SAAD; see section 1) were overall €926 with large differences between regions (€504 in Canarias and about €1300 in Cantabria and País Vasco). These regional differences do not seem to be related to differences in the shares of people aged 65+ (the correlation coefficient between columns (8) and (10) in Table 1 is low, 0.12), but to differences in the shares of beneficiaries (the correlation coefficient between columns (8) and (9) is high, 0.78). The total cost of the system by beneficiary was overall €7922, again with large regional disparities, ranging from about €6600 in Andalucía and Murcia to €10 404 in Cantabria.

Table 1
Total costs of the dependency system by regions (ACs) in Spain (in millions of euros, 2018, except the last two columns, which are in euros per person)

ACs	Total cost of SAAD	Total AGE	Total ACs	Co-payment	Total AGE (%)	Total ACs (%)	Co-payment (%)	Pop. aged 65+ (%)	Beneficiaries of SAAD (% of pop.)	Total cost of SAAD per person aged 65+	Total cost of SAAD per beneficiary
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Andalucía	1 403	246	870	286	18	62	20	17	2.5	982	6610
Aragón	207	36	139	32	17	67	15	22	2.2	726	7085
Asturias	173	29	116	28	17	67	16	25	2.1	665	7855
Baleares	124	23	84	18	18	68	14	16	1.5	668	7150
Canarias	177	29	119	29	16	67	16	16	1.0	504	8185
Cantabria	164	18	120	27	11	73	16	22	2.7	1300	10 404
Castilla y León	685	135	418	133	20	61	19	25	3.9	1134	7338
Castilla-La Mancha	499	69	332	98	14	67	20	19	2.9	1300	8626
Cataluña	1 430	189	968	274	13	68	19	19	2.0	998	9226
C.Valenciana	583	85	434	64	15	74	11	19	1.5	607	7845
Extremadura	210	42	131	37	20	62	18	20	2.7	959	7177
Galicia	454	91	281	82	20	62	18	25	2.2	673	7558
Madrid	1 201	172	760	269	14	63	22	18	2.2	1025	8474
Murcia	232	36	166	30	15	71	13	16	2.4	1000	6629
Navarra	100	15	72	13	15	72	13	20	2.1	786	7338
País Vasco	638	74	457	107	12	72	17	22	3.0	1307	9808
Rioja	72	10	47	14	14	66	20	21	2.6	1097	8889
Spain	8352	1298	5513	1542	16	66	18	19	2.3	926	7922

Source: Adapted from Jiménez-Martín and Viola (2019) and the Association of Directors and Managers in Social Services (*Asociación Estatal de Directoras y Gerentes en Servicios Sociales*, https://www.directoressociales.com/documentos/dictamenes-observatorio.html). Population (pop.) and beneficiaries of the SAAD correspond to 2018 numbers and are taken from Instituto Nacional de Estadística (www.ine.es) and Instituto de Mayores y Servicios Sociales (www.imserso.es), respectively. Numbers for the autonomous cities of Ceuta and Melilla are not provided.

3.3 Characteristics of purchasers and providers

The main purchaser (health insurer) is the AGE along with the ACs. Within the general scheme, regional health services contract hospital care, primary care, preventive activities and long-term services with public and private providers.

There is no mandatory insurance for long-term care in Spain (see section 3.2), and the private insurance market of long-term care is very limited. Private insurers focus on covering the gap between public reimbursements and actual fees, as well as providing access to additional services (complementary insurance).

For hospital care, in addition to public providers, a certain amount of activity is contracted out to private providers, typically aimed at reducing waiting lists for surgical procedures or high-technology diagnostic tests, but also to complement long-term care services and palliative care. Private hospitals, however, play a subsidiary role in the Spanish health care system, with some notable exceptions in the ACs of Catalunya, Madrid and C.Valenciana (Bernal-Delgado et al. 2018).

Providers of long-term care services can be public or private (for profit or not), but they need to be accredited. Dependants who are eligible for specific financial benefits (in particular, those linked to services purchased outside the SAAD network; see section 2) will be able to spend these benefits only on accredited centres and services. Accreditation is granted by the ACs, but the minimum state-wide requirements are determined by the AGE based on the recommendation from the Territorial Council of the SAAD. These basic requirements include regulations regarding quality of employment and staff qualifications, material resources, equipment and documentation. Institutional long-term care service providers are required to have minimum ratios of workers per care recipient and type of worker for carers and geriatricians (BOE 2012a).

Most of the institutional and day care providers are private. For instance, by December 2015, 57% of day care centres were private (section 2) even though they are publicly subsidized at 60% (European Commission 2016). The share of private institutional care providers is even larger, with only 24% of residences being publicly owned (although an additional 22% of residents in institutional care centres receive a public subsidy to be placed in a private centre). Providers often receive substantial public subsidies in order to make their service more affordable for care recipients (European Commission 2016). There are large regional disparities in the distribution of beds and services offered (section 2) as well as in term of their prices (section 9).

3.4 Criteria for eligibility to care: entitlement, means-testing, characteristics of the individual

Benefits from SAAD are universal for all Spanish nationals who have been residents in Spain for at least five years; residence is required for at least two years immediately before the claim is filed. Exemptions to this rule are in place for Spanish returnees (BOE 2013). The claimant needs to be a resident in the region of application.

Eligibility depends on an assessment of the degree of dependency, evaluated on the basis of the Scale of Dependency (*Baremo de Valoración de Dependencia*) (BOE 2011). The scale measures limitations with various ADL related to feeding, personal hygiene, dressing and ambulating and instrumental ADL (IADL) such as preparing meals, cleaning and maintaining the house, health management and maintenance, moving within the community and decision-making[12]. Each single activity receives a specific weight and a coefficient indicating the required level of support and supervision. The final assessment is expressed as a numerical score and is equal to the weighted average of all 51 included activities (besides the eight for measuring limitations with decision-making), each multiplied by the coefficient of required support and supervision. Individuals with a score below 25 are not entitled to any service or financial benefits from the SAAD.

There are three degrees of dependency, which are defined as follows[13]:

- Degree I (Moderate Dependency, 25 to 49 points in the Scale of Dependency): the individual requires help for several basic ADL at least once a day or needs help on a sporadic basis or limited to personal autonomy.
- Degree II (Severe Dependency, 50 to 74 points in the Scale of Dependency): the individual needs help for several ADL, two or three times a day but does not need permanent help from a carer nor extensive help to ensure personal autonomy.
- Degree III (High dependency, 75 to 100 points in the Scale of Dependency): the individual needs help for several ADL several times per day, and because of total loss of physical, mental, intellectual or sensorial autonomy, s/he needs permanent help from a carer or needs generalized help to ensure personal autonomy.

Responsibility for assessing the degree of dependency and benefit entitlement lies with the regions (ACs). Once an applicant is recognised as dependant, an individual care program is prepared by the AC's social services, which includes

12 Decision-making is evaluated only for people with a potential mental health condition.

13 Initially, there were two additional sub-levels within each grade, but these were eliminated in 2012, as they did not result in an improved assessment of individual dependency and there were no practical differences in caring by levels within the same degree of dependency. The goal was to improve access to benefits, assessment of dependency and management of the system (BOE 2012a).

a list of appropriate services for the degree of dependency as well as the corresponding entitlement to allowances (BOE 2013). This program is established with the participation of the beneficiary through consultation and opinion seeking and, where applicable, with the beneficiary's family.

Access to benefits is means-tested for both in-kind (service) and financial benefits (see section 8), and there are incompatibilities between different benefits (see section 2).

4
Base for payment by facility

The base for payment refers to the unit of activity upon which prices are defined and set. Similar to other countries, the base for payment method in Spain varies by categories of facility. The common thread is the adjustment of the payment level based on the level of the complexity of the health condition, physical functioning and medical needs (Barber, Lorenzoni and Ong 2019).

Most of the publicly funded health services in Spain use global budgets as the funding mechanism[14]. The system builds on a contractual agreement between the Regional Health Service and the provider (that is, hospitals, primary care settings, etc.). These agreements, known as *contratos programa,* regulate the quantity of services and the overall cost, but also introduce quality-oriented elements aligned with the objectives of the regional strategies on quality and safety: typically, waiting list reduction programmes, extension of day-case surgery and reduction of safety events. In addition, part of the compensation to providers might be based on outcomes set upon territorial objectives such as accessibility, responsiveness and attention to chronic patients (Bernal-Delgado et al. 2018).

4.1 Primary care

Global budgets, capitation[15] and pay for performance[16] are the funding mechanisms for primary care. Public health care centres within the statutory NHS mainly deliver primary care services. As in the case of hospitals, contractual agreements are set following a benefits package-based approach. Typically, the primary care management structure of the health care area signs an annual contract-programme with the Regional Health Service based on capitation criteria (with some ingredient of demographic structure and population dispersion), including some specification linked to the priorities of the Regional

14 A global budget provides fixed funding for a specific population group and offers more flexibility in allocating resources than other payment methods (Barber, Lorenzoni and Ong 2019).

15 Capitation consists of a prospective fixed lump-sum payment per person enrolled for care with a provider within a given period (typically one year) covering a defined set of services, independent of whether the services are provided (Barber, Lorenzoni and Ong 2019).

16 Pay for performance are payments to health care providers for meeting specific performance targets, such as process quality or efficiency measures, or penalties for poor outcomes, such as medical errors or avoidable readmissions (Barber, Lorenzoni and Ong 2019).

Health Service. This contract's specifications cascade down, translating into contracts with each primary care team (that is, the group of specialized doctors and nurses in charge of the primary care in each basic health zone). It is a negotiated process, in setting objectives and standards of care. For example, it has been the main vehicle in implementing rational drug-use programmes and in fostering the prescription of generic drugs (Bernal-Delgado et al. 2018).

Individual-oriented health promotion and preventive medicine services are mostly integrated as part of the primary care package of benefits (for instance, medical counselling and hypertension or diabetes control). Those services are funded as part of the primary care payment mechanisms. In turn, collective services such as vaccination campaigns or population screening programmes (breast, colorectal or cervical cancer) are funded via earmarked budgets (Bernal-Delgado et al. 2018).

4.2 Outpatient services

Outpatient services in hospitals within the statutory Spanish NHS are funded through global budgets (see section 4.3 for more details).

4.3 Hospitals

With some exceptions, public hospitals are normally funded through global budgets set against agreed spending headings. The main part of the budget is fixed by means of a formula that accounts for the number of discharges, the case-mix weight (generally episode-based all-patient diagnosis-related groups (AP-DRGs)) and a structure-related tariff. Some procedures are excluded from this financing formula and are paid following a fee-for-service (FFS) mechanism. Although from a budgetary perspective contractual agreements were implemented to shift from retrospective global budgeting to a prospective payment mechanism, the method is not properly acting in this way, as the financial body usually ends up assuming budgetary deviations through "operating grants" and risks are not truly transferred to the public providers. On the other hand, the degree of sophistication of the contract design itself and the extent to which the budget depends on performance is uneven across ACs (Bernal-Delgado et al. 2018).

In addition to public providers, a certain amount of activity is contracted out to private providers, typically aimed at reducing waiting lists for surgical procedures or high-technology diagnostic tests, but also to complement long-term care services and palliative care. These are generally prospective volume contracts with some ex-post correction clauses. Depending on the nature of the specific activity, the contractor determines the basis for payment; hence, long-term care activity is usually measured in terms of stays, whereas surgical interventions and diagnostic tests follow a FFS scheme (González López-Valcárcel, Puig-Junoy and Rodríguez-Feijoo 2016).

4.4 Skilled nursing facilities

Skilled nursing facilities in Spain are mostly located in the AC of Catalunya and are paid on a per diem basis (IDIS 2016). Reference costs for long-term care services within the SAAD are set by law based on recommendations from the Territorial Council of the SAAD. Legislation is shared by the AGE and ACs, where the national regulation (basic legislation common to all the ACs) frames the ACs' legislation. For skilled nursing facilities, these regulations were not specified, but have been set later by some ACs[17]. These reference costs are used to calculate co-payment levels based on the dependant's economic capacity. Payments are covered to some extent with financial benefits from the SAAD (see section 8).

4.5 Residential facilities

Residential care services use a per diem payment scheme. Reference costs for long-term care services within the SAAD are set by law based on recommendations from the Territorial Council of the SAAD. For residential care, the national reference cost increases with the degree of dependence and is set between €1100-1600 (of 2012) per month, but can be modified by the ACs (see section 3). These reference costs are used to calculate co-payment levels based on the dependant's economic capacity. There is a distinction between assistance services and board and lodging costs (B&L). Co-payments cover the first B&L, but costs of B&L are always covered (also for those on very low income, i.e. income levels below the IPREM; see section 8).

4.6 Home-based care (health and social)

Reference prices per hour and type of home care services are fixed by the public administration. Home care comprises personal (or health) care and assistance (or social) services; these are funded with public benefits (in-kind or cash) and co-payments (see section 2). National reference prices for personal care and assistance services are set at €14 and €9 per hour of care respectively (in 2012 euros), but this amount can be modified by the ACs (see section 3). There is no adjustment to these prices by degree of dependency, but the intensity of home care increases with the beneficiary's degree of dependency (see section 3).

4.7 Day care

Day care services use a per diem payment scheme. Reference costs for long-term care services within the SAAD are fixed by the public administration based on recommendations from the Territorial Council of the SAAD (see above). For day (and night) care centres, the national reference cost is €650 per month (in 2012), but this amount can be modified by the ACs (see section 3). These reference costs are used to calculate co-payment levels based on the dependant's economic capacity.

17 For the AC of Catalunya, see http://portaldogc.gencat.cat/utilsEADOP/PDF/8029/1776874.pdf.

4.8 Hospice

In the case of hospice or palliative care, per diem fees are the most common payment scheme, and the unit price depends on the condition of the patient, the therapeutic complexity and the characteristics of the hospital. There is nevertheless no official information on the current situation of palliative care in Spain (Bernal-Delgado et al. 2018).

5 Informal care linked to cash transfers to families for dependants

Cash transfers for informal care are one of the benefits included in the SAAD (more specifically, this is referred to as "financial benefit for care provision within the family when a relative is acting as principal carer"; see section 3). The level of the benefit depends on the care recipient's degree of dependency and her/his economic means. Informal carers have to sign an agreement with the IMSERSO and pay contributions to social security, even though these are financed by the State's General Budget.

To be eligible for cash transfers (BOE 2012b, 2013), an alternative provision of care through service benefits is not possible due to a lack of provision of public or accredited private services in the dependant's area of residence, and the dependant is cared for at home, which meets some minimum physical and living conditions for an adequate provision of care. The carer is the spouse or a close relative and has been caring for the dependant for at least one year before benefit application; if the carer is not a close relative, s/he is cohabiting with the dependant and has been caring for the dependant for at least one year before benefit application. Under specific circumstances, e.g. in areas with limited access to public or private accredited caring services, the carer can be also a neighbour as long as s/he has been caring for the dependant for at least one year before benefit application (cohabitation is required if the beneficiary has a severe or high dependency, otherwise cohabitation is not necessary, but the beneficiary's area of residence has to be classified as a "rural area").

There has been an over-use of financial benefits for informal care, which was foreseen as exceptional when the Dependency Act was passed in 2006 (Jiménez-Martín, Labeaga-Azcona and Vilaplan-Prieto 2016). For instance, by December 2010, almost half of the awarded benefits (48%) were financial benefits for informal care (IMSERSO 2011). One possible explanation for this is a preference for informal care, at least among some dependants in Spain. Another explanation is that informal care is less expensive than formal care for regional governments. A comparison between service (in-kind) benefits and financial benefits for informal care shows that the latter imply a lower expenditure for the ACs. In particular, a cash benefit for informal

care represents 77% of the cost of a public day care centre place and 52% of the cost of a public nursing home place (Jiménez-Martín, Labeaga-Azcona and Vilaplan-Prieto 2016).

Over the last years there has been a prioritization of in-kind (service) benefits over financial benefits for informal care, as the former are more labour-intensive and tend to pay above-average wages, which can help develop a "sector of long-term care" with "good jobs" (see section 3)[18]. This can be illustrated in the SAAD's minimum level of protection, funded by the AGE, where the proportion of service benefits in comparison with financial benefits for informal care was introduced as an additional criterion for funding allocation in 2012 with an initial weight of 10% that was increased to 50% after five years (see section 3). As a result, the share of cash benefits for informal care over the total benefits in the SAAD had decreased to 34% by December 2016 (IMSERSO 2017a) and to 30% by December 2019 (IMSERSO 2020b).

There is, nevertheless, still a great reliance on informal care in Spain that falls heavily on women. Currently, women account for up to 90% of non-professional carers (IMSERSO 2020a). As female labour force participation continues to increase, it is expected that Spain will become increasingly reliant on formal care (Spijker and Zueras 2020).

6
Process by which prices are determined (for the categories of facilities)

6.1 Unilateral administrative price setting

Health and long-term care services in Spain – except pharmaceutical care – are in general fully governed by the ACs. This includes planning, accreditation, quality assurance, financing and also pricing. The ACs determine maximum official tariffs for health care services provided within the Spanish NHS and for those purchased from private providers, as well as maximum reference costs for long-term care services provided within the SAAD[19].

Regarding the relationship with health care providers, the ACs' Health Departments contract with both public and private providers in terms of number of services, quality and cost. In the case of public providers, the system is based on a contractual relationship (the so-called "programme-contract") between the financing body and the health care provider (typically hospitals)

18 This was one of the initial goals when the Dependency Act was passed in 2006 and became even more relevant during the years of high unemployment rates that followed the Great Recession in Spain (the unemployment rates remained at 20% or higher during the years 2010-2016, with a peak of 26-27% in 2013 (INE 2019)).

19 Health care services purchased from private providers are paid according to these public predefined tariffs and contract accomplishments (Bernal-Delgado et al. 2018). Reference costs are used in long-term care services to calculate co-payment levels (see section 8). These costs are determined by the AGE based on the recommendations from the Territorial Council of the SAAD but can be modified by the ACs.

and is not properly a method of purchasing services, but a method to assign budgets to hospitals (see section 4). Since there is not a clear separation between purchaser and provider, financial risk is not transferred to providers. Unit prices (i.e. price per assistance unit or any other hospital production unit) are calculated from historical costs data, and although the system is said to be prospective, the financing body assumes budgetary deviations through specific grants (Bernal-Delgado et al. 2018; Sánchez-Martínez et al. 2006).

Prices paid by public purchasers to private providers in the context of contracting-out agreements do not reflect unit costs. Official maximum tariffs for all the services and processes that are liable to be subject of contracting-out are established. These tariffs - based on historical patterns rather than on cost accounting estimations - work as a reference point in contract negotiations. The ACs' Health Departments act as monopsonies, and the agreed prices are usually influenced by the institutional features of the market, such as the providers' power of negotiation or the degree of competition between them, and are not related to costs (Sánchez-Martínez et al. 2006).

7
Technical process of price setting (for the categories of facilities)

7.1 Process of data collection from providers

In Spain, a fee schedule consisting of an official tariff and reference costs establishes the payment rates for every covered health service and long-term care service provided within the SAAD, respectively.

In many cases, tariffs and reference costs are static based on some value established in the past and are not updated systematically.

In many cases, these tariffs and reference costs vary between ACs in an unsystematic way that is unrelated to differences in costs of care provision between ACs.

7.2 Costing methods

Price levels that are too low or too high create incentives for over- or under-utilization. This gives an incentive for purchasers to estimate prices that reflect the actual costs of the given service across a set of providers (Barber, Lorenzoni and Ong 2019).

Hospital cost calculations in Spain are mostly based on a full costing approach as opposite to other systems like direct costing or activity-based costing. Regional and hospital differences arise on the method used to allocate indirect costs to cost centres and also on the approach used to measure

resource consumption. Costs are typically calculated by disaggregating expenditure and allocating it to cost centres and then to patients and DRGs (Sánchez-Martínez et al. 2006).

7.3 From cost submission to price setting

One obstacle to cost assessment in Spain lies in the separation between costs and prices (Sánchez-Martínez et al. 2006). The process of setting prices for health and long-term care services is far from reflecting cost information (section 6). The paradox is that, although there are costing systems promoted by health authorities that enable public hospitals to calculate true unit costs, payments to hospitals are based on public tariffs, which do not aim to reward unit costs. Methods of payments generally ignore unit costs, either average or marginal, and in many cases, tariffs are not updated systematically. Hence, incentives from the provider's perspective to develop cost information systems are scarce.

Additionally, reference costs for long-term care services provided within the SAAD do not respond to costs but rather to budgets set by the ACs.

8
Methods of adjustments

This section includes price adjustments and add-on payments based on the facility and the beneficiary's characteristics. These are common when prices are set unilaterally or negotiated collectively to ensure that specific services or caring for specific populations are covered, particularly where there are additional costs of providing care or it is considered unprofitable (Barber, Lorenzoni and Ong 2019).

8.1 For health needs/beneficiary characteristics

Coverage in the SAAD is universal and means-tested (see section 3). The amount of financial and service (in-kind) benefits depends on both the beneficiary's degree of dependency and economic capacity.

Three degrees of dependency are considered: moderate dependence (Degree I), severe dependence (Degree II) and high dependence (Degree III). An individual care program determines the services or benefits that best match the dependant's needs (see section 3). Granted financial benefits and hours of in-kind benefits increase with the degree of dependence (see section 2).

Economic capacity is determined based on the dependant's income, net wealth, age and type of service benefit. In particular, the dependants' economic capacity will be equal to their income plus 5% of their net wealth if they are over age 65, plus 3% if they are 35 to 65 years-old and plus 1% if they are below age 35. In the case of receipt of residential care

services or the equivalent financial benefit to hire such a service, net wealth includes also the value of the house owned by the beneficiary, as long as there are no other dependants residing in that house (BOE 2008a).

There is a co-payment, which depends on the beneficiary's economic capacity. The law establishes that beneficiaries must contribute financially to the funding of services through a co-payment defined in terms of the beneficiary's economic capacity (BOE 2012a). There is a minimum exempt from co-payment, which is referenced to the monthly amount of the Public Income Indicator of Multiple Effects (*Indicador Público de Renta de Efectos Múltiples*, abbreviated as IPREM), excluding residential care[20]. Co-payment is progressive up to a maximum of 90% of the cost of service and financial benefits, depending on the beneficiary's economic capacity. ACs can increase these co-payments.

The Territorial Council of the SAAD determines a set of common (minimum) criteria to cover the cost of benefits to ensure the principle of equality between all dependants in Spain (BOE 2012a). There has been wide regional disparity both in the timing of the approval of co-payment and in the means test (del Pozo-Rubio, Pardo-García and Escribano-Sotos 2017; Jiménez-Martín, Labeaga-Azcona and Vilaplana-Prieto 2016). The most important difference is that five out of the 17 regions (ACs) consider only the beneficiary's income, while the other 12 include both income and net wealth to determine a dependant's economic capacity (BOE 2018b).

Besides the dependant's economic capacity, co-payments vary by type of benefit or facility:

Services benefits:

- **Residential care services (BOE 2012b):**
  Co-payment varies with the dependant's economic capacity and with the cost of the service.

  There is a distinction between assistance services and B&L. Co-payments cover first B&L.

  The reference cost of residential care for co-payment increases with the degree of dependency and set between €1100-1600 per month in 2012. This amount follows negotiated prices of residential care places (*precios de concertación de plazas*) and can be increased by up to 40% if higher care intensity is required. It is updated annually with the IPREM.

  Actual co-payment is determined by the following equation: CP = EC – Min, where CP and EC are, correspondingly, the beneficiary's co-payment and economic capacity, and Min corresponds to a minimum exempt from co-payment for personal expenses equal to 19% of the monthly IPREM (ACs

20 The IPREM is used as reference index for social assistance benefits in Spain. Its monthly amount has been €537.84 since 2017. ACs can use a different index but, if this results in more generous service and financial benefits, the difference must be financed entirely with their own additional and voluntary contributions (see section 3).

may set a lower amount for Min). If the formula results in a negative amount, there is no co-payment. The costs of B&L are always covered by the corresponding public administration, at least to some extent.

A beneficiary's contribution may amount up to 90% of the cost of a public nursing home (BOE 2008a).

- **Home-based care services (BOE 2012b):**
  The reference cost of home care is, correspondingly, €14 and €9 per hour for personal care and assistance services to cover housing needs in 2012.

- Actual co-payment decreases with the number of hours of care, as illustrated in the following equations for severe and high dependants (there is no formula for moderate dependants, who receive up to 20 hours per month of home care):
  - if monthly hours of care are 21-45 (which corresponds to severe dependants):
    CP = ((0.4 x HC x EC)/IPREM) – (0.3 x HC),
  - if monthly hours of care are 46-70 (which corresponds to high dependants):
    CP = ((0.3333 x HC x EC)/IPREM) – (0.25 x HC),
    where HC is the cost per hour of the corresponding home care service.

  The minimum monthly co-payment was set to €20 in 2012.

- **Day- and night-centre services (BOE 2012b):**
  The reference cost of day and night centre services for co-payment was €650 per month in 2012 without meal or transportation expenses. This cost is in accordance with negotiated prices at private centres. This amount can be increased by up to 25% if higher care intensity is required and is updated annually with the IPREM.

  Actual co-payment increases with the dependant's economic capacity as follows: CP = (0.4 x EC) – (IPREM/3.33).

  If EC is below the IPREM, there is no co-payment.

  A beneficiary's contribution may amount up to 65% of the cost of a place in a public day care centre (BOE 2008a).

- **Tele-assistance services (BOE 2012b)**
  Actual co-payment increases with the dependant's EC, from zero when EC is lower than the monthly IPREM, to 50% when EC is equal to 1-1.5 times the monthly IPREM, and 90% when EC is higher than 1.5 times the monthly IPREM.

Financial benefits:
The final benefit will be equal to the legislated upper bound of the corresponding financial benefit when the dependant's EC is equal or less than the monthly IPREM.

- Financial benefit for paid personal assistance, which is intended to support the hiring of professional services (BOE 2012b)

The monthly benefit that the dependant receives (MB1) depends on the cost of the service (CS), a minimum exempt from co-payment for personal expenses equal to 19% of the monthly IPREM (Min) and the dependant's EC as follows: MB1 = CS + Min – EC.

- Financial benefit for care provision within the family when a relative is acting as principal carer (informal care) (BOE 2012b):

  The monthly benefit (MB2) varies with the beneficiary's EC and degree of dependence as follows: MB2 = (1.33 x Ceiling) – (0.44 x EC x Ceiling)/IPREM, where Ceiling is the legislated upper bound of benefits for informal care, which increases with the degree of dependency.

  The resulting MB1 of financial benefits for informal care cannot be higher than the corresponding MB2 that would result if the informal care had to be purchased.

- Financial benefits for the care recipient to hire services

  These are equal to €715 per month for high dependants and €426 per month for severe dependants (see section 2) and cover only a certain fraction of the cost of the service, namely, 85% of the cost of a day centre and 45% of the cost of a nursing home for major dependants (Jiménez-Martín, Labeaga-Azcona and Vilaplana-Prieto 2016).

8.2 Access, financial protection and quality

Geographical price adjustments are common to ensure that health facilities are adequately reimbursed and compensated for factors outside their control (Barber, Lorenzoni and Ong 2019). For instance, most of the publicly funded health services in Spain use global budgets as the funding mechanism, where part of the compensation from the ACs' Health Departments to the providers can be based on outcomes set upon territorial objectives such as accessibility, responsiveness and attention to chronic patients (see also section 4). A similar example can be found in the SAAD's second level of financing, with matched contributions from the AGE and ACs (also called the "agreed level"), which takes into account the geographical dispersion of the dependants. This "agreed level" considers also the number of returned emigrants to the ACs (who return usually after retirement to their AC of origin), as this increases the number of potential dependants.

Prices can be also adjusted to promote greater access for specific populations (Barber, Lorenzoni and Ong 2019). For instance, as discussed earlier in this section, in the SAAD, most service benefits include a minimum exempt from co-payment, which is referenced to the monthly IPREM (€537.84 per month since 2017). Private institutional and day care providers also often receive substantial public subsidies in order to make their service more affordable for dependants (see section 3).

9
Mean price for base for payment by provider (in national currencies)[21]

This section reports mean prices of the main long-term care services by base for payment to public and private providers in Spain.

- Tele-assistance:
  Annual prices of tele-assistance services per user in Spain are higher if provided outside the SAAD network (€198.48 in 2015) than within the network (€181.86 in 2015). The corresponding amount of co-payment (see also section 8), both in euros and as a percentage, is also higher if the service is provided outside (€47.69 in 2015, or 24.0%) than within the network (€42.23 in 2015, or 23.8%) (IMSERSO 2017b). The latest numbers for 2019 (IMSERSO 2020c) do not distinguish between prices of services provided within and outside the SAAD network but show a decline in the overall annual prices per user (€176.42 in 2019) with an increase in the level of co-payment (€54.84 in 2019, or 31.1%).

  There are large regional differences in prices of tele-assistance. To some extent, this is because some regions combine tele-assistance with other devices and benefits that enrich the service, such as fall, movement or smoke detectors. Annual prices per user in 2019 varied from €83.50 in Navarra to €299.30 in Extremadura, with co-payment being highest in Illes Balears (79.7%) followed by Navarra (67.2%) and zero in Castilla-La Mancha, Extremadura, La Rioja and C. Valenciana (in 2018) (IMSERSO 2020c).

- Home care:
  Public prices of home care are higher if provided within the SAAD than by the municipalities (IMSERSO 2017b). On average, they were €14.61 per hour in 2019. A user's co-payment was on average 11.3% (IMSERSO 2020c).

  Average hourly prices of home care in 2019 varied between around €9.00 in Extremadura and Galicia and €17.00 in Aragón and Illes Balears. As for co-payment, this was as low as 1.6% in Andalucía and as high as 44.2% in Murcia (IMSERSO 2020c)[22].

- Day centres:
  Prices per user in day centres are increasing with the user's degree of dependency. Prices also depend on the type of provider. For instance, on average, annual prices per user were €9077.02 in public centres with a co-payment of

21 Prices of services in this section are taken from the latest biannual report of IMSERSO published in 2017, which covers users of social services for older people in Spain, some of which are not included in the SAAD.

22 For Canarias and C. Valenciana, co-payment rates are missing in 2019. The latest numbers from 2016 showed rates that fall beyond the 2019 interval (51.23% in Canarias and 0.22% in C. Valenciana), while hourly prices were close the regional average (IMSERSO 2017c).

24.0% and €10 077.65 in private subsidized ("charter") centres with a co-payment of 21.6% per user in 2019 (IMSERSO 2020c).

There are large differences across regions. For example, annual prices per user in public centres in 2019 were lowest in Navarra (€3786.00), which had, however, the highest share of co-payment (99.4%) resulting in one of the highest levels of co-payment, only below those in País Vasco (€4976.24) and Illes Balears (€4030.41). Public annual prices in 2019 were highest in Illes Balears (€11 078.96), followed by Catalunya (€10 753.92) and C. Valenciana (€10 621.00). The share of co-payment in Catalunya was among the lowest (18%), only above that in Murcia (9.4%), which had also the lowest level of co-payment (€980.83). For C. Valenciana the share of co-payment was not available in 2019, but it was zero in 2017 (IMSERSO 2018)[23].

- Residential care centres
  Prices per user in residential centres depend on the type of provider. For instance, in 2019, on average, annual prices per user were €20 685.73 in public centres with a co-payment of 36.3% (€7500.47) and €19 324.27 in private subsidised "charter" centres with a co-payment of 40.4% (€7809.78) (IMSERSO 2020c). Average annual prices have increased substantially in public centres since 2015 (by about 30%), but the share of co-payment has declined (by about 6 percentage points). Instead, in private centres, both annual prices and co-payment rates have increased since 2015 (by about 20% and 4 percentage points, respectively) (IMSERSO 2017b).

  There are large differences across regions both in prices and co-payments. For instance, annual prices per user in public centres varied in 2019 between €10 460.15 in La Rioja and €28 144.72 in Madrid. Co-payment in public centres was highest in Navarra as a percentage (81.0%) but in País Vasco as a level (€13 109.65). The lowest level of co-payment corresponded to C. Valenciana (€5751.01), which had also one of the lowest relative co-payments (about 26%), only above that in Madrid (20.9%)[24].

23 Public annual prices and co-payment rates in a few other regions with missing information in 2019 were within the intervals discussed above in 2016-2017 (IMSERSO 2017c, 2018).

24 Public annual prices and co-payment rates in a few other regions with missing information in 2019 were within the intervals discussed above in 2016-2017, except for Extremadura which had the lowest annual price (€8794.92, in 2016) as well as one of the lowest co-payment rates along with Asturias and Canarias in 2016 (about 17%) (IMSERSO 2017c).

10
Infrastructure for costing and pricing

10.1 Institutional entities (to what extent existing bodies cover different aspects of care for older persons)

Long-term care is coordinated within the Territorial Council of the SAAD. This is a cooperation body where the central government, the ACs and the local governments are represented. By means of this council, the central government and the ACs agree on a framework for intergovernmental cooperation, the intensity of services, the terms and amounts of financial benefits, the criteria for co-payments by the beneficiaries, and the scale of dependency that is used for the recognition of dependency.

The Territorial Council of the SAAD is also responsible for the regular assessment of the system, whose results are published on the IMSERSO's webpage (www.imserso.es), and by the Institute for Older People and Social Services, a public body of the Ministry of Social Affairs (since 2020, the Ministry of Social Rights and 2030 Agenda). The central government is responsible for the Information System of the SAAD (SISAAD).

Based on the recommendations from the Territorial Council, the AGE sets the basic legislation that is common to all ACs. This includes minimum criteria for benefits and also reference costs of services. The ACs can modify these, but if this results in higher long-term care expenditures, the difference has to be financed with additional contributions from the ACs.

Managing the SAAD is a competence of the ACs. Long-term care services are fully operated by the ACs, which includes planning, accreditation, quality assurance, financing and pricing.

Local authorities take part in the Territorial Council of the SAAD and can also complement the set of benefits mainly by financing community services. In practice, though, they play a subordinate role in the system.

Health care services are coordinated within the Territorial Council of the Spanish NHS. As for long-term care services, the AGE sets the basic legislation that is common to all ACs, even though health care services are fully operated by the ACs, except for pharmaceutical care, which is governed by the AGE.

Both the Spanish long-term care and health care systems are highly decentralized.

10.2 Stakeholder consultation

Many stakeholders have an interest in the outcomes of price setting and regulation, particularly medical doctors and health care provider associations. Lack of formal consultation and stakeholder engagement can lead to stalemates in the price setting process. A balance must be found between maintaining

dialogue with stakeholders, including the health industry, while also observing objectivity and independence. To address this challenge, formal consultation processes have been implemented that involve stakeholders in the discussion of the base price and the cost elements that it covers (Barber, Lorenzoni and Ong 2019).

Within the Territorial Council of the SAAD, there is an advisory body which includes various stakeholders representing mainly public interests such as the State Council of Older Persons (*Consejo Estatal de Personas Mayores*), the National Disability Council (*Consejo Nacional de la Discapacidad*), the State Council of Non-Governmental Organizations for Social Action (*Consejo Estatal de Organizaciones no Gubernamentales de Acción Social*), and the Consultative Committee (*Comité Consulyivo*). There are no specialists representing professional associations and industry in this advisory board.

The Territorial Council of the Spanish NHS contains various working groups that compose the Commission for Public Health: the committee on environmental health, the working group on epidemiological surveillance, the working group on occupational health, the working group on health promotion, and the committee on vaccination programmes.

Participation and recommendations from this advisory body and working groups are encouraged in order to reach the widest possible consensus in what concerns health care and long-term care legislation.

10.3 Information disclosure (prices and quality)

Price transparency, or publishing service prices charged by health care providers, is one means to help consumers make informed choices (Barber, Lorenzoni and Ong 2019).

Health care information in Spain is usually placed on accessible institutional websites using static documents and interactive tools. For instance, official tariffs for health care services, information about statutory benefits and hospital waiting times is easily available. However, other relevant information on quality of health care, such as that on hospital clinical outcomes, is less available (Bernal-Delgado et al. 2018).

Overall, there is limited information on prices and quality of long-term care services in Spain, with substantial heterogeneity across regions (ACs). Reference costs of long-term care services that are provided within the SAAD are not systematically reported for all ACs. Detailed budget information of the ACs' spending on social services in order to disentangle long-term care spending is also hard to find or not available. Official data on co-payments are also not available. The SISAAD (see section 3) does not have up-to-date information on the contributions made by the beneficiaries. The estimation of co-payment at the national level is therefore complex, because in practice each of the ACs has its own model of co-payment (European Commission 2019). The IMSERSO's biannual report on older

persons publishes aggregate mean prices for some facilities by type of provider (public or private) and region, as reported in section 9.

11
Evidence on the effects of price setting and price regulation on stated objectives

At the present time, there have been few evaluations of the Spanish public long-term care system, especially regarding the effects of price setting and price regulations on stated objectives of the system.

Most of the evaluations of the Spanish public long-term care system have looked at the financial sustainability of the system (e.g. Sosvilla-Rivero and Moral-Arce (2011)), at the over use of financial benefits for informal care over service benefits (Peña-Longobardo et al. 2016), and at the low impact on job creation that the introduction of the SAAD has had so far (BOE 2014).

One notable exception is the study by Costa-Font, Jiménez-Martin and Vilaplana (2018), which focused on the effect of changes in caregiving affordability on the delivery of hospital care in terms of hospital admissions and length of stay. The study used quasi-experimental evidence from the introduction of the SAAD in 2007 which, as discussed in this report, introduced a new caregiving allowance for informal care and expanded the availability of publicly funded home care services. It found evidence of a reduction in both hospital admissions and utilization among both those receiving a caregiving allowance and, albeit less intensely, among beneficiaries of publicly funded home care, which amounted to 11% of total healthcare costs. These effects were stronger when regions had an operative regional health and social care coordination plan in place. Consistently, the subsequent reduction in the benefit that occurred in 2012, five years after its implementation, was found to significantly attenuate such effects. Greater access to affordable long-term care may thus reduce both hospital care admissions and utilization. These results are important for policy insofar as they suggest that expanding long-term care services and support can provide additional savings in the provision of hospital care.

12
Best practices for other countries, in particular middle- and low-income countries

The Spanish public long-term care system, introduced in 2007, has taken significant steps in providing coverage and care for the dependent population.

The main challenges of the system appear to be the long waiting lists for benefits for those formally recognized as dependants, the large inequalities in the provision of long-term care services and benefits between regions; the lack of transparency of the system; and the insufficient funding and inadequate financing arrangements, which results in low prices paid to providers and possibly low-quality services for long-term care for dependants.

Based on the Spanish experience, the following best practices can be highlighted for other countries to consider when setting up a public long-term care system:

- Be explicit about the goals of the system (e.g. covering all dependants or only those with a major dependency).
- Contrast alternatives on how the system should be financed (taxes, individual-level contributions, a mix of the two, etc.).
- Assess as accurately as possible the overall number of potential dependants, distinguishing also high, severe and moderate dependants.
- Guarantee the coverage of all beneficiaries. Ensure that laws regulating care for older persons are enforced and do not result in, for instance, long waiting lists for persons who are already entitled to benefits or for persons that are waiting for medical assessment of their potential dependency.
- Establish prices that approximate the most efficient way of delivering care.
- Expand home care and community services, which are very cost-effective and whose demand is usually high (as dependants prefer to stay in their homes). This will also reduce waiting lists for access to services.
- Invest in data infrastructure, improve price transparency, and report quality information along with prices.
- In order to enhance the financial sustainability of the public long-term care system over time, project as accurately as possible the number of dependants by degree of dependency and by the relevant geographical unit that corresponds to the administration jurisdiction that will be operating the system.

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Case study

Sweden

Luca Lorenzoni

Organization for Economic Co-operation and Development

Paris, France

Abstract

Health and social care for the elderly are important parts of Swedish welfare policy. Sweden is internationally regarded as a model for care for the frail and dependent elderly (eldercare). It has a tax-based universal comprehensive coverage for eldercare, and most eldercare is funded by municipal taxes and government grants. The system has very generous coverage, little cost-sharing at the point of service and a strong emphasis on improving elderly well-being by encouraging them to remain at home for as long as possible.

Four main features characterize Sweden's eldercare governance model:

- *Decentralized governance*. While the legal framework is set at the national level, both the Health and Medical Services Act (1982) and the Ädelreformen (Elderly Reform Bill, 1992) specify that care for the elderly is organized within a decentralized political structure. The municipalities have the legal obligation and autonomy to provide social services and services to fulfil the nursing and housing needs of the elderly.
- *Focus on keeping dependent people at their homes*. One of the main aims of the Ädelreformen was to provide incentives for municipalities to organize home-based elderly care – often termed as "ageing in place". While the number of eldercare beds still remains well above the OECD average, Sweden has seen one of the largest reductions in eldercare beds in the OECD area between 2007 and 2017, with a reduction of 15 beds per 1000 people aged 65 years old and over, compared to a reduction of 3.4 beds across the OECD during the same period. Sweden has also seen one of the most marked increases in the share of home care eldercare recipients in the OECD, and the hours allocated to home-based services amounted to 5.28 million in 2018, compared to 4.82 million in 2007.
- *Emphasis on choice and the market*. Provider competition is regarded as an important tool for driving performance improvement. The 2009 Law on System Choice in the Public Sector opened the provider market to competition across (public and private) providers of home care and residential care services, under the assumption that municipalities and recipients would choose providers based on their performance. Municipalities participating in a choice system have to disclose on a national website provider details, acceptance criteria and quality information. Municipalities have significant autonomy to grant licenses for operation, set prices and monitor compliance.

- *A powerful use of incentives.* Sweden has made significant use of financial incentives to steer change. Starting in 2010, there have been occasions when the annual transfers from the central government to municipalities have included performance targets based on outcomes results for elderly care. The Ädelreformen reform, the Law on System Choice in the Public Sector, and the use of performance targets in connection with transfers from the state to the municipalities have created an environment where eldercare providers' performance is encouraged through incentives for providers to compete, for users to choose across providers, and for municipalities to deliver value and quality.

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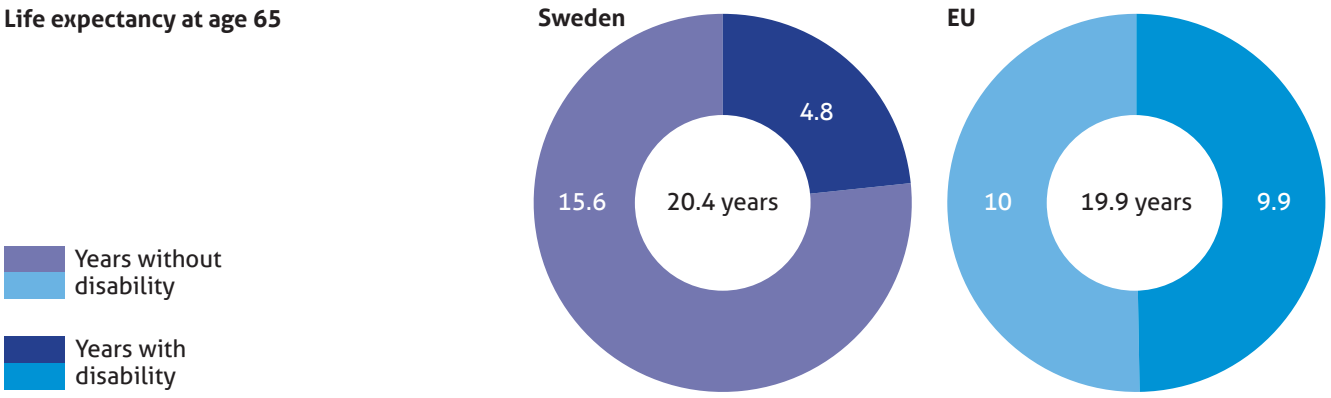
1
The context

Sweden had a population of 10 million inhabitants in 2018, which is expected to reach 13.9 million in 2070. In 2017, the life expectancy at birth of the Swedish population was 82.5 years, more than 1.5 years above the European Union (EU) average (80.9 years). Progress, however, has been slightly slower in Sweden than elsewhere in the EU. Between 2000 and 2017, Swedes gained 2.7 years of life, compared with 3.6 years for all EU citizens. The gender gap in Sweden has narrowed, as men have gained more years in life expectancy than women.

The share of people aged 65 and over is steadily growing in Sweden because of rising life expectancy. In 2017, one in five people in Sweden were aged 65 and over, up from 16% in 1980; this is projected to reach one in four people by 2050. In 2017, Swedes aged 65 could expect to live slightly more than 20 years – an increase of about two years since 2000 – and most of these years are spent without disability (Figure 1). The fact that Swedes are living longer brings about new challenges in terms of the sustainability of welfare systems and their financing (Government Offices of Sweden 2013). The challenges concern the declining share of people regarded as being of working-age, as fewer and fewer people will have to support an increasing percentage of the population. An ageing population also means that costs for elderly care can be expected to rise, especially since new health technologies tend to be cost inflating (Marino and Lorenzoni 2019).

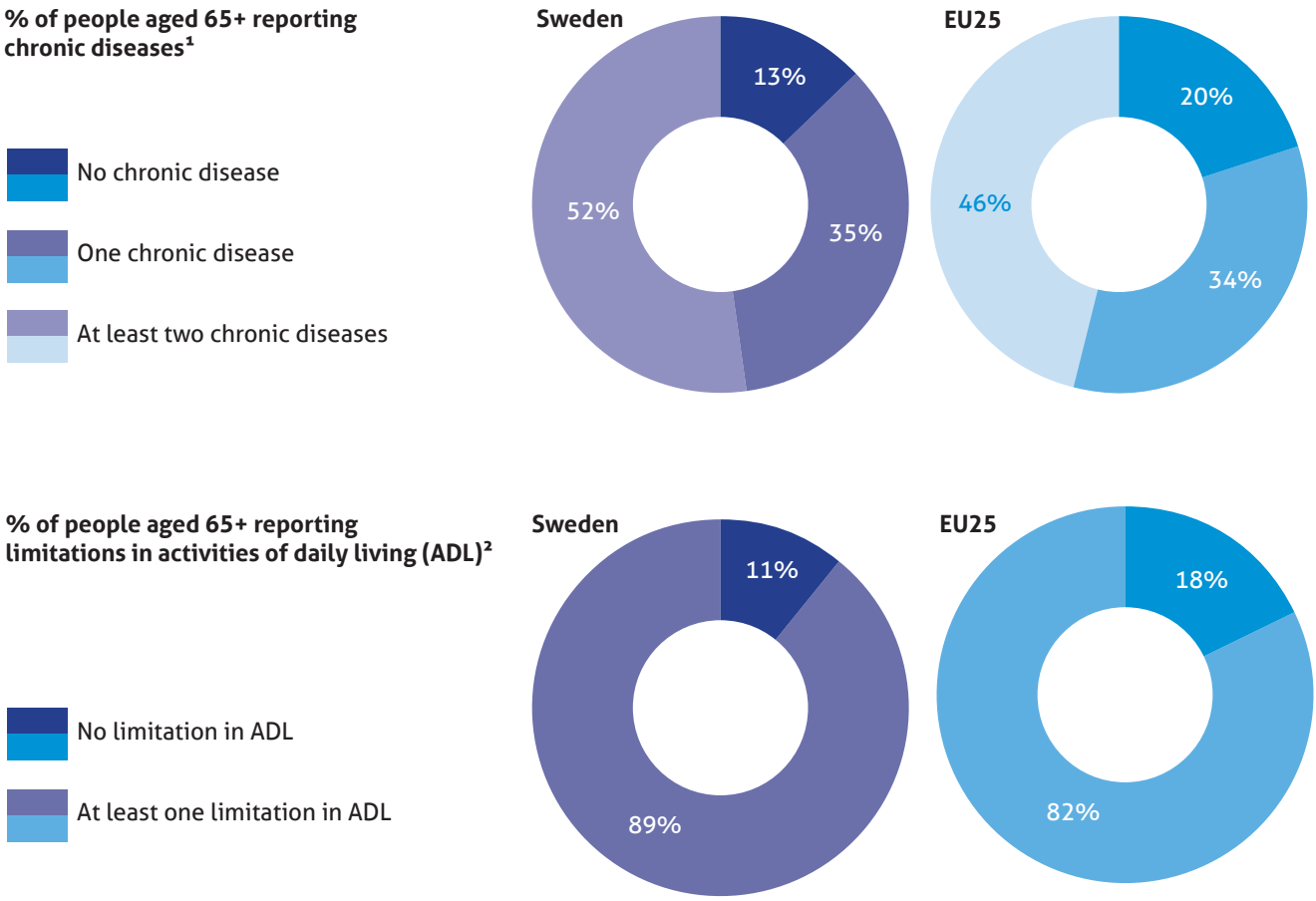
While nearly half of Swedes aged 65 reported them having at least one chronic condition, this does not necessarily hinder them from living a normal life and carrying on their usual activities. Most people are able to continue to live independently in old age; just over one in five people aged 65 and over reported some limitations in basic activities of daily living (ADL), such as dressing and eating, that may require assistance with fewer than one in twelve people reporting severe limitations (Figure 2). This proportion is much lower than the EU average and mainly concentrated among people aged over 80. In Sweden, adults aged 65 years and older in the lowest income quintile are more than twice as likely to report living in poor health compared to adults in the highest income quintile (OECD 2019a).

Figure 1
Comparison between Sweden and the European Union (EU) of life expectancy at age 65 and years with disability.



Source: OECD (2019c).

Figure 2
Comparison between Sweden and the European Union (EU) of people aged 65+ reporting chronic diseases and limitations in ADL.



Notes: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson's disease, Alzheimer's disease, rheumatoid arthritis and osteoarthritis. 2. Basic ADL include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet.

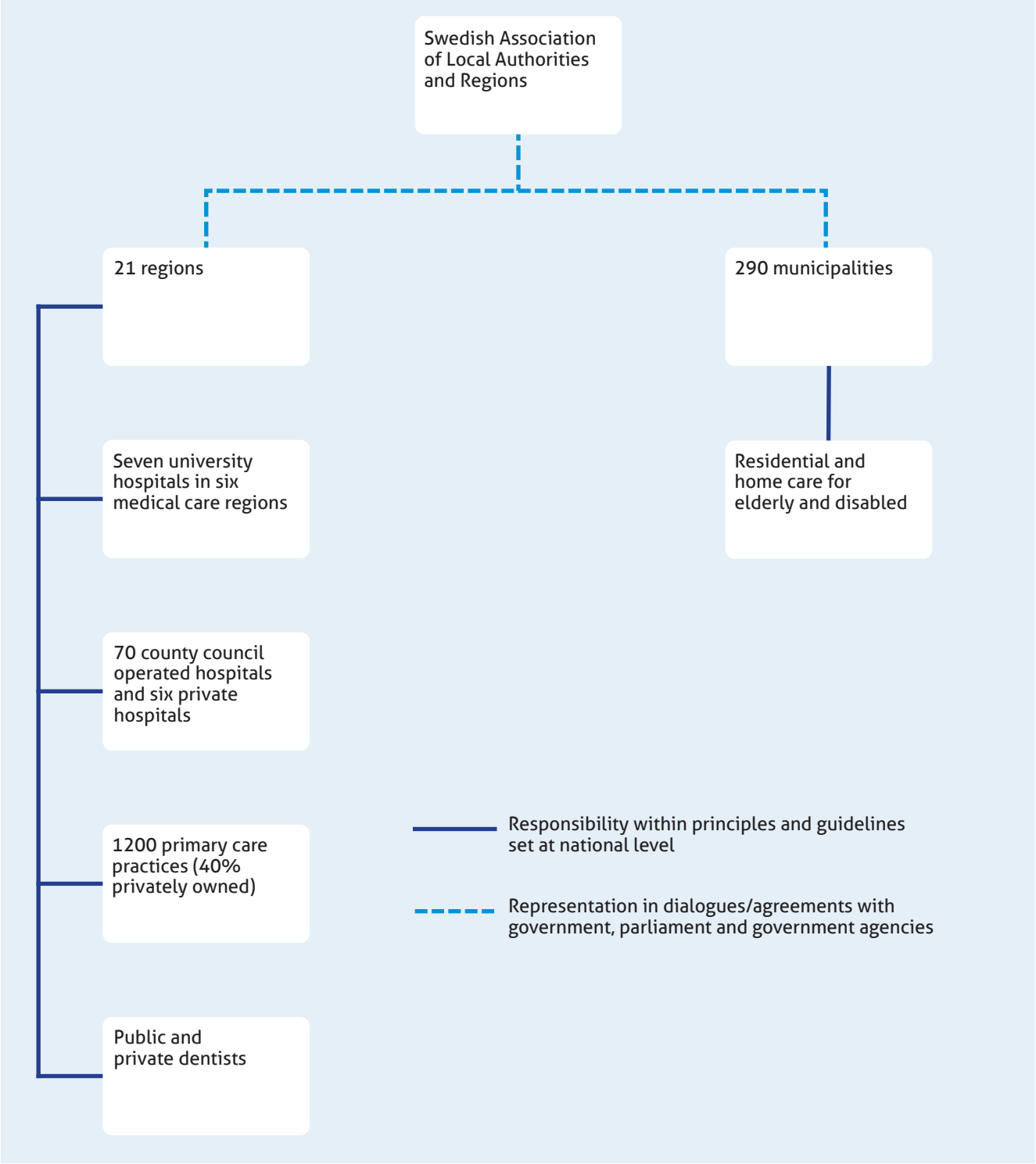
Source: OECD (2019c).

The Swedish health care system is decentralized. At the central government level, the Ministry of Health and Social Affairs is responsible for developing legislation on health care, social insurance and social issues. These laws and regulations are the basis also for the planning, funding and provision of eldercare services through the cooperation of regions and municipalities. To this aim, the central government is in constant dialogue with the Swedish Association of Local Authorities and Regions, a cooperative national organization that represents all regions and municipalities.

Sweden is divided into 290 municipalities and 21 regions (including Gotland, an island in the Baltic Sea, which is both a municipality and a region). The size of the population in the municipalities varies widely, from slightly less than 2500 in Bjurholm to almost 1 million in the largest city, Stockholm. The average population in each region is about 487 000 inhabitants. The Stockholm region is the largest, with about 2.4 million inhabitants, whereas the smallest is Gotland, with about 60 000 inhabitants (Statistics Sweden 2020).

At the regional level, there are 17 regions and 4 regional bodies (Västra Götaland, Skåne, Halland and Gotland). There is an appointed governor with an administrative board, which is the regional representative of the national government. Policy-making assemblies are directly elected by the residents of the region. Health care is the largest and most important part of the regional responsibilities. At the local level, there are 290 municipalities (including Gotland). Each municipality has an elected assembly – the municipal council – that makes decisions on municipal matters. The municipal council appoints the municipal executive board, which leads and coordinates municipality work. The municipalities are responsible for matters relating to their inhabitants and their immediate environment, such as primary and secondary education and care of older and disabled people (Figure 3). Moreover, they are responsible for the water supply, sewerage and streets, spatial planning, rescue services and waste disposal. Regions and municipalities are highly autonomous with respect to central government. Both have the right to levy and collect taxes.

Figure 3
Overview of the regional and local level organization of the Swedish health care system



Source: Adapted from Anell, Glenngård and Merkur (2012) and reproduced with permission.

2
Description of eldercare services

In the Swedish language, the notion "long-term care" is not used. Instead, policies in this field are qualified as "eldercare". All forms of eldercare are covered by the Social Security Act (2001), which ensures that older people have "the right to claim public service and help to support their day-to-day life if their need cannot be met in any other way." Similarly, the Health and Medical Services Act (1983) calls the health system to maintain a good standard of health among the entire population and provide care on equal terms.

Eldercare includes both varying forms of assistance in a home environment, institutional (or special-housing) care (old people's homes, residential care, homes for the demented/dementia units, nursing homes and similar). It includes personal care – such as help with bathing, getting dressed and in and out of bed – as well as help with shopping, cooking, cleaning and laundry. It also provides elderly in need with assistive devices, transportation, housing adaptations, handicap aids and support for informal caregivers.

Different kinds of residences for the elderly are available, including assisted living and nursing homes (Table 1). Assisted living means that the person lives in her/his own apartment with a security alarm and has access to certain shared services and rooms. The person also has access to a nurse, occupational therapist and physiotherapist. To move into an assisted living home, the person must have received a decision approving for social assistance. This decision is based on an overall assessment of the person's care needs, sense of insecurity and age. If the person needs support and assistance once she/he has moved into an assisted living home, she/he can apply for home help services. In an assisted living home, unlike normal housing or accommodations for seniors, the person is able to choose her/his home help services provider.

A nursing home is a residence with service and care around the clock. Residence in a nursing home includes all the assistance the person needs, including a nurse and access to a doctor, occupational therapist and physiotherapist. There are also shared community areas for socialising. The person can live in a nursing home for the rest of her/his life, even if need for care changes. The person needs an assistance decision to be granted a place. When a person has been granted a nursing home, she/he can choose the home she/he prefers[1]. There are nursing homes with specialist skills to handle a particular diagnosis or disability, e.g. Parkinson's disease or a physical disease. A person can choose her/his own nursing home with

1 The Social Services Act states that as far as possible, married couples and partners are to be given the opportunity to continue to live together even if they have different care needs. In those cases where this is possible, a husband or wife can choose to move to a nursing and care facility even if he or she does not have an equally great need for assistance.

specialist skills but will only be granted a place at a facility designed for her/his specific needs.

Table 1
Overview of the types of residences for the elderly (from age 65).

	Assisted living	Nursing home
Key features	Own apartment with personal security alarm For care needs that are difficult to provide at home Nurse available Community room for activities and meals	Own apartment or room with personal security alarm Extensive assistance if needed Full service and care round the clock
How to apply	An assistance decision is required Granted according to need	An assistance decision is required Granted according to need Possibility to choose residence and provider

Source: adapted from Elderly care for people living in the city of Stockholm (https://aldreomsorg.stockholm/olika-former-av-aldreomsorg/).

A person can also stay in a nursing home for a short time. Short-time care may recur regularly; hence, the person lives alternately in her/his own home and in a nursing home. Short-term care can be granted to relieve people caring for a close relative at home. Short-term care may also be provided while the city district administration assesses the person's future need for care and housing or if the person has been in hospital and needs time to recover before returning to her/his own home. Short-term care is not covered by the freedom of choice rules, which means that the person cannot choose a provider.

Home care comprises help with daily activities such as shopping, cooking, cleaning and laundry as well as help with personal care, such as help with bathing, going to the toilet, getting dressed and getting in and out of bed.

The following eldercare services are also available in Sweden: meal services, home adaptation and personal security alarms. There are also transportation services for care recipients who are unable to use public transport. In addition, local authorities also provide non-means tested grants to assist the disabled to use their homes in an efficient manner.

Regions and municipalities can, within the limits established in legislation, decide what level of priority they will assign to the elderly versus other age groups. The fact that eldercare is mainly funded by local taxation underlines the independence of the local authorities from national government. With the Local Government Act, which came into force in 1992, municipalities were handed responsibility over local nursing homes and other forms of institutional eldercare. In contrast, the responsibility for health care belongs to the regions.

Over the years, all regions and municipalities, except the municipalities within the Stockholm region, have formed agreements on transferring the responsibility for home health care also in all ordinary homes from the regions to the municipalities. This has led to a more coherent organization. However, regions are still responsible for patients until they are discharged from a hospital. The responsibility of medical care and rehabilitation for elderly in ordinary homes is shared between municipalities and regions. This places high demands on the coordination of care between municipalities and regions. A lack of coordination may lead to an inefficient use of resources, cooperation issues, and lack of continuity as well as attempts by regions and municipalities to transfer both responsibilities and costs to one another. From 1 January 2010, local authorities have to draw up an individualized care plan for each recipient. The care plan states clearly each step of the required services and treatment. The plan also identifies the official in charge of the case and specifies which authority is responsible for which component of the services and care provided.

Sweden engaged in a deinstitutionalization of their eldercare supply through the promotion of home-based solutions and a reallocation of public eldercare spending towards home-based care. In Sweden, the number of eldercare beds has declined over the decade 2007-2017 from 86.5 to 71.5 per 1000 people 65 years and above (OECD 2019a). In the meantime, Sweden is one of the OECD countries where the number of elders receiving care at home increased the most (+9%) in 2016 (OECD 2017).

3
Eligibility criteria and utilization

In the Swedish universal care regime, comprehensive, publicly financed and high-quality services are available to all citizens according to need rather than ability to pay. There is therefore no means-testing criterion applied to the provision of eldercare. The Swedish eldercare system is decentralized, and municipalities are responsible for institutional care such as nursing homes, residential care facilities and group homes for persons with dementia, and home-help care and services. There are no national regulations on eligibility, and local authorities decide on the service levels, eligibility criteria and the range of services provided for home help and institutional care.

Need for care is assessed either by a general practitioner or through a request for assessment to the relevant local authority. For direct requests to the authority, the potential recipient as well any eventual relatives are interviewed by a municipal assessor representing the Social Board in the municipality. The municipal Social Board then decides on the provision of services based on the GP or municipal assessor's proposal. The legislation gives no details on the assessment procedure itself, the criteria to be used in the needs assessment or in determining the extent of support required, and whether the care can be provided in the recipient's own home or not.

Nowadays, even relatively severe dependency cases needing extensive medical care can be treated in the home of the recipient. Home help is offered in flexible hours, in some cases including up to seven visits per day or more. In other cases, however, home care is not advisable (for instance, due to the inadequacy of the home), and institutional care will be considered as a last resort policy. A new provision has been introduced in the Social Services Act, which makes it possible for the local Social Services Committee to offer home services to older people without an individual need assessment. The purpose is to provide local municipalities with the opportunity to grant older women and men home help services in an easier way and with greater scope for participation and self-determination from the user's perspective.

In October 2018, 11.8% of the Swedish population aged 65 years or above received an average of 22.8 hours of home care services, a decrease from 12.6% and 24.3 hours respectively in 2007 (Table 2).

Table 2
Number of persons receiving home care services and average number of hours of services per month by type of management, 2007-2018.

		% of persons		Average number of hours		
Year	Number of persons 65 + receiving home care	Municipal management	Private management	Municipal management	Private management	Total
2007	198 877	89.3	10.7	24.0	26.4	24.3
2008	201 922	87.5	12.5	21.9	28.4	22.7
2009	205 797	86.2	13.8	21.8	26.9	22.5
2010	210 966	84.5	15.5	22.0	27.9	22.9
2011	220 607	84.3	15.7	21.5	29.5	22.7
2012	219 564	83.2	16.8	21.7	32.1	23.4
2013	219 695	81.9	18.1	22.1	31.3	23.8
2014	221 634	81.5	18.5	22.2	32.1	24.1
2015	223 250	81.7	18.3	23.1	32.5	24.8
2016	228 476	82.2	17.8	22.2	30.5	23.7
2017	231 324	82.3	17.7	21.6	30.8	23.2
2018	236 360	83.0	17.0	21.0	31.5	22.8

Source: adapted from the National Board of Health and Welfare Statistics (2019a).

Note: in municipal management, health and social care provided primarily by staff employed by the municipality; in private management, health and social care is ultimately the responsibility of the municipality, but is provided by someone other than the municipality, such as a company, foundation or cooperative on behalf of, and paid by the municipality, or where the municipality purchases places in residential care homes from private entities.

From 2007 to 2018, a large part of elderly received home services primarily by staff employed by the municipality, even if the share of persons to whom services were provided by private management increased by more than 6 percentage points to 17 % (Table 2). The average number of hours of home services provided per month decreased by 1.5 hours between 2007 and 2018, whereas the number of hours provided by private management increased by 5 hours during the same period.

There is a large variation in the proportion of services provided by the private management and the average hours of service by region. In Norrbotten, a region in the north of Sweden, almost all services are provided by staff employed by the municipalities, whereas in Stockholm, the capital region, more than half of the persons aged 65 years or above received privately managed services (Table 3). In 2018, the average number of hours of home services in Gotlands was two times the number of hours provided in Blekinge, a region in the southeast of Sweden.

Table 3
Number of persons receiving home care services and average number of hours of services per month by region by type of management, 2018.

		% of persons		Average number of hours		
Region	**Number of persons 65+ receiving home care**	**Municipal management**	**Private management**	**Municipal management**	**Private management**	**Total**
Stockholm	42 387	49.1	50.9	23.6	33.4	28.6
Västra Götalands	39 781	94.4	5.6	19.1	27.8	19.6
Skåne	33 555	88.9	11.1	21.0	14.9	20.3
Östergötlands	11 149	89.2	10.8	17.6	30.6	19.0
Jönköpings	8937	92.0	8.0	20.6	31.7	21.5
Värmlands	8172	94.2	5.8	20.5	21.7	20.6
Gävleborgs	8129	87.1	12.9	17.6	36.2	20.0
Dalarnas	7793	94.8	5.2	22.6	41.7	23.6
Örebro	7501	92.9	7.1	20.9	47.1	22.8
Södermanlands	7377	84.3	15.7	19.8	29.9	21.4
Hallands	6924	87.6	12.4	26.6	35.8	27.7
Västmanlands	6798	75.9	24.1	18.5	34.3	22.3
Västernorrlands	6790	93.6	6.4	21.3	29.9	21.9
Kalmar	6782	97.3	2.7	25.7	33.1	25.9
Västerbottens	6637	85.6	14.4	23.9	36.8	25.8
Norrbottens	5942	97.8	2.2	25.5	32.6	25.6
Uppsala	5924	74.9	25.1	24.7	35.1	27.3
Blekinge	5071	92.4	7.6	15.9	24.0	16.5
Kronobergs	5069	94.3	5.7	19.0	39.1	20.1
Jämtlands	4133	89.3	10.7	18.5	15.8	18.2
Gotlands	1509	80.4	19.6	26.4	53.5	31.7
Total	236 360	83.0	17.0	21.0	31.5	22.8

Source: adapted from the National Board of Health and Welfare Statistics (2019a).

In October 2018, a little over 88 000 persons aged 65 years or older were living permanently in residential care homes (National Board of Health and Welfare 2019b), down from 97 500 in 2007 (- 9.7%). The proportion of elderly persons living in privately managed residential care homes increased every year from 2007 until 2014. Since then, the increase has levelled out, and around one in five persons are served by privately managed facilities (Table 4).

Table 4.
Number of permanent residents by type of facility management, 2007-2018.

		% of residents	
Year	Number of permanent residents aged 65 or older	Municipal management	Private management
2007	97 494	86.2	13.8
2008	96 736	84.7	15.3
2009	95 377	83.5	16.5
2010	93 980	81.4	18.6
2011	92 212	79.9	20.1
2012	90 521	79.5	20.5
2013	88 986	79.1	20.9
2014	88 712	79.1	20.9
2015	87 903	80.5	19.5
2016	88 886	79.5	20.5
2017	88 208	80.4	19.6
2018	88 044	80.5	19.5

Source: adapted from the National Board of Health and Welfare statistics (2019a).

The proportion of residents in privately managed residential care homes varies by region. At the one end, all services are provided by municipal managed facilities in Blekinge, whereas one in two residents are served by privately managed facilities in Stockholm (Table 5).

Table 5
Number of permanent residents by region by type of facility management, 2018.

		% of residents	
Region	**Number of permanent residents aged 65 or older**	**Municipal management**	**Private management**
Stockholm	15 608	50.9	49.1
Västra Götalands	14 104	90.3	9.7
Skåne	10 331	75.6	24.4
Östergötlands	4573	72.5	27.5
Jönköpings	3439	98.8	1.2
Gävleborgs	3202	89.6	10.4
Norrbottens	3183	98.9	1.1
Västmanlands	3067	86.4	13.6
Västernorrlands	3015	97.0	3.0
Västerbottens	2932	99.5	0.5
Uppsala	2909	63.8	36.2
Dalarnas	2885	92.1	7.9
Värmlands	2757	87.6	12.4
Hallands	2725	75.7	24.3
Södermanlands	2723	90.1	9.9
Örebro	2713	95.7	4.3
Kalmar	2261	94.6	5.4
Kronobergs	1873	84.8	15.2
Blekinge	1677	100.0	0.0
Jämtlands	1482	91.2	8.8
Gotlands	585	67.2	32.8
Total	**88 044**	**80.5**	**19.5**

Source: adapted from the National Board of Health and Welfare statistics (2019a).

4
Funding and co-payments

Health expenditure is mostly paid through local taxes, along with contributions from the national government via general grants, subsidies to the regions for outpatient medicines and specific national programmes. In 2018, the government invested 1 billion Swedish kronor (kr; €100 million) to improve access to care, with the two main objectives of providing greater treatment guarantees in primary care and developing 'patient contracts'. The latter are described as a coherent map of planned care that would contribute to 1) increasing care coordination, treatment and prevention efforts for patients with multiple health care contacts; 2) ensuring that all patients receive the care they need within a reasonable time; 3) ensuring that patients get an overview of planned care so that they can follow the care initiatives step by step and ask questions; and 4) increasing collaboration between health care providers and between regions and municipalities in care coordination and transitions.

Sweden allocated 10.9% of its GDP to health spending in 2019, the third highest share among EU countries and well above the EU 27 average of 8.3%. Sweden also has the third highest spending on health per person among EU countries, at €3919 [2] in 2019. Public expenditure accounts for 85 %, which is considerably above the EU average (73%). Households pay most of the remaining health spending (14%) directly out of pocket, while voluntary health insurance only accounts for about 1% of health spending. However, the number of people with private voluntary health insurance coverage is increasing rapidly, as this facilitates quicker access to consultation and care than using the public services.

Expenditure on care for the elderly by municipalities has slightly increased at an annual average of 0.2% (in constant 2017 prices) between 2013 and 2017 (Table 6). During this period, expenditures on nursing homes decreased by 0.4% annually, whereas expenditure for home care services increased by 1.9%. In 2017, expenditures on nursing homes and home care accounted for 56.9% and for 33.6% of total municipality expenditures for the elderly respectively. Between 2013 and 2017, the share of expenditures on nursing home in total municipality expenditures for the elderly decreased by one and half percentage points, while the share of home care increased by more than two percentage points during the same period.

2 Adjusted for differences in purchasing power.

Table 6
Expenditures on eldercare by municipalities, in constant prices, 2013-2017

	Year					
Expenditure (in billion SEK)	**2013**	**2014**	**2015**	**2016**	**2017**	**% share 2017**
Total	120.5	123	120.7	122.2	121.7	100
% change		2.1	-1.9	1.2	-0.4	
Nursing homes	70.5	70.7	68.5	69.6	69.3	56.9
% change		0.3	-3.1	1.6	-0.4	
Home care	37.9	40.1	40.5	41	40.9	33.7
% change		5.8	1.0	1.2	-0.2	
Other services	12.1	12.2	12.7	11.6	11.5	9.4
% change		0.8	4.1	-8.7	-0.9	

Source: adapted from the National Board of Health and Welfare (2019c).

The average expenditure per user varied significantly among municipalities. For home care services, the most expensive municipality spent more than five times the amount of the least expensive municipality, whereas for nursing homes, this difference was slightly lower (4.5 times). In 2018, spending per user of nursing homes was 3.4 times higher than the spending per user of home care (Table 7). Furthermore, spending decreased with increasing municipality size, whereas for home care services, expenditure was lower in municipalities with a population greater than 70 000.

Table 7
Average annual expenditure per user by municipality, 2018.

	Mean expenditure per user (in SEK)		Mean expenditure per user (in EUR)	
Municipality population	**Home care**	**Nursing home**	**Home care**	**Nursing home**
< 15000	286 709.8	1 005 976.4	27 568.2	96 728.5
15000 – 30000	294 616.8	928 013.4	28 328.5	89 232.1
30000 – 70000	264 520.4	883 140.6	25 434.6	84 917.4
70000 – 200000	238 946.3	837 407.3	22 975.6	80 519.9
> 200000	238 383.5	830 651.8	22 921.5	79 870.4
Total	**279 279.5**	**944 919.4**	**26 853.8**	**90 857.6**

Source: adapted from the National Board of Health and Welfare (2020).

Approximately 85% of eldercare funding comes from municipal/county taxes, and another 10% comes from national taxes. Users pay only a small share of the costs out-of-pocket[3]. Cost sharing for eldercare services is set according to the Social Services Act, with the aim of protecting recipients from excessive fees. A ceiling fee is set annually by the government, representing the maximum amount that a recipient can be charged. This ceiling is set without means testing in principle, although it may be reduced if the recipient's monthly income is below the minimum cost of living (the "reserve amount") as annually defined by the government. The reserve amount is the minimum amount to cover daily costs, rent and long-term additional costs due to individual needs. For a single person the reserve amount in 2015 was 5023 kr/month after housing costs. This means that if the person income after housing costs were paid was below 5023 kr/month, there was no elderly care fee. Within these rules, each municipality will determine its own schedule of cost-sharing fees for recipients.

As an example, Table 8 reports user's fees set by the City of Stockholm. The fee a beneficiary pays is based on her/his income, housing costs and what kind of assistance the person is granted. A person will never have to pay more than the maximum fee for the assistance she/he is granted. However, the person may pay a lower fee depending on her/his income, housing costs and certain other costs.

Table 8
Fee by assistance granted. City of Stockholm

Fee group	Scope of assistance granted	Max fee per month in SEK (EUR)
1	Only a personal security alarm or basic facilities in assisted living	142 (13.9)
2	1-4.5 hours of home care services and/or respite care 17-20.5 hours per month	492 (48.2)
3	5-10.5 hours of home care services and/or respite care 21-26.5 hours per month and/or day care activities 1-2 day per week	896 (87.8)
4	11-25.5 hours of home care services and/or respite care 27-41.5 hours per month and/or day care activities 3-4 day per week	1194 (117)
5	26-40.5 hours of home care services and/or respite care 42-56.5 hours per month and/or day care activities 5 day per week	1650 (161.7)
6	41-55.5 hours of home care services and/or respite care 57 hours or more per month and/or day care activities 6-7 day per week	1872 (183.4)
7	More than 56 hours of home care services per month. Short-term care and nursing home with round-the-clock care	2139 (209.6)

Source: Stockholms Stadt (2021).

3 In Sweden, fees are applied to almost all types of services and goods, with exceptions for maternal and child health services provided in primary care settings and some services for people aged over 85. The regions set the fees independently, and the fee structure provides an incentive to consult primary care over hospital visits. Only the fees for prescribed medicines and dental services are set at a national level.

Results of an OECD survey show that an hour of home care costs nearly €61 in Sweden, whereas institutional care costs from €1590 per week (Muir 2017). This survey also shows that in Sweden the costs for a person with severe needs represent three times and six times the median disposable income for individuals of retirement age for institutional care and home care, respectively (Muir 2017; OECD 2019a).

5
Contracting out eldercare services

There are two primary ways that Swedish municipalities contract out residential elderly care (Winblad, Blomqvist and Karlsson 2017; Bergman, Jordahl and Lundberg 2018): either through direct procurement according to the Public Procurement Act (2016), or through the freedom of choice system according to the Free Choice Act (2008). In the former case, private companies submit offers, either exclusively on price or on price and quality combined, and a municipality decides who gets the contract. In the latter case, the municipality sets the price and specifies some minimum quality requirements, and the individual choses a provider, according to her/his preferences, from an authorized list of providers that have met the municipality's criteria.

The evidence is that prices have played a determining role when contracts are awarded, even if most municipalities have some form of quality "base line" which all tenders must pass in order to be considered. According to Swedish competition law, contracts between the municipality and private providers cannot be entered into without a transparent and non-discriminatory selection process, which means that non-profit organizations are obliged to compete for municipal contracts on the same basis as for-profit firms. Notably, what is contracted out is the operation of nursing homes, which implies that the facilities are in most cases still owned by the municipalities. Swedish law also stipulates that the staff employed at the nursing home in question must retain their employment for at least one year after a new provider takes over the operation. Contracts are relatively short, typically 3–4 years, with the possibility of a single extension. It is important to note that contracting out nursing homes is voluntary and was used in about one third of municipalities in 2016. There is also large regional variation in this regard, as some municipalities chose to contract out all local nursing homes, i.e. 100%, whereas others chose to contract out only a limited number.

Compared with nursing homes, home care is characterized by low entry and low switching (Bergman, Jordahl and Lundberg 2018). From 2007 to 2014, the privately produced share of home care had increased from 10.7% to 18.5% of users and from 11.6% to 24.6% of the delivered hours of service. Between 2015 and 2018, these shares have decreased to 17% and 23.5% respectively (National Board of Health and Welfare

2019b). Within each municipality, the per hour payment is equal for all providers, including services provided by the municipality. Add-on payments may apply for night-time services and services in remote areas (Bergman, Jordahl and Lundberg 2018).

A system with free choice of providers requires robust, timely and reliable pieces of information on quality. For consumer choice to encourage better quality, it is essential that information regarding services and their quality be valid, clear and accessible and that consumers have the effective ability to exercise choice across a plurality of providers. To this aim, an 'Open Comparisons' national quality monitoring system for long-term care was established by the Swedish Government, the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions in 2007. The Open Comparisons tool shows providers' quality of care delivered to the elderly based on 28 indicators along with grading of provides' performance. A relative comparison between municipalities is based on a traffic light system. Quality of elderly care indicators are also avaialble online (https://kolada.se/verktyg/jamforaren/?_p=jamforelse&focus=16551).

6
The role of the private sector

The Local Government Act of 1991 made it possible for municipalities to outsource the provision of eldercare to non-governmental actors, both for-profit and non-for-profit. To stimulate a greater variety of eldercare providers and enhance the quality of services provided, the government introduced a new law in 2008, the Act of System of Choice in the Public Sector. This Act applies when a contracting authority decides to apply a system of choice regarding services within health and social services. 'System of choice' means a procedure where the individual is entitled to choose the supplier to perform the service and with which a contracting authority has approved and concluded a contract. The contracting authority shall treat suppliers in an equal and non-discriminatory manner. The contracting authority must also observe the principles of transparency, mutual recognition and proportionality when applying a system of choice. The aim of this act is to make it easier for a variety of commercial providers to enter the market of service and care for the elderly. The law works as a voluntary tool for those municipalities who want to let recipients choose suppliers, and to expose public sector providers to competition from the private sector.

Municipalities and regions can decide on how to organize the provision of eldercare, including collaboration with different providers. Either a municipality or a private provider (which can include private companies but also trusts and cooperatives) may provide institutional and home care. However, even when care is actually provided by the private sector, municipalities

and country councils still have the exclusive responsibility for financing care and ensuring an adequate level of quality.

Sweden has a higher proportion of private for-profit companies providing welfare services than any other country in Europe. Competition and choice can be effective and positive. Nevertheless, in a broader perspective, private interests often deviate from the interests of society (OECD 2019b). In effect the possibility of generating profits in the publicly financed welfare sector could result in for-profit organizations not acting as society would like them to do. The welfare sector must therefore be regulated so that organizations operating within it work to further society's interests.

In Sweden, large international corporations increasingly dominate the eldercare services market (Harrington et al. 2017). Of all nursing home care in Sweden, 12 934 permanent and temporary beds (13.5% of all beds) were provided by the five largest chains in 2015. This corresponded to 71.8% of private beds, and the 10 largest chains provided 86.8% of private beds. The two largest corporations, Attendo (92 homes, 5024 beds) and Ambea (77 homes, 3358 beds), ran half of the beds in for-profit homes. In the context of the Scandinavian tradition of universal, tax-financed care services centred on public provision, the recent wave of marketization and the increasing role of for-profit companies in residential care for older people were unexpected. In Sweden, for-profit chains operated 17% nursing home beds. This growth was considerable given that there were no for-profit actors in Scandinavia before the beginning of the 1990s.

The government has recently introduced increased license requirements and special rules for procurement in the welfare sector, including home help services for the elderly. The legislation aims at ensuring that private organisations have sufficient prerequisites for conducting business with good quality, and at strengthening the confidence in the sector.

Sweden was one of the pioneering countries to privatize its eldercare system ("marketization" started in the 1990s). Recent empirical research shows that the marketization of eldercare appears to be associated with an increase in some aspects of care quality like, for instance, choice offered by meals-on-wheels companies (Stolt, Blomqvist and Winbald 2011) or mortality rates (Bergman et al. 2016), but the results are mixed and inconclusive (Winblad, Blomqvist and Karlsson 2017). The increase in user satisfaction following the free-choice reform seems to be related to choice opportunity instead of private provision (Bergman, Jordahl and Lundberg 2018). The marketization of eldercare services is a controversial matter, because it raises potential quality-related and working condition issues as private eldercare providers could be involved in cherry-picking clients, and the influence of increased competition from private providers on public providers is uncertain. The marketization of the eldercare sector can lead to the emergence of competition issues when it takes place by take-overs (OECD 2019b).

An increase in the for-profit provision of publicly funded care services through policies promoting marketization, an increase of family care as well as services paid out-of-pocket appears to challenge universalism towards what Ranci and Pavolini (2015) call "restricted universalism" (Szebehely and Meagher 2018; Ulmanen and Szebehely 2018).

7
Informal caregiving, cash benefits to family members and housing adaptation

Municipalities are required by law (since 1 July 2009) to provide support to informal carers. According to the Social Services Act, municipalities need to respect and cooperate with informal carers, offering support tailored to their needs. The aim is to alleviate the workload of carers and its impact on their health status, as well as providing the carers with necessary information and knowledge. The Act also aims to provide recognition of the work provided by carers and acknowledge its importance. In accordance with the above, support for informal carers takes different forms. Carers have the right in some circumstances to take leave from their work in order to provide care for a terminally ill relative. Municipalities also provide support groups or centres for carers, which can be a source of mutual support. Municipalities can provide "Respite leave", giving carers temporary leave from their caring responsibilities, with responsibilities being taken over by home care providers or charities over that period (provided for free in about 50% of municipalities; in others a small charge is required) or by institutional providers on a temporary basis. In addition, there are different services that provide informal carers with advice, including one-on-one sessions, websites and assistance from volunteers.

There are two types of cash benefits available for family carers in Sweden: the attendance allowance and the carers allowance. These allowances are, however, not provided everywhere as each municipality may decide whether to provide this programme or not and also decide what the eligibility criteria and level of payment should be. The "attendance allowance" is given on top of services provided to the care recipient. It is a net cash payment given to the care recipient to be used to pay for help from a family member. The level of reimbursement is at most about 4000 kr/month (€450). The other benefit is the "carers allowance": the municipality employs a family member to do the care work. Carers allowance is taxed and gives the same salary and similar social security as for home-help workers in the municipality's own services.

In July 2016, the government introduced government grants for arranging and providing housing for older people. The purpose of the grants is to encourage renovation of existing residential properties for elderly people and the construction of new ones, as well as covering modifications to properties in order to enable older people to remain in their homes through

improved accessibility and safety. 150 million Swedish kronor was allocated for this purpose in 2016, 300 million Swedish kronor in 2017 and from 2018, 400 million Swedish kronor is allocated on a yearly basis. Parliament decided in April 2018 to adopt the government's proposal for a new law on housing adjustment contributions. The new legislation entered into force in July 2018 and aims at providing housing for disabled people, giving them the opportunity to live an independent life in their own housing.

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Case study

United States of America

Luca Lorenzoni

Organisation for Economic Co-operation and Development

Paris, France

Abstract

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and other types of assistance that are needed by individuals over an extended period of time. The need for LTSS affects persons of all ages and is generally measured by limitations in an individual's ability to perform daily personal care activities, such as eating or walking, and activities that allow individuals to live independently in the community, including shopping and meal preparation. The probability of needing LTSS increases with age. LTSS vary widely in their intensity and cost depending on the individual's underlying conditions, the severity of his or her disabilities, the setting in which services are provided and the caregiving arrangement.

There are no universal LTSS benefits in the United States, and the current system combines a small private insurance market with means-tested coverage through Medicaid. Medicaid allows for the coverage of LTSS services over a continuum of settings, ranging from institutional care to community-based LTSS. People become eligible because they have low incomes and assets and meet specific thresholds for functional impairment.

Under the Medicaid program, prices are usually set unilaterally at the state level following guidelines established at the national level. The base for payment ranges from a day of stay for nursing facilities to a unit of service for home-based care. Prices vary across and within states and are also based on adjustment factors, such as geographical location, to the base price. Managed LTSS plans play a key role in the delivery of health care to Medicaid enrolees. These plans receive capitated payments per enrolee, including both home- and community-based services and/or institutional-based services. Prices are determined through either administered pricing or competitive bidding.

Despite the strong case for risk pooling, there are few private insurance options covering LTSS available. Private insurance for LTTS remains a niche product covering only a small proportion of total LTSS costs.

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1
What are long-term services and supports and who uses them

Long-term services and supports (LTSS) refer to an extensive range of health and health-related services and other types of assistance needed by individuals who lack the capacity for self-care due to physical, cognitive, or mental conditions or disabilities[1]. Most LTSS are not skilled medical care, but rather help with basic personal tasks of activities daily living (ADLs; such as eating, bathing, dressing, etc.) and instrumental ADLs (IADLs; such as housekeeping, managing money, etc.) over an extended period to maintain or improve an optimal level of physical functioning and quality of life among people with disabilities (Favreault 2020).

LTSS are delivered in a variety of settings, some institutional (e.g. intermediate care facilities for people with intellectual and developmental disabilities, nursing homes), and some home- and community-based (e.g. adult day services, assisted living facilities and personal care services at home). As of 2016, there were 4 600 adult day services centres[2], 12 200 home health agencies, 4 300 hospices, 15 600 nursing homes and 28 900 residential care communities. Home health agencies (80.6%) and residential care communities (81.0%) had the highest percentages of for-profit ownership (Harris-Kojetin et al. 2019). In 2016, there were 811 500 residents living in residential care communities and 1 347 600 residents in nursing homes. In 2015, about 4 456 000 persons received services from home health agencies (Harris-Kojetin et al. 2019).

The need for LTSS affects persons of all ages – children born with disabling conditions, working-age adults with inherited or acquired disabling conditions, and the elderly with chronic conditions or diseases. Although people of all ages may need LTSS, the risk of needing these services increases with age. The majority of long-term care (LTC) services users are aged 65 years and over: 94.6% of hospice patients, 93.4% of residential care residents, 83.5% of nursing home residents, and 81.9% of home health beneficiaries (Harris-Kojetin et al. 2019).

The LTC services delivery system has changed substantially over the last 30 years. Although nursing homes are still a major provider of LTC services, there has been growing use of skilled nursing facilities for short-term post-acute care and rehabilitation. Additionally, people desire to stay in their own homes as well as federal and state policy developments have led to growth in a variety of home- and community-based alternatives. The major sectors of paid LTC services providers now also include adult day services centres, assisted living and

1 Experts disagree on whether Medicare expenditure for skilled nursing facilities and home health agencies – since they are post-acute services – should be categorised as LTSS. This report – consistent with the approach used by the U.S. Congressional Budget Office – includes them as part of LTSS.

2 Adult day health centers provide social and other related support services in a community-based setting for part of the day.

similar residential care communities, home health agencies and hospices (Harris-Kojetin et al. 2019).

2
How much do LTSS cost

LTSS vary widely in their intensity and cost depending on the individual's underlying conditions, the severity of his or her disabilities, the setting in which services are provided and the caregiving arrangement (i.e. informal versus formal care). For those receiving LTSS at home, the cost for these services can vary depending on the amount and duration of the care provided. According to a survey[3] on the amount of paid LTSS received by adults living at home, the median cost of homemaker services (e.g. meal preparation, housework) was US$ 21 an hour, whereas the median cost of care provided by a home health aide (e.g., hands-on assistance with personal care needs) was US$ 22 an hour in 2018. Adult day health centres had a median cost of US$ 72 per day in 2018. Residential settings that provide housing and services as well as institutional settings that provide room and board tend to have higher annual costs than home care services, on average. Assisted living facilities that provide homemaker services (meals, laundry, or housework) and may provide personal care for those who need assistance with ADLs (but do not yet require constant care provided in a nursing home) had a median daily cost of US$ 123 in 2018. Nursing home care, on the other hand, generally costs more, because it provides assistance 24 hours a day and includes the cost of room and board. In 2018, the median daily cost of nursing home care was about US$ 245 for a semi-private room and US$ 275 for a private room. These estimates are national figures and can vary widely by state (Table 1).

3 CareScout – a Genworth company – completed over 15 000 surveys of nursing homes, assited living facilities, adult day facilities and home care providers. Survey respondents were contacted by phone between May and June 2018 (https://pro.genworth.com/riiproweb/productinfo/pdf/131168.pdf).

Table 1
Mean price and variation across state by type of service, 2018.

Type of service	Median hourly price (in US$)	Median daily price (in US$)	Lowest price in US$ (State)	Highest price in US$ (State)
Nursing home (private room)		275	174 (Oklahoma)	452 (Connecticut)
Nursing home (semi-private room)		245	153 (Oklahoma)	415 (Connecticut)
Assisted living facility		132	94 (Missouri)	305 (District of Columbia)
Home health aide	22		16 (Louisiana)	28 (Washington)
Homemaker services	21		16 (Louisiana)	28 (Washington)
Adult day services		72	35 (Alabama, Mississippi, Texas)	136 (Vermont)

Source: compiled by the Author on the basis of the Genworth Cost of Care Survey (https://www.genworth.com/aging-and-you/finances/cost-of-care.html).

The cost of obtaining paid assistance for these services, especially over a long period, may far exceed many individuals' financial resources. Moreover, public programs that finance this care, such as Medicaid or Medicare, may not cover all the services and supports an individual may need. Large personal financial liabilities associated with paid LTSS may leave individuals in need of LTSS and their families at financial risk. Among older adults with significant disabilities, only 40% could fund at least two years of extensive home care if they liquidated all their assets (Johnson and Wang 2019).

3
Who pays for LTSS

Spending on LTSS is a significant component of total personal health care spending. In 2016, an estimated US$ 366.0 billion was spent on LTSS[4], representing 12.9% of the US$ 2.8 trillion spent on personal health expenditures (Collelo 2018). LTSS are financed by a variety of public and private sources. In 2016, public sources paid for the majority of LTSS spending (70.3%). Medicaid and Medicare were, respectively, the first- and second-largest public payers, and accounted for nearly two-thirds (64%) of all LTSS spending. Other public programs – such as the Veterans Health Administration and Children's Health Insurance Program – that finance LTSS for specific populations account for a much smaller share of total LTSS funding (6.3%). It is important to note that the eligibility requirements and benefits provided by these public programs vary widely. Moreover, among the various public sources of LTSS financing, none are designed to cover the full range of services and supports that may be desired by individuals with LTC needs.

In the absence of public funding for LTSS, individuals must rely on private sources of funding. In 2016, private sources accounted for 29.7% of LTSS expenditures. Within the category of funding, out-of-pocket spending was the largest component (over half of private sources), comprising 15.7% of total LTSS expenditures. Second was private insurance (7.5%), which includes both health insurance and LTC insurance (LTCI). Other private funding, which largely includes philanthropic contributions, accounted for 6.5% of total LTSS.

4 A substantial amount of LTSS is also provided by family members, friends and other uncompensated caregivers. Thus, formally reported spending on LTSS underestimates total expenditures, as spending data do not include uncompensated care provided by these caregivers.

4
Medicaid

Medicaid is a means-tested health and LTSS program funded jointly by federal and state governments. Medicaid funds are used to pay for a variety of health care services and LTSS, including nursing facility care, home health, personal care and other home and community-based services. Each state designs and administers its own program within broad federal guidelines. Medicaid is the largest single payer of LTSS in the United States (Thach and Wiener 2018); in 2016, total Medicaid LTSS spending (combined federal and state) was US$ 154.4 billion, which accounted for 42.2% of all LTSS expenditures. In 2016, LTSS accounted for 30.6% of all Medicaid spending.

Medicaid beneficiaries who use LTSS are a diverse group of people, extending from young to elderly, with many different types of physical and cognitive disabilities. About half of Medicaid beneficiaries receiving LTSS are adults age 65 and older (MACPAC 2014). Given beneficiary preferences to age at home or in a home-like setting, Medicaid spending for these beneficiaries increasingly is for home and community-based services (HCBS). With HCBS, a beneficiary may receive a few hours of personal care services each day for assistance with bathing, dressing and preparing meals. Such services usually supplement support from informal caregivers such as family members and neighbours.

Despite increasing use of home and community-based services, the organization, financing, and delivery of Medicaid-funded LTC services remains biased towards institutional care. Recognizing the challenges, the Affordable Care Act contains a number of provisions to help states balance their Medicaid long-term service delivery systems by expanding access to an array of home and community-based services and reducing dependence on institutional care, including:

- a new State Balancing Incentive Payments Program to encourage states to increase Medicaid LTSS in the home and community
- state plan options for HCBS including Community First Choice
- increased funding for rebalancing initiatives like "Money Follows the Person" (MFP)

The goal of the Medicaid balancing initiatives is to create a person-driven, long-term support system that offers people with disabilities and chronic conditions choice, control and access to services that help them achieve independence, good health and quality of life. A balanced system is (as seen at: https://www.medicaid.gov/medicaid/long-term-services-supports/balancing-long-term-services-supports/index.html):

- person-driven: the system gives people choice over where and with whom they live, control over the services they get

and who they get services from, the chance to work and earn money, the option to include friends and supports to help them participate in community life;

- inclusive: the system encourages people to live where they want to live, with access to a full array of community services and supports;
- effective and accountable: the system offers high quality services that improve quality of life. Accountability and responsibility are shared between public and private partners and includes personal accountability and planning for LTC needs, including greater use of private funding sources;
- sustainable and efficient: the system efficiently coordinates and manages a package of paid services appropriate for the beneficiary, paid for by the right entity;
- coordinated and transparent: the system coordinates services from various funding streams to provide a seamless package of supports and uses health information technology to effectively provide transparent information to consumers, providers and payers; and
- culturally competent: the system provides user-friendly, accessible information and services.

The goals of the MFP program are:

- increase the use of HCBS and reduce the use of institutionally-based services;
- eliminate barriers in state law, state Medicaid plans and state budgets that restrict the use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary LTSS in the settings of their choice;;
- strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and
- put procedures in place to provide quality assurance and improve HCBS

Medicaid policies to determine eligibility for LTSS focus on finances (income and assets) and measures of functional status, rather than the existence of a specific clinical condition. In other words, people become eligible because they have low incomes and assets and meet specific thresholds for functional impairment.

In general, states are required to provide Medicaid to individuals receiving Supplemental Security Income (SSI) benefits. In 42 states and the District of Columbia, individuals eligible for SSI are automatically eligible for full Medicaid benefits, including LTSS offered under the state plan, if they meet specific functional eligibility criteria. Some states establish more restrictive criteria for LTSS benefits – either income and resource thresholds or functional eligibility criteria – than SSI.

The federal government does not require states to use a particular assessment tool to determine eligibility or to develop a care plan. Almost all states use at least one tool that they developed themselves, and a recent review shows that there are at least 124 tools currently in use and, on average, states are using three different tools each for different populations (MACPAC 2016). Virtually all states assess functional limitations, clinical needs or health status, and behaviour and cognitive status.

States can also use one or more optional pathways designated in federal laws and regulations to provide eligibility to people with a need for LTSS. These include:

- Poverty-related pathway: this is an optional pathway allowing the state to cover individuals with incomes up to 100% of the federal poverty level (FPL) who have disabilities or are over age 65. This pathway and the Medicaid buy-in and medically needy eligibility pathways (see below) also use the SSI age and disability eligibility criteria. These enrolees are entitled to full Medicaid benefits including state plan LTSS if the individual meets the state's Level-of-care (LOC)[5] or targeting criteria. The level of income and resources that qualify an individual for the poverty-related pathway varies by state.
- Medically needy pathway: this pathway allows states to cover individuals with high medical expenses relative to their income once they have spent down to a state's medically needy income level. The income threshold and the budget period used in medically needy eligibility determinations are state specific. States may offer full Medicaid or a more limited set of state-specified benefits to this group. They may also provide institutional LTSS and home and community-based services waiver benefits to those meeting LOC criteria.
- Special income-level pathway: under this pathway, states may cover individuals who meet LOC criteria for certain institutions and have incomes up to 300% of the SSI benefit rate (which is about 222% FPL). Functional eligibility for this pathway is determined using the state-established LOC criteria that typically require enrolees to need institutional-level services and supports. In 2018, 42 states and the District of Columbia had a special income level eligibility pathway. Most states with a special income level eligibility pathway set the income level at 222% of the federal poverty level (MACPAC 2018a).

States also have policies that allow LTSS users to protect portions of their income or resources and still qualify for Medicaid-covered LTSS. These include:

- Personal allowances: states must establish monthly levels of income that an LTSS user may retain to cover the cost of

5 A level of care determination is a decision made about an individual's physical, mental, social, and/or emotional status.

certain personal expenses after fulfilling any cost-sharing requirements. Enrolees using either institutional or HCBS LTSS may retain a monthly allowance to pay for goods and services not provided by the facility or covered by Medicaid (e.g. clothing or room and board costs of HCBS users).

- Income disregards: Medicaid law allows states to adopt rules that would prevent the impoverishment of a spouse of a Medicaid beneficiary receiving LTSS. Additionally, the law exempts a community-residing spouse's income for the purposes of Medicaid eligibility and allows the institutionalized spouse to transfer income to a limited-income community spouse, up to a state-determined maximum level (https://www.medicaid.gov/medicaid/eligibility/spousal-impoverishment/index.html).

Federal law also allows for the establishment of certain trusts[6] that may not be counted for the purposes of determining Medicaid eligibility, thereby allowing individuals with higher incomes or resources to qualify for Medicaid LTSS. Pooled income trusts are run by non-profit associations on the behalf of individual beneficiaries.

Beneficiaries receiving LTC services in an institution or in the community qualifying through certain eligibility groups are required to apply their income exceeding specified amounts toward the cost of their care. Within federal guidelines, a beneficiary may retain a certain amount of income for personal use based on the services one receives (Colello 2017).

A description of the system used by Medicaid to pay for services provided in nursing facilities, at home and in the community, in residential care settings as well as through managed care programs is reported below.

4.1 Nursing facilities

Nursing facilities are institutions certified by a state to offer 24-hour medical and skilled nursing care, rehabilitation or health-related services to individuals who do not require hospital care. Nursing facility services are mandatory benefits that must be covered by all state Medicaid programs.

Medicaid is the primary payer of nursing facility services. Nationally, Medicaid covers over 60% of nursing facility residents (Harris-Kojetin et al. 2019). In fiscal year 2017, Medicaid spending on institutional LTSS was approximately US$ 58 billion, or about 10% of total program benefit spending (MACPAC 2018a).

States have broad flexibility to determine payments to nursing facilities. Federal rules do not prescribe how nursing facilities should be paid or how much they should be paid, but require that Medicaid payment policies should promote efficiency,

6 Examples are Miller Trusts (also known as Qualified Income Trusts), which are used in some states that offer the special income level eligibility pathway and do not have a medically needy spend-down provision, and "Type A" special needs trusts, which are established on behalf of an individual with a disability under the age of 65 in some states.

economy, quality, access and safeguard against unnecessary utilization. Under fee-for-service (FFS) payment arrangements, state Medicaid programs typically set and pay nursing facilities a daily rate, called a per diem. States often apply a variety of adjustments and incentives to the base payment, and there is considerable variation in rates both within and across states. Nursing facility FFS payment policies differ on many dimensions, such as the inflation adjustments used in rate settings, how many days Medicaid pays for "bed holds" due to hospitalization or therapeutic leave and adjustments made based on resident acuity levels (MACPAC 2014).

As an example, in Illinois the reimbursement rates are facility specific. Individual rates are set for each nursing facility, taking into account individual facility costs, variations in patient case mix, geographical location and other facility characteristics such as occupancy level. These rates vary between US$ 98 and US$ 257 per day (https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/LTC.aspx). The reimbursement rate has three components: nursing and direct care component; support service component; and capital component. In the state of New York, the per diem reimbursement rates are facility specific too and vary between US$ 131 in a nursing home in Yates county and US$ 603 at the Henry J Cartes Skilled Nursing Facility in New York City (https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/). A large variation in per day rates – ranging from US$164 to US$ 308 – is also reported for Florida (https://ahca.myflorida.com/medicaid/cost_reim/nh_rates.shtml).

The quality of care provided in nursing facilities has been an ongoing issue of concern to policy makers. The U.S. Department of Health and Human Services Office of Inspector General and the U.S. Government Accountability Office have called attention to nursing home quality deficiencies and identified opportunities for improvement in patient care, information shared with consumers, and federal oversight (United States Government Accountability Office, 2015; OIG 2018). Among the programs the Centers for Medicare and Medicaid Services (CMS) uses to address nursing facility quality concerns and share information with consumers are the following:

- Special Focus Facility Initiative, which requires corrective actions for nursing facilities with a history of serious quality issues (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf);
- Five-Star Quality Rating System, which uses nursing facility inspections, staffing data, and quality measures to assign ratings to nursing facilities (https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/fsqrs.html); and
- Nursing Home Compare website, which shares information including the ratings system results to consumers to aid in

their selection of a nursing facility (https://www.medicare.gov/nursinghomecompare/search.html).

4.2 Home and community-based services

Home and community-based services (HCBS) allow people with significant physical and cognitive limitations to live in their home or a home-like setting and remain integrated with the community. HCBS are optional benefits, and states vary considerably in how they organize their HCBS programs. Some states provide certain HCBS in the state plan, which requires that those services be made available to all eligible beneficiaries (although states may include LOC criteria). States may also use waiver authorities to limit the number of beneficiaries receiving services, target specific populations, or limit availability to certain parts of the state. States may also use Section 1115 research and demonstration waivers to provide HCBS or use some combination of state plan and waiver options.

The term HCBS encompasses a wide range of services including personal care services provided in a home or residential care setting, supported employment, non-medical transportation and home-delivered meals. States may not cover the same types of HCBS, or they may cover similar services using different service terms and payment methodologies. As a result, Medicaid spending on beneficiaries using HCBS varies widely, particularly for beneficiaries with the greatest LTSS needs (MACPAC 2018c).

Medicaid beneficiaries increasingly are receiving LTSS through HCBS. In fiscal year (FY) 2016, Medicaid programs spent approximately US$ 94 billion on HCBS, which represented a 10% increase in HCBS spending over FY 2015 (Eiken et al. 2018). Nearly one in three HCBS users were 65 years old or more (MACPAC 2018c).

As HCBS grows as the predominant way of delivering LTSS to Medicaid beneficiaries, HCBS policy continues to evolve. Current developments in HCBS include the following:

- States are implementing new requirements that HCBS settings must meet to be eligible for Medicaid payment. These requirements are meant to ensure that beneficiaries receiving HCBS have adequate choices, their rights are protected, and HCBS is truly integrated into the community.
- States are also implementing electronic visit verification (EVV) for personal care services. These commonly are web-based applications that enable personal care services providers to verify their visits to beneficiaries' residences. EVV helps Medicaid programs ensure that authorized personal care services are delivered to prevent disruptions in beneficiaries' care and protect the Medicaid program against fraud.

- A number of efforts are underway to develop and test quality measures for HCBS to aid policymakers in the oversight of LTSS programs. These efforts, which span both Medicaid FFS and managed LTSS programs, place emphasis on beneficiary experiences and outcomes.

Under FFS payment arrangements for home health services, state Medicaid programs typically pay home health agencies a price per visit. States often apply a variety of adjustments, and there is considerable variation in prices both within and across states. As an example, in Washington State, the fee is set by county and includes a price for brief skilled nursing visit (US$ 29), a price for a session of 15 minutes of physical therapy (between US$ 20-23), a price for a session of speech therapy (between US$ 87-101), a price for a session of 15 minutes of occupational therapy (between US$ 21-25) and a price for a home health aide visit (between US$ 53-59) (see https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules). In Illinois, the different types of visit – physical, speech and occupational therapy and home health aide – have the same price (US$ 72) (see https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/HHFeeSchedule.aspx). In Florida, a registered nurse visit is paid US$ 31 , a licenced practical nurse visit US$ 26 and a home health aide visit US$ 17 (see https://ahca.myflorida.com/medicaid/review/fee_schedules.shtml). A home health aide visit, a speech therapy session by a licenced therapist and a physical therapy evaluation are paid US$ 46, 107 and 116, respectively, in Texas (see http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx). In Colorado, a visit (up to 2 and half hours) of a registered nurse is paid US$ 112, and a home health aide visit lasting less than one hour is paid US$ 38 (see https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule). In Mississippi, prices are provider-specific and set for four different type of services: skilled nursing care (ranging from US$ 80 to US$ 116); physical therapy (ranging from US$ 65 to US$ 68); speech therapy (ranging from US$ 65 to US$ 68) and home help aide (ranging from US$ 35 to US$ 49) (see https://medicaid.ms.gov/wp-content/uploads/2019/10/FY2020HomeHealthRates.pdf).

4.3 Residential care settings

Residential care settings (RCS) are a diverse set of community-based settings for individuals who are unable to live independently due to functional or cognitive limitations. RCS include homes, where a few beneficiaries reside with a provider or paid caregiver, and larger group settings, where a beneficiary may live in his or her own apartment. RCS vary in the types of services they provide and the degree of impairment of the populations they serve. Personal care services, such as assistance with ADL and IADL, are commonly offered in RCS (Carder, O'Keeffe and O'Keeffe 2015). Some RCS include dementia care units, which provide specialized services to

individuals with Alzheimer's disease or other forms of dementia. Primarily state laws regulate RCS.

The Medicaid rate-setting methodology for RCS varies by state. The methods used to set prices for services delivered in RCS are the following (the number of states that use each method is reported within brackets) (see https://www.macpac.gov/subtopic/table-3-medicaid-rate-setting-methods-for-services-delivered-in-residential-care-settings-by-state-2016/):

- Flat rates (18): the facility receives the same payment regardless of its individual facility costs and regardless of the type and amount of services actually provided. These rates may vary by factors such as urban/rural location or single/multiple occupancy unit.
- Tiered (16): the reimbursement system is based on state-defined levels of care for the facility level or at the individual level. At the individual level, individuals are assigned to a tier based on their assessment or needs, and there is a payment level associated with each category. At the facility level, the entire facility is slotted into a tier, which could be by licensure category that varies by the level of service they provide or the disability level of the residents that they serve.
- Case mix (6): reimbursement rates vary by the case mix of the facilities or individuals. Case mix only applies when there are no tiers or categories and the payment rate is determined along a continuum based on the individual's assessment. Providers are paid based on the number of hours and level of assistance needed by the resident. The case-mix adjusted rate for a facility is calculated by averaging the assessment levels for all residents and multiplying that index by the standard rate set by the state.
- Cost based (7): the reimbursement rate of each facility varies with the costs of each facility.
- FFS (10): payment is made for each separate service provided. Payment amounts are determined by the number of units of specific types of services used by a Medicaid beneficiary, which are identified from the resident's service plan.
- Negotiated (14): reimbursement rates are not fixed, but are the result of deliberations between stakeholders (e.g., individual residents, providers, the state, or a managed care organization).

Table 2 shows the details of the rate-setting methodology for services delivered in RCS for selected states. Details of the rate-setting methods clearly show significant variations in the process of price setting, the payment unit and the adjustment factors to the base payment.

Table 2.
Rate-setting methodology for residential care services, selected states

State	Rate-setting methodology	Details
Alaska	Flat or cost-based	Providers are reimbursed at the lesser of billed charges or a unit rate based on an established fee schedule. The fee schedule is revised at least every four years based on provider-reported costs. The unit rate varies by facility type (government-owned versus non-government-owned), size of facility (5 or fewer beds, 6–16 beds, 17 or more beds) and geographic region. Providers receive an acuity add-on payment for residents who require one-to-one staffing care 24 hours per day.
California	Tiered	The reimbursement system has five service levels for residential care facilities for the elderly (RCFEs). Daily rates range from US$ 52 per day for tier US$ 1 to US$ 200 per day for tier 5. RCFEs cannot negotiate the services to be delivered or the payment rate. The reimbursement rate for tier 5 is based on the state-wide weighted average skilled nursing facility daily rate.
Connecticut	Case mix	Providers receive a base rate plus additional amounts based on the individual participant's assessed cognitive, functional and behavioural needs.
Florida	Managed Care Organisation (MCO)-negotiated	Rates are negotiated between MCOs and providers. The MCOs have the flexibility to determine their payment models.
Illinois	Flat	A flat daily rate is paid. While the rate does not vary by type or frequency of service, it does vary by geographic location. Rates are calculated at 60% of the average weighted nursing facility rate in a specific geographic area. The dementia program rates are 72% of the average weighted dementia care nursing facility rate in a geographic area.
Iowa	Cost-based	Fee schedules for the various services are determined by the Department with advice and consultation from appropriate professional groups. Providers are reimbursed the lower of their actual charges or the maximum allowance under the fee schedule for the service. Fee schedules may be increased or decreased by the Iowa legislature through its Medicaid appropriations.
Nevada	Tiered	For the frail elderly waiver program, the state uses a tiered rate system based on three levels of care for each individual that ranges from minimal assistance with an ADL to maximum assistance with four or more ADLs.
New York	Tiered	Providers are paid rates based on 16 classification groups. The rate is related to an average residential health care facility rate consisting of a direct component and an other-than-direct component. The direct component of the rate for each classification group is determined by a state-wide mean direct case mix neutral cost multiplied by a case mix index for the classification group; this amount is divided by a regional direct input price adjustment factor for the patient classification group and trended by the applicable weighted average regional roll factor.
Oregon	Tiered negotiated	The state has five rate levels for assisted living facilities. The level is based on residents' assessed needs, including the need for assistance with ADLs. Rates for adult foster home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process.

State	Rate-setting methodology	Details
Washington	Tiered	Tiered rates are determined by assessing beneficiaries with the Comprehensive Assessment Reporting Evaluation (CARE) tool. Seventeen levels of care classifications determine rates. Reimbursement rates are also determined by the location of the facility. Facilities in King County or other counties determined to be Metropolitan or Non-Metropolitan receive different rates. Facilities that retain a Medicaid occupancy percentage of sixty percent or higher also receive a higher rate.

Source: compiled by the Author on the basis of MACPAC "Medicaid Rate-Setting Methods for Services Delivered in Residential Care Settings by State, 2016" (https://www.macpac.gov/subtopic/table-3-medicaid-rate-setting-methods-for-services-delivered-in-residential-care-settings-by-state-2016/).

4.4 Managed care

States design and administer their own Medicaid programs within federal rules and determine how they will deliver and pay for care for Medicaid beneficiaries. Nearly all states have some form of managed care in place – comprehensive risk-based managed care and/or primary care case management programs. As of July 2019, 40 states contract with comprehensive, risk-based managed care plans to provide care to at least some of their Medicaid beneficiaries (Hinton et al. 2019). State Medicaid programs increasingly use managed care as one of several strategies to improve care coordination and manage costs for populations with complex health care needs and disproportionately high Medicaid expenditures. The theory behind this shift is that managed care plans can do things that state Medicaid agencies cannot, such as use sophisticated network contracting, information technology and utilization management systems to (try to) squeeze out low-value care and improve the health of beneficiaries (Goldsmith, Mosley and Jacobs 2018). In addition, importantly, contracting with managed care organisations shifts responsibility for politically troublesome negotiations over provider payment to private enterprises.

Managed long-term services and supports (MLTSS) refers to an arrangement between state Medicaid programs and managed care plans through which the managed care plans receive capitated payments for LTSS, including both home- and community-based services and/or institutional-based services. In fully integrated models, these payments for MLTSS are combined with payments for primary, acute and behavioural health services, and the capitation payment is comprehensive. As of June 2019, 24 states operate MLTSS programs, in which state Medicaid agencies contract with managed care plans to deliver LTSS, up from just eight states in 2004 (MACPAC 2018b).

The administration of MLTSS is generally similar to Medicaid managed care, but the mix of services and the wide range of needs of beneficiaries who receive LTSS adds complexity, particularly for rate setting and care coordination[7]. Factors involved in setting monthly capitation rates per beneficiary include the range of services provided, the wide variability in the needs of beneficiaries receiving LTSS and the need to promote program goals through financial incentives. By law, states must develop and get CMS approval of rates that are actuarially sound. Actuarially sound rates are projected as providing for all reasonable, appropriate and attainable costs required of the managed care plan to fulfil the terms of its contract with the state. These rates must be developed in accordance with requirements for CMS's review and approval of rates (United States Government Accountability Office 2017):

- Baseline data and carve outs: to project costs, states rely on various data, such as data on demographic, health and functional factors; the setting of care; and the scope of benefits. The sources and extent of these data, referred to as base data, vary by state. States require managed care plans to provide encounter data, and states may also use financial data from the managed care plan and claims data from the Medicaid FFS population. Plans cannot arbitrarily raise provider contracts or other costs; costs reflected in the rate setting must be reasonable and are judged against industry standards.
- Expected trends and incentives: states and their actuaries project costs and set rates based on these data with adjustments and assumptions to account for missing, incomplete, or anomalous data, the extent to which covered populations and services are reflected in the data, changes in benefits and policies and trends in utilization and prices of services.
- Certification: when setting or amending rates, states must submit an actuarial rate certification that explains how the rates were developed. CMS expects the rate certification to provide sufficient detail, documentation, and transparency to enable another actuary to assess the reasonableness of the methodology and the assumptions. CMS reviews the rate certification for compliance with agency requirements, including the rate guide for that year. CMS may ask questions of the state until CMS can assess that the data, assumptions and rate development were reasonable and meet generally accepted actuarial principles and practices, at which point CMS approves the rates for the state to pay to the managed care plans.

7 MLTSS plans typically employ care coordinators who assess beneficiaries' needs and develop plans of care for the wide range of LTSS for which they qualify.

States typically pay for risk-based managed care services through fixed periodic (usually monthly) payments for a defined package of benefits. These payments are typically made on a per member per month basis. Plans then typically negotiate with providers to deliver services to their enrolees, either on a FFS basis, or through arrangements under which they pay providers (e.g. primary care providers) a fixed periodic amount to deliver services.

The approaches that states use for determining capitation payments to managed care plans depend on the methods that they use to contract with these plans. In general, the following approaches are used to establish rates (MACPAC 2011):

- Administered pricing: capitation payments are determined by the state; plans determine whether they wish to apply for participation in the program.
- Competitive bidding: states typically issue a request for proposals and then select managed care plans based on an evaluation of their proposed rates and services.

Administered pricing allows states to set rates at the lower end of an actuarially sound range, rather than having to accept a competitive bid potentially at the higher end of the range. States may use administered pricing, for example, when faced with budgetary limitations. States may also use hybrid approaches, such as setting a range of rates and then asking plans to bid competitively within that range, or negotiating with plans based on the administered pricing or their competitive bids.

As an example, the capitation rates set by Medicaid for LTC services to elderly and disabled in Arizona, and the lower bound, mid-point and upper bound of the capitation rate used for competitive bidding by Medicaid in California are reported in tables 3 and 4 below.

Table 3
Medicaid managed care plans capitation rates, Arizona, January-September 2020.

Beneficiary	Contractor	Geographical service area	Annual capitation rate (in US$)
Dual	United Healthcare	North	3125
Dual	Banner-UFC	South	3685
Dual	Mercy Care	South	3438
Dual	United Healthcare	Central	3020
Dual	Banner-UFC	Central	3889
Dual	Mercy Care	Central	3812
Non-dual	United Healthcare	North	6525
Non-dual	Banner-UFC	South	6514
Non-dual	Mercy Care	South	7211
Non-dual	United Healthcare	Central	7112
Non-dual	Banner-UFC	Central	7875
Non-dual	Mercy Care	Central	7855

Note: Dual: refers to a beneficiary enrolled in both Medicare and Medicaid programs

Source: compilation by the Author on the bais of Arizona Health Care Cost Containment System Contractor Capitation Rates (https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/capitationrates.html).

Table 4
Medicaid managed care plans capitation rates, selected counties, California, FY 2017-18

			Monthly capitation rate (in US$)		
County	Health Plan	Category of beneficiary	Lower Bound	Midpoint	Upper Bound
Fresno	Anthem Blue Cross	Adult	227.3	234.8	242.6
Fresno	Anthem Blue Cross	Seniors and Persons with Disabilities (SPD)	752.7	774.5	797.3
Fresno	Anthem Blue Cross	SPD/Dual	155.4	160.6	166.1
Fresno	CalViva Health	Adult	243.3	251.4	259.8
Fresno	CalViva Health	SPD	862.3	887.3	913.3
Fresno	CalViva Health	SPD/Dual	181.9	187.9	194.2
San Francisco	Anthem Blue Cross	Adult	248.8	257.6	266.9
San Francisco	Anthem Blue Cross	SPD	844.6	869.7	895.8
San Francisco	Anthem Blue Cross	SPD/Dual	460.6	474.2	488.5
San Francisco	San Francisco Health Plan	Adult	243.3	251.7	260.5
San Francisco	San Francisco Health Plan	SPD	755.6	777.9	801.2
San Francisco	San Francisco Health Plan	SPD/Dual	185.7	192.1	198.8

Note: Dual: refers to a beneficiary enrolled in both Medicare and Medicaid programs

Source: compiled by the Author on the basis of California Department of Health Care Services Medi-Cal Managed Care Capitation Rates (https://data.chhs.ca.gov/dataset/medi-cal-managed-care-capitation-rates-geographic-managed-care-gmc).

5
Medicare

Medicare is a federal program that pays for covered health services for the elderly and for certain non-elderly individuals with disabilities. Unlike Medicaid, Medicare is not intended to be a primary funding source for LTSS. Medicare covers primarily acute and post-acute care, including skilled nursing and home health services. These post-acute Medicare benefits provide limited access to personal care services both in the home care setting and in skilled nursing facilities (SNFs) for certain beneficiaries. While Medicaid nursing and home health benefits are available to eligible beneficiaries as long as they qualify, Medicare benefits are generally limited in duration. In addition, Medicare SNF and home health benefits include coverage of rehabilitation services that will, presumably, prevent a decline in the beneficiary's physical condition or functional status.

A description of the system used by Medicare to pay for services provided in skilled nursing facilities and at home as well as a description of the Medicare Advantage program is reported below.

5.1 Skilled Nursing Facilities

Medicare provides coverage for short-term stays in SNFs for specialized nursing care and rehabilitation work after spending time in the hospital. If an individual qualifies for short-term Medicare coverage in a skilled nursing facility, Medicare pays 100% of the cost (room, meals, nursing care) for the first 20 days. For days 21 through 100, a daily co-pay of US$ 164.5 (in 2017) is to be paid, whereas if a stay is longer than 100 days, the individual is responsible for the full cost, unless she/he has additional insurance (such as Medigap[8]) that covers it.

In 2017, Medicare spent US$ 28.7 billion to provide care to beneficiaries in 15 277 facilities (of which 71% for profit and 73% located in urban areas) (Medicare Payment Advisory Commission 2019c).

Beginning on 1 October 2019, Medicare daily payments to SNFs are unilaterally determined by CMS by summing payment rates for six components of care—nursing, physical therapy (PT), occupational therapy (OT), speech-language pathology services, nontherapy ancillary services and supplies (NTA) and non–case mix (room and board services). For each component of care, the base payment is adjusted for geographic differences in labour costs by multiplying the labour-related portion of the daily rate – 70.9% for FY 2020 – by the hospital wage index in the SNF's location; the result is added to the nonlabour portion. The wage-adjusted base rates for five of the components are adjusted for case mix, with each component having its own set of factors. In addition, payments for three

8 A Medicare Supplement Insurance (Medigap) policy helps pay some of the health care costs that Medicare doesn't cover, like co-payments, coinsurance and deductibles. Medigap policies are sold by private companies.

components (PT, OT and NTA) are adjusted for the day of the stay, with higher payments for care furnished during earlier days in a stay. Payments for NTA services during first three days are three times those for NTA services during later days. Payments for PT and OT services are the same for the first 20 days of a stay and slowly decrease for later days.

Medicare daily rates for SNF for FY 2020 are shown in Table 5.

Table 5
Medicare rates for Skilled Nursing Facilities, 2020.

	Per diem rate (in US$)					
Location	Nursing	Physical therapy	Occupational therapy	Speech-language pathology services	Nontherapy ancillary services	Non-case mix
Urban	105.9	60.7	56.5	22.6	79.9	94.8
Rural	101.2	69.2	63.6	28.5	76.3	96.5

Source: compiled by the Author on the basis of Medicare Payment Advisory Commission (2019a).

5.2 Home health care

Medicare home health care provides a range of skilled nursing services, therapy, medical supplies and medical social services at home, which include:

- Skilled nursing care provided on a part-time basis — no more than eight hours a day over a period of 21 days or less. It includes services such as injections, feeding through a tube, and changing catheters and wound dressings.
- Physical, speech and occupational therapy from professional therapists to help the individual walk again, overcome problems in talking, or regain the ability to perform everyday tasks — whatever the medical condition requires.
- Help from home health aides in personal activities, such as going to the bathroom, dressing, or preparing a light meal if this help is necessary in relation to the person's illness or injury. However, if this personal care is the only kind of care the individual needs, she/he does not qualify for home health coverage.
- Medical supplies such as catheters and wound dressings related to the beneficiary condition.
- Medical social services such as counselling for social or emotional concerns related to the illness or injury, and help finding community resources if needed.

To get this coverage, the individual must meet all the following conditions:

- Be homebound — that is, unable to leave home without considerable effort, unaided or at all.
- A doctor must certify[9] that the individual needs one or more specified professional services – skilled nursing, physical or occupational therapy, or speech pathology. A plan of care must be established and regularly reviewed by a doctor.
- Medicare must approve the home health agency that provides the service.

In contrast to coverage for SNF services, Medicare does not require a preceding hospital stay to qualify for home health care. In addition, unlike for most services, Medicare does not require co-payments or a deductible for home health services. Beneficiaries who meet program coverage requirements can receive an unlimited number of home health episodes[10].

In 2018, about 3.4 million Medicare beneficiaries received home care, and the program spent US$ 17.9 billion on home health services (Medicare Payment Advisory Commission 2020). Medicare spending for home health care more than doubled between 2001 and 2017, and accounted for 3% of Medicare FFS spending in 2017. In 2017, 11 844 home health agencies provided an average of 16.5 visits per episode of care – down from 18.9 in 2002 (Medicare Payment Advisory Commission 2019c).

Medicare purchases home health services in units of 60-day episodes. To capture differences in expected resource use, patients receiving five or more visits are assigned to 1 of 153 home health resource groups (HHRGs) based on clinical and functional status and service use as measured by the Outcome and Assessment Information Set (OASIS)[11]. The HHRGs range from groups of relatively uncomplicated patients to those of patients who have severe medical conditions, severe functional limitations, and need extensive therapy. The 153 HHRGs are divided into five categories based on the amount of therapy provided and the episode's timing in a sequence of episodes. Four of the categories are based on a combination of whether the episode is an early episode (first or second episode) or late episode (third and subsequent episode) and whether the

9 Medicare requires that a physician certify a patient's eligibility for home health care and that a patient receiving services be under the care of a physician. In 2011, Medicare implemented a requirement that a beneficiary have a face-to-face encounter with the physician ordering home health care. The encounter must take place in the 90 days preceding or 30 days following the initiation of home health care. Contacts through nonphysician practitioners or authorized telehealth services may be used to satisfy the requirement.

10 In 2017, the average number of 60-day episodes per user was 1.9, and the average payment per episode was US$ 3039 (Medicare Payment Advisory Commission 2019c).

11 The Outcome and Assessment Information Set is a group of standard data elements developed, tested and refined over two decades through a research and demonstration program funded primarily by CMS, with additional funding from the Robert Wood Johnson Foundation and the New York State Department of Health. OASIS data elements were designed to enable systematic comparative measurements of home health care patient outcomes at two points in time.

episode has zero to 13 therapy visits or 14 to 19 visits. A fifth separate category exists for episodes that have 20 or more therapy visits, and it is not affected by episode timing. These separate categories permit the case-mix system to differentiate between the resource use of different levels of therapy utilization and multiple episodes. The system is calibrated to provide higher payments for later episodes in a sequence of consecutive episodes (third and subsequent episodes) and raises payment as therapy visits increase[12]. The HHRG model has the highest predictive power among case-mix models for home health care payment mainly due to the inclusion of previous health service use to predict future use (van den Bulck et al. 2020).

Each HHRG has a national relative weight reflecting the average relative costliness of patients in that group compared with the average Medicare home health patient. The payment rates for episodes in each local market are determined by adjusting a national average base amount—the amount that would be paid for a typical home health patient residing in an average market—for geographic factors and case mix. The base payment amount for 2018 is US$ 3039.6. To adjust for geographic factors, the per episode payment rate is divided into labour and non-labour portions; the labour portion (77%) is adjusted by a version of the hospital wage index to account for geographic differences in the input-price level in the local market for labour-related inputs to home health services. The total payment is the sum of the adjusted labour portion and the nonlabour portion. To adjust for a case mix, the base rate is multiplied by the relative weight for each HHRG. When a patient's episode of care involves an unusually large number or a costly mix of visits, the Home Health Agency (HHA) may be eligible for an outlier payment. To be eligible, imputed episode costs must exceed the payment rate by a certain amount set annually by CMS.

The home health prospective payment system has two programs intended to improve quality. The first is a pay-for-reporting program under which HHAs must report quality-of-care data for standardized measures (e.g., OASIS) to avoid a two-percentage point reduction in their annual basket update (see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html). Medicare also implemented a home health value-based purchasing program in 2016 in nine states (see https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model). The program adjusts HHAs' Medicare payments (upward or downward) based on their performance on a set of quality measures relative to their peers. Agencies received bonuses or penalties based on their performance on a set of 24 quality measures. The size of any bonus or penalty varied according to

12 In 2020, three major changes to the payment system will be implemented: a new 30-day unit of payment in place of the current 60-day unit; the elimination of the number of therapy visits as a variable in the payment system; and the use of a new case-mix system, the Patient Driven Grouping Model (432 home payment groups) (Medicare Payment Advisory Commission 2020).

performance, but the program's design capped any increases or decreases at 3% of Medicare payments. Quality bonus payments were funded through a payment withhold of 5% in 2018, increasing to 8% by 2021. Performance will be evaluated on outcomes measures collected in the OASIS, patient experience survey measures from the Home Health Consumer Assessment of Health Providers and Systems and claims-based quality measures.

5.3 Medicare Advantage

Medicare Advantage (MA) is a type of Medicare health plan offered by a private company that contracts with Medicare. MA plans include Health Maintenance Organizations; Preferred Provider Organizations; Private FFS Plans; Special Needs Plans; and Medicare Medical Savings Account Plans. If a beneficiary is enrolled in a MA plan, most Medicare services are covered through the plan. Enrolment in MA plans reached 21.9 million beneficiaries – more than one third of all Medicare beneficiaries – in 2019 (Medicare Payment Advisory Commission 2019c).

CMS determines the amount paid to MA plans for each beneficiary based in part on bids submitted by MA plans for what they expect Medicare covered services for their enrolee population will cost, on average. CMS then sets the plan's base payment rate—that is, the payment rate for a beneficiary of average health status—based on how the bid compares with a pre-established benchmark. The benchmark is an administratively determined bidding target. Benchmarks for each county are set by means of a statutory formula based on percentages (ranging from 95% to 115%) of each county's per capita Medicare spending. Plans with quality ratings of 4 or more stars may have their benchmarks raised by up to 10% of FFS spending in some counties. If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare, and enrolees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it ranges from 50% to 70%. The plan must then return the rebate to its enrolees in the form of supplemental benefits, lower cost sharing, or lower premiums.

Medicare then uses beneficiaries' characteristics, such as age and prior health conditions, and a risk adjustment model—the CMS–hierarchical condition category (CMS–HCC)—to develop a measure of their expected relative risk for covered Medicare spending. The payment for an enrolee is the base rate for the enrolee's county of residence multiplied by the enrolee's risk measure, also referred to as a risk score (Medicare Payment Advisory Commission 2019b).

Some important changes were recently made to the MA program through the passage of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act

and new rules published by CMS. MA plans and providers who work with them will soon have greater flexibility to offer additional supplemental non-medical benefits to address the health of people with chronic illnesses. Starting in 2020, MA plans will be allowed, but not required, to offer chronically ill enrolees nonmedical services for social needs that affect health as long as there is a "reasonable expectation that the services will help people with chronic conditions improve or maintain their health or overall function." Examples of these services include home-delivered meals, transportation for nonmedical needs, indoor air quality equipment (e.g., air conditioner for someone with asthma), and minor home modifications (e.g., permanent ramps, widening of hallways or doorways to accommodate wheelchairs). The effects of this policy will – most likely – vary among MA plans (Thomas et al. 2019) and remain uncertain (Sorbero and Kranz 2019).

6
The Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) established as a permanent Medicare and Medicaid benefit by the Balanced Budget Act of 1997, attempts to help nursing home eligible seniors avoid institutional care by providing them with a mix of coordinated acute and LTC services in the community.

Individuals who are 55 or older, certified by their state of residence as being eligible for nursing homes, and live in the service area of a PACE program are eligible to enrol in PACE. Designed for the frail elderly or people with disabilities, PACE programs are centred around the adult day health centre, where participants receive medical and social services and an interdisciplinary team comprising physicians, nurse practitioners, social workers, nutritionists, therapists, personal care attendant, and drivers. The typical PACE enrolee is dually eligible for both Medicare and Medicaid, over 75 years old and female with multiple chronic conditions as well as more than one ADL limitation. As of January 2019, 31 states had PACE programs with over 44 000 individuals participating, most of whom were dually eligible (ICRC 2019). Enrolment in PACE is voluntary and PACE is optional for states.

PACE is a Medicare managed care program and a Medicaid state plan option. Therefore, PACE organizations receive two capitation payments per month for their dually eligible enrolees and assume full financial risk for all the health care services that beneficiaries use. The Medicare portion of the capitated payment is derived from a formula that reflects the high frailty level of PACE beneficiaries, while the Medicaid payment is negotiated between the PACE provider and the state Medicaid agency. While CMS does not account for the functional status directly in the risk adjustment model used to

set payment rates to Medicare Advantage plans, it does make an additional payment adjustment, known as the "frailty adjustment", for plans that disproportionately enrol beneficiaries with functional limitations— including the PACE organizations. To implement this adjustment, CMS adds a fixed amount to the risk score of each community-residing beneficiary in a given plan to reflect the higher average costs of caring for beneficiaries with functional limitations. To calculate this adjustment, CMS first estimates frailty adjustment factors based on functional status information for Medicare FFS beneficiaries from the Consumer Assessment of Healthcare Providers and Systems survey and then applies these factors to a given plan based on functional status information from the Health Outcome Survey (United States Government Accountability Office 2018).

The literature provides evidence associating PACE with reduced risk of hospitalization, but findings for other outcomes – including nursing facility use, effects on spending and mortality – are mixed (MACPAC 2019).

7
Other public payers, out-of-pocket spending and other private funds

Of all LTSS expenditures, a relatively small portion of the costs is paid for with public funds other than Medicare or Medicaid. Collectively, these payers covered 6.3% of all LTSS expenditures in 2016, totalling US$ 23.1 billion. Among these public payers, over half of spending (US$ 12.8 billion, or 55.5%) was for LTSS provided in residential care facilities for individuals with intellectual and developmental disabilities, mental health conditions and substance abuse issues. Spending in this category also includes LTSS paid for or operated by the Veterans Health Administration[13] (US$ 5.7 billion, or 24.6%). Another US$ 3.8 billion, or 16.4%, includes state and local subsidies to providers and temporary disability insurance. A smaller percentage was spent on general assistance, which includes expenditures for state programs modelled after Medicaid, as well as federal and state funding for nursing facilities and home health under the Children's Health Insurance Program (CHIP). In addition, some public LTSS spending includes two types of programs that capture federal health care funds and grants to various federal agencies and Pre-existing Conditions Insurance Plans. Spending from these sources totalled US$ 800 million, or 3.5%.

Out-of-pocket spending was 15.6% of total LTSS spending, or US$ 57.0 billion, in 2016. Expenditures in this category include deductibles and co-payments for services that are primarily paid for by another payment source as well as direct payments

13 The Veterans Health Administration (VHA) is America's largest integrated health care system, providing care at 1,243 health care facilities, including 172 medical centers and 1062 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled Veterans each year.

for LTSS. While there are daily co-payments for skilled nursing services after a specified number of days under Medicare, there are no co-payments for Medicare's home health services. In addition, some private health insurance plans provide limited skilled nursing and home health coverage, which may require co-payments. Moreover, private LTCI often has an elimination or waiting period for policyholders that requires out-of-pocket payments for services for a specified period of time before benefit payments begin. Once individuals have exhausted their Medicare and/or private insurance benefits, they must pay the full cost of care directly out-of-pocket. With respect to

Medicaid LTSS, individuals must meet both financial and functional eligibility requirements. Individuals not initially eligible for Medicaid, and not covered under a private LTCI policy, must pay for LTSS directly out-of-pocket. Eventually, these individuals may spend down their income and assets and thus meet the financial requirements for Medicaid eligibility.

Other private funds generally include philanthropic support, which may be directly from individuals or obtained through philanthropic fund-raising organizations such as the United Way. Support may also be obtained from foundations or corporations. In 2016, other private funding accounted for 6.5% of total LTSS spending, or US$ 23.9 billion.

8
Private Insurance

Private health insurance and LTCI play a small role in financing LTSS: 7.5% of total LTSS spending, or US$ 27.6 billion, was funded through these sources in 2016. Private insurance expenditures for LTSS include both health and LTCI. Similar to Medicare LTSS funding, private health insurance funding for LTSS includes payments for some limited home health and skilled nursing services for the purposes of rehabilitation. Private LTCI, on the other hand, is purchased specifically for financial protection against the risk of the potentially high costs associated with LTSS. In addition, a number of hybrid products that combine LTCI with either an annuity or a life insurance policy have emerged. The Medicaid Long-Term Care Insurance Partnership Program[14] offers a LTCI policy that is linked to Medicaid eligibility.

At the end of 2017, there were 6.8 million LTC insurance policies in force. The number of policies has been constantly decreasing since 2012, when a spike of 7.4 million policies was reached (National Association of Insurance Commissioners 2018). The average age of buyers in 2015 was 60 years, about the same as over the previous decade. The shift of sales toward higher-income individuals continues. The median income of

14 The Partnership Program is designed to encourage the purchase of LTCI by offering a plan that will allow Medicaid to disregard an amount of the policyholder's assets equal to the dollar amount of LTCI benefits paid under a qualified Partnership Policy for the purpose of determining eligibility and estate recovery for Medicaid.

current buyers doubled between 2000 and 2015, and the assets of new buyers are also increasing: 4 in 5 had assets in excess of US$ 100 000 in 2015 (LifePlans, Inc. 2017).

Private insurance companies sell two basic types of LTC insurance policies: individual policies and group policies. Individual policies (also called "nongroup" policies) are sold directly to individuals, usually by insurance agents but sometimes through direct mail or phone solicitations. These policies must meet certain minimum standards set by the Division of Insurance that regulates the insurance market in each state. They usually are renewable or non-cancellable; provide at least 730 days (or a comparable dollar amount) of coverage; do not include an elimination period (waiting period) of more than 365 days; provide benefits based upon no more than two ADLs; offer an applicant the opportunity to buy inflation protection and nonforfeiture benefits; do not have a pre-existing condition limitation that lasts for more than six months after the policy's effective date; do not limit benefit payments because an individual develops Alzheimer's Disease, mental illness, alcoholism or other chemical dependency after the policy is issued. Group policies are sold through employers and associations who sponsor group plans as a benefit to their employees and members. Some insurers also sell group policies directly to individuals through out-of-state "group trust" arrangements. Employer, association and group trust policies are not subject to all the same state protections (minimum standards). At the end of 2017, more than two thirds of policies were individual (National Association of Insurance Commissioners 2018).

LTC policies can vary greatly from one insurer to the next. Policies may include benefits for care in a nursing home, care provided in an assisted living facility, home health care or personal care provided at home. Some may pay for family benefits, such as caregiver training, but most will not pay for services provided by family members. The most flexible policies allow for the use of benefits to cover any necessary LTC service in whatever setting eventually needed by the insured person. Most LTC policies limit both the amount they will pay each day (daily maximum benefit) and over the life of the policy to a maximum number of days or dollars (lifetime maximum benefit). These limits depend on the choices made when a policy is first subscribed. Lifetime maximum benefits usually are stated in number of days of coverage and usually range between two years and unlimited coverage. Although individual policies are required to cover the equivalent of two years of care, group policies may offer less. Daily maximum benefit amounts also vary, and usually do not cover the entire cost of a day of LTC services.

Inflation protection maintains the level of coverage even as the cost of LTC care rises. There are two basic types of inflation protection: "automatic" and "special offer," each of which can take a variety of forms. Automatic inflation protection increases benefits each year by a fixed percentage. Special offer inflation

protection gives the option to purchase inflation protection at set intervals, such as every three years. Nonforfeiture benefits provide something back to the insured person if, for whatever reason, coverage is dropped ("let it lapse") after years of paying premiums. If the nonforfeiture benefits is not purchased and the policy is allowed to lapse, premiums paid over the years will "forfeit".

"Benefit triggers" refer to the conditions under which an insured person is eligible to claim benefits under the policy subscribed. The way benefit triggers are defined in the policy can have an impact on how easily an insured person may qualify for benefits. Not only do benefit triggers vary between policies, but also the same policy might use a different trigger for home or community-based care than it does for nursing home care. Most policies use inability to perform certain ADLs to determine if an insured person is eligible for policy benefits. Before paying benefits, insurers usually require certification by a physician or licensed health care practitioner that the insured person cannot perform certain ADLs because of physical or cognitive impairments. Many policy benefits usually do not start the first day that the insured person enters a nursing home or use other LTC services. Instead, the policy's elimination period (waiting period) or a deductible must be satisfied. An elimination period or deductible requires the insured person to pay for LTC expenses for a specified number of days or a dollar amount before the insurer will pay benefits. The longer the elimination period or higher the deductible, the lower the premium paid.

The main features of the LTC insurance policies in force from 1990 to 2015 are reported in Table 6. Coverage limited to nursing homes or institutional alternatives has virtually disappeared from the market, whereas such coverage represented 63% of new sales in 1990. Almost all policies sold at the end of 2015 provide coverage for both institutional and home-based services (integrated policies). The average daily nursing home benefit has increased by only 5% over the last five years, and the home care benefit amount remains close to the nursing home level, reflecting the dominance of integrated policies. The decline in benefit duration continues, with the average falling to a new low of four years, and 3 in 5 policies had a duration of coverage of three years or less. There has been a drop in policies with unlimited (lifetime) durations, which are no longer sold by most companies because of insurers' general aversion to uncapped liabilities as well as rating agencies negative view of them.

In theory, the significant financial uncertainties in terms of potential need, intensity and duration of LTC provide a powerful rationale for sharing this risk across individuals. Yet, in countries such as the United States where private LTC insurance is sold, population coverage remains low due to demand and supply side issues (Colombo et al. 2011). First, well-known market failures due to asymmetric information in the private LTC insurance market, such as adverse selection and moral

hazard, lead insurers to protect themselves by limiting access to coverage. Adverse selection would translate in only those with high-perceived LTC risk buying in or keeping the insurance policy, while moral hazard would translate in the insured using more LTC services than they would have required because they are covered. Second, insurers face significant uncertainty regarding future costs, or the evolution of supply and organisation arrangements for LTC. For instance, future trends in the onset of dependency are unknown, and there is uncertainty with respect to the costs of providing a unit of care as well as with the projected return from the invested accumulated reserves. This may result in insurers setting relatively higher premiums or paying lower benefits. Premium mark-up may lead to lower demand for private LTC coverage because of its higher prices. Third, challenges associated with the ability of insurers to control the covered LTC risk might also lead to premium volatility. To ensure the financial viability of an insurance plan, insurance contracts include clauses that allow for the level of premiums to increase if the overall level of risk shared within a pool of insurer's increases. Premium volatility makes the cost of private LTC coverage less predictable and may reduce the confidence in these types of insurance plans. Fourth, low demand for private LTC insurance may also reflect individuals' myopia in planning for the financial risk associated with LTC. For instance, the risk associated with dependency is often deemed as too remote to warrant coverage starting at a relatively young age. Last, low demand may also reflect competing financial obligations and priorities faced by individuals and families, such as paying for children' education, schooling, and buying a house. For households with low income, the cost of subscribing to a private LTC coverage can represent a high share of their disposable income.

A recent report (U.S. Department of Treasury 2020) found that insurers have dramatically increased premiums for policies, both new and in-force, and this has led to much lower demand. Also, the total number of insurers actively selling in the market has dramatically contracted.

Table 6
Main features of private long-term care insurance.

	Mean by year			
	2000	2005	2010	2015
Policy type				
Nursing home only	14%	3%	1%	1%
Home care only	9%	7%	4%	3%
Nursing home and home care (integrated)	77%	90%	95%	96%
Daily benefit amount for nursing home	US$ 109	US$ 142	US$ 153	US$ 161
Daily benefit amount for home care	US$ 106	US$ 135	US$ 152	US$ 155
Nursing home only elimination period	65 days	80 days	85 days	49 days
Combined policies elimination period	47 days	81 days	90 days	91 days
Nursing home benefit duration	5.5 years	5.4 years	4.8 years	4 years
Annual premium[15]	US$ 1677	US$ 1918	US$ 2283	US$ 2727

Source: compiled by the Author on the basis of LifePlans, Inc. (2017).

15 Given that LTC policies are level-funded (i.e. benefits are prefunded) and the LTC risk is highly correlated with age, if everything else is held constant, premiums will increase as purchase age goes up. Thus, premiums for 75-year-old buyers are twice as high as for those between 55 and 64, even though the latter purchase more comprehensive products.

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