

POLICY BRIEF 11

How can European states design efficient, equitable and sustainable funding systems for long-term care for older people?

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This policy brief is one of a new series to meet the needs of policy-makers and health system managers.

The aim is to develop key messages to support evidence-informed policy-making, and the editors will continue to strengthen the series by working with authors to improve the consideration given to policy options and implementation.

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How can European states design efficient, equitable and sustainable funding systems for long-term care for older people?

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Key messages

Policy issue and associated policy challenges

- Long-term care expenditures are projected to rise significantly as a percentage of GDP in many countries. In OECD countries this is estimated at between 2% and 4% by 2050. In the EU25, by 2040 the 65+ age group will account for 28% of the population.
- Population ageing, changes in informal family support, increasing care costs and raised expectations of services pose major challenges to sustainability.
- State supported collective funding solutions can ensure that protection is provided to all those in greatest need and also help avoid catastrophic costs.
- Private sector solutions alone have failed to provide a sustainable insurance system that can cover a large proportion of the population. Continued reliance on family support is not possible for all.

Policy options

- One policy option is the provision of a *safety net system* that minimizes state intervention and concentrates support on one population subgroup: those individuals lacking the financial ability to pay for the cost of services. Experience suggests this can be very effective in controlling state expenditure, but tight restrictions on eligibility can generate significant unmet need.
- Another option is a *universal system* that covers the entire population but at significantly greater cost. Co-payments may still be levied for some services. Tax-funded universal systems employ expenditure constraints and define eligibility criteria to optimize resource use. Social insurance funded systems tend to be needs driven rather than budget constrained, but in the absence of cash payments can lack flexibility.
- A *progressive universalism* approach combines universal entitlement with a means-tested element. The universal nature of support can increase public support for the system among those who would not qualify for some benefits under the minimum safety benefit system. As in the case of universal schemes, this can also have the effect of raising the profile of long-term care services, and reduce the stigma attached to the receipt of care in means-tested systems.

Facilitating implementation

- To be sustainable long-term care systems need to be affordable, fair and flexible. In a given context, public consensus needs to be achieved around any mechanism of long-term care funding.
 - National governments, as part of their stewardship of the health system, can consider steps to: (i) ensure that comprehensible information and advocates to help individuals navigate long-term care systems are in place; (ii) assure quality standards, provide support for informal carers and facilitate flexibility in care package choices (such as through cash payments); and (iii) pursue measures to improve coordination between the long-term care and associated sectors.
 - With many countries facing similar challenges, member states of the European Region may be able to draw on lessons from international experience in long-term care systems, both from Europe and beyond.
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Executive summary

Assessing different options for the funding of long-term care – that is, non-medical assistance provided to people with physical or mental health needs to help cope with the everyday activities of life – raises three key issues. First, it requires an assessment of the future need for long-term care services across the population, and of its broader socioeconomic repercussions. Second is the rationale for using public funds for funding long-term care, and how this varies depending on the specific country context. Finally, it begs the question of the way in which funding arrangements can be implemented in order to maximize fairness and efficiency in the system.

Across Europe data suggest that an ageing of the population, coupled with changes in the availability of informal family support, increasing costs of care and raised expectations on the quality, intensity and flexibility of services may raise major challenges for policy-makers contending with maintaining or extending coverage and support for long-term care systems. Long-term care expenditures are projected to increase from just over 1% of GDP in OECD countries to between 2% and 4% of GDP by 2050. In the EU25 alone the proportion of the population aged 65+ is projected to increase from 17% in 2007 to more than 28% by 2040.

Making the case for public sector intervention

The case for public sector intervention for long-term care funding is strong. The lifetime costs of long-term care services can be substantial and may deplete the assets of all but the richest service users. State supported collective funding solutions can make sure that enough protection is provided to those in greatest need, and/or with the least ability to pay, and help avoid catastrophic costs. The private sector has failed to provide a sustainable insurance system that can cover a large proportion of the population; although in some countries it does provide a complement to state support. Neither is a continued reliance on family support possible for all.

A number of different criteria can inform the development and public acceptability of long-term care funding mechanisms. They include the extent to which funding mechanisms are equitable and promote a partnership between personal, family and state responsibility. Another factor is whether systems are sufficiently transparent in how they define long-term care, rules on funding, and entitlements to services.

What alternative approaches to funding long-term care might be considered?

Differing national contexts, such as the relative importance placed on the

formal long-term care sector, societal values, reliance on family care and resource constraints, will all play a role in determining which funding mechanism is adopted. More universal systems, for instance, have been located typically among Nordic and, more recently, other northern European countries. In southern and eastern European countries, public social care systems have been based around the concept of a safety net, whereby public support is selectively targeted to those in greatest need and with lowest financial means. Differences in social values will affect, for instance, the distribution of support between users with and without informal carers, and whether the state concentrates on providing a safety net for those unable to afford care charges, or whether it offers equal support to all.

Provision of a minimum safety net

One policy option is the provision of a system that minimizes state intervention, and concentrates support on one population subgroup: those individuals lacking the financial ability to pay for the cost of services. In “safety-net” systems public resources available for long-term care are cash-constrained and do not necessarily change with needs. Thus they can be very effective in controlling state expenditure. They are usually funded through a combination of general (central and/or local) tax revenue and user charges levied at the point of need, calculated on the basis of means-tested rules.

Need-eligibility criteria are tough. Eligibility for financial support and calculation of user charges are typically determined by a combination of exclusion criteria, for instance, having assets with a value above a maximum threshold, as well as rules defining “assessed income” such as level of earnings, pension income and returns on savings. Support tends to be restricted to a limited, core set of activities centred around personal care tasks (e.g. feeding, washing, eating, dressing). As a result, means-tested systems can generate significant unmet need. The system may be perceived as unfair to prudent savers and provide strong incentives for individuals to deplete their assets, and perhaps even to minimize their income, in order to increase the amount of subsidy they receive. Such systems may also have high transaction costs, because of the need for an administrative system to apply the means-testing rules.

Universal funding systems

An alternative option is a system that provides cover for the entire population. This implies significantly greater levels of state expenditure than in a safety-net system. It should promote greater equality and social cohesion, ensuring that all people meeting need criteria can access services regardless of their financial status. Almost all universal systems are progressive, raising much revenue from a combination of earmarked contributions and payroll taxes. Co-payments may

still be levied for some services.

Tax-funded systems can also employ expenditure constraints and define eligibility criteria to make the best use of existing resources. Universal social insurance long-term care systems typically assess eligibility on the basis of clear, algorithm-driven, written rules linking levels of disability to entitlement to certain levels of state support. This offers a more transparent allocation process and provides greater assurances about the service users' "rights" to support. As a result, social insurance expenditure is needs driven, rather than budget constrained.

Entitlement systems can lack flexibility in the way they match care packages to individual need levels, because of the difficulties that exist in incorporating into entitlement rules important factors influencing the need for social care, such as attitudes, relational characteristics and environmental factors.

Progressive universalism funding mechanisms

A third approach combines universal entitlement to state help with a means-tested element, which ensures that those in greatest financial need receive the greatest amount of state support. These systems, grouped under the banner of progressive universalism, aim to minimize state financial commitments while retaining an element of universality. This is intended to promote social cohesion and provide some insurance benefits to all, while limiting (relative to universal schemes) state expenditure.

The universal nature of support can increase public support for the system among those who would not qualify for entitlement to some benefits under the minimum safety benefit system. This support increases as the income of the potential care recipient decreases. As in the case of universal schemes, this can also have the effect of raising the profile of long-term care services, and can reduce the stigma attached to the receipt of care in means-tested systems.

Identifying alternative ways of bringing about the implementation of long-term care funding mechanisms

To be sustainable, any long-term care system needs to be affordable, fair and flexible. Measures to help build consensus on the roles of individuals and the state in any system of long-term care funding include public consultation to explore and exchange ideas and gauge public acceptance on the need for co-payments. Different sources of revenue will generate different incentives, and will imply varying degrees of income redistribution. A tax on income is usually progressive but may not always ensure that contributions are collected from those who have non-waged incomes. In some countries earmarked taxation might perhaps be more publicly acceptable. The inclusion of housing wealth in any means-testing system may be particularly contentious.

As any system is implemented, adequate but accessible information should be made available through a variety of means. Support for advocates to help individuals in care package choices may also be needed. Steps to assure quality standards, provide support for carers and facilitate flexibility in care package choice may also help. The use of cash payments may be one way of helping to increase service user choice. Measures might also be taken to improve coordination between the long-term care and associated sectors.

It is clear that different long-term care systems are at very different stages of development across Europe, and that a number of funding mechanisms have been adopted. Much can be learnt from the experience of different countries. International bodies such as the European Commission and World Health Organization, through information portals, policy dialogues and schemes that encourage cross-border partnerships, may be well placed to collate and disseminate knowledge, tailoring it to the specific circumstances observed across Europe.

Policy brief

How can European states design efficient, equitable and sustainable funding systems for long-term care for older people?

Assessing different options for the funding of long-term care – that is non-medical assistance provided to people with physical or mental health needs to help cope with the everyday activities of life – raises three key issues. First, it requires an assessment of the future need for long-term care services across the population, and of its broader socioeconomic repercussions. Second is the rationale for using public funds for funding long-term care, and how this varies depending on the specific country context. Finally, it begs the question of the way in which funding arrangements can be implemented in order to maximize fairness and efficiency in the system.

Policy context

What do we know about current and potential future drivers of demands for long-term care?

Before considering different approaches for funding long-term care it is important to assess potential demand for such services. This will have a critical impact on the different models of service provision that may be funded through the public sector and the extent to which individuals may have to make a contribution towards the costs of care.

Long-term care expenditures have been projected to increase from just over 1% of GDP in OECD countries to between 2% and 4% of GDP by 2050 (1). Arguably, the principal factor driving future levels of long-term care expenditure is the increase in the volume of older people in need of services. This increase responds on the one hand to a significant rise in the absolute and relative number of older people in society, and on the other to changes in the age-specific prevalence of disability (2, 3). In the EU25 the proportion of the population aged 65+ is projected to increase from 17.07% in 2007 to 20.68% by 2020 and 28.25% by 2040 (4).

Whether the prevalence of disability among successive cohorts of older people will increase or not is particularly important, because the effect of the predicted rises in the number of older people on service demand could be more than offset by a significant reduction in the prevalence of disability (5). The key question is whether the extra years of life that new cohorts of older people enjoy are spent in a disability-free state or not. Analysis of data in Austria, for example, suggests that over a 20-year period to 1998 both life expectancy and healthy life expectancy increased (6). However, much more evidence is required

to predict with confidence likely future disability trends among older people Europe-wide as patterns vary significantly across countries (7). Other key factors that will influence future demands for long-term care include the availability of informal care, the evolution of unit cost of services, and changes in the levels of wealth of older people.

Changes in the availability of informal care

Although the volume of informal care far outweighs the contribution of formal care workers, levels of informal support vary significantly across Europe. For instance, Italy and the Netherlands are estimated to have approximately 4 million and 1.2 million informal carers compared to 125 000 and 100 000 formal care professionals respectively (8). The availability of informal care will respond to a range of influences, including the proportion of older people living alone and the willingness of family and friends to provide informal support. In terms of living arrangements, the proportion of people over the age of 65 who are living alone varies markedly across Europe, with the lowest numbers still seen in some southern European countries (19% of total population) compared to 34%, 32% and 24% in the Nordic countries, western and eastern European nations respectively (9).

These patterns have been evolving over time. In Italy, for instance, the rate of women aged 65 and older living alone has almost doubled (from 22% to 40%) in the period from 1970 to 2000. These changes are not just seen in southern Europe – significant increases can also be seen elsewhere: rising in Great Britain from 34% to 48% and in the Netherlands (from 28% to 41%) (10). In part, these changes respond to factors such as the rising rate of divorce. Any decrease in the rate of cohabitation is particularly important, because co-resident carers are typically those that provide the most intensive levels of support.

Across countries, there are marked differences in the nature of social expectations about the role of the family and the community in supporting people in need (11). Whereas it is still the case in most countries that the family is expected to provide the bulk of the assistance required, in recent times there has been a decrease in many countries in the willingness to provide informal care. There are also changes in the gender of carers: the reduction in the life expectancy gap between men and women means that in some countries the levels of informal support provided by male older people to their dependent spouses has increased.

Informal care is important not just because of its buffering effect on demand for formal services. Providing informal support often has an important knock-on effect for the carers' opportunities in the labour market and, as a result, on their ability to prepare themselves financially for their old age, for instance by

contributing to a pension scheme (12, 13). In countries of central and eastern Europe increasing employment participation, a higher average exit age from the labour force and migration flows towards western Europe have already been noted to have increased pressure to find alternatives to care provided by the family (14). Moreover, there is a need for greater policy awareness of the health-related risks of caring. Indeed, very intensive levels of informal care have been linked to increased risks of health problems, including depression and high levels of stress (15, 16).

Changes in the unit costs of services

The support required for people with physical and/or mental health problems (for example, those who need help with feeding, dressing or washing) involves significant levels of human input. The labour-intensive nature of these social care services means that their unit costs tend to increase over time in line with wages, rather than with general price levels. In turn, this means that the unit cost inflation in the social care sector tends to exceed average inflation levels in the economy (17).

In the UK for instance, recent studies predicting future social care expenditures have assumed yearly unit cost increases in social care services that are 2% above general prices levels, equivalent (other things being equal) to approximately a 50% increase in real expenditure levels over a 20-year period (18, 19). In the case of long-term care insurance, it is typically assumed that there will be a gross inflation rate of approximately 5% per annum for long-term care packages (20, 21). In addition to the pure price inflation effect, the unit costs of such care can also be expected to rise owing to growing expectations and demands for improvements in the quality of the services voiced by more assertive, future cohorts of older people.

Changes in the availability of financial resources

Society's capacity to meet the future demand for long-term care services will depend on its wealth, both in terms of the ability of individuals to pay for their care packages, and of society's ability to fund a collective care system. Policy-makers therefore need to be mindful of the state and distribution of accumulated wealth in the population. There is evidence to suggest that pensioners have enjoyed greater financial resources over the last 20 years through, for instance, the indexation of their pensions to earnings, and in particular through the revalorization of wealth accumulated in housing stocks (22).

However, as the current economic climate demonstrates, such wealth can rapidly decline as a result of a major economic downturn and in the near future it may be the case that many older people will find themselves in a comparatively worse position than their immediate predecessors. Work to

estimate the potential impacts and duration of the economic downturn and what implications this will have on the future ability of individuals to contribute towards the costs of care is urgently needed.

Another key driver of the ability of society to fund long-term social care needs are the taxes and/or social contributions of the working age population. However, the overwhelming majority of EU countries are faced in the near term, notwithstanding the possibility of increased inward migration, with a relative (and in some cases absolutely) shrinking of the working age population (see Figure 1). This reduction implies that, in the absence of substantial inward migration, maintaining the funding of social care systems in countries where the birth rate remains below the replacement ratio might lead to significant increases in tax burden. Added to other financial pressures, such as the need to contribute to pensions schemes, increases in the tax burden of the working population could prove difficult from a political point of view and could undermine the degree of public support for a collective care system. In addition, increases in taxation have also been criticized on the grounds that they can generate perverse incentives for individuals in terms of their patterns of labour participation.

A common policy response to the increase in the old-age dependency ratio has been to push back the legal age for retirement, as well as providing incentives to encourage older workers to remain in the workforce (24). In Hungary, for instance, legislation has been proposed to raise the retirement age from 61/62 to 64 for women and from 62 to 65 for men by 2020. Retirement ages for men and women in the Czech Republic have been increasing by two months and four months every year respectively since 1996. By 2013, the aim is to reach the target retirement age of 63 for males and 59–63 for females, depending on the number of children raised. Denmark will increase the national retirement age for men and women from 65 to 67 between 2024 and 2027 and in Germany it will increase for both men and women from 65 to 67 between 2012 and 2029.

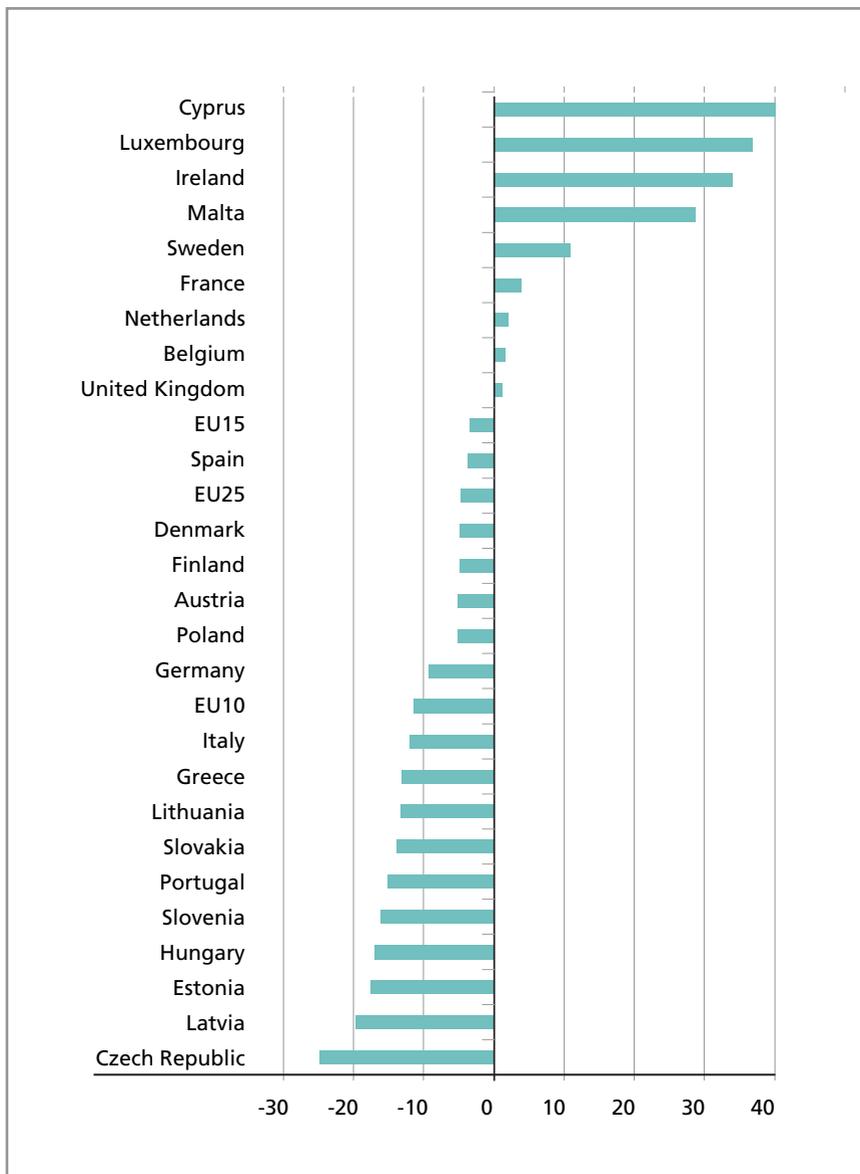
Why should the public purse contribute towards long-term care funding?

Before considering the question of what policy options might be considered for long-term care funding, it is worth spending some time exploring the rationale for collective funding arrangements in social care. Should each of us arrange and pay for our own care independently, or are there arguments in favour of a collective solution for funding social care costs? If so, what and whose care should be funded collectively?

Market failure

Allocative deficiencies in the private market (family provision of care, private

Figure 1. Projected changes in employment
 (% change of employed people aged 15–64 between 2003 and 2050) EU25



Source: European Policy Committee and Commission of the European Communities (23)

long-term care insurance markets and the markets for care services), such as the risk of impoverishment and insufficient access to adequate care, provide strong arguments in favour of government intervention through regulation and/or funding and/or provision of services to avoid a risk of negative external effects burdening the immediate family as well as society.

Reliance on family support will not be possible for all people in need, as many dependent older people have no living kin, or because their relatives might themselves be frail, have conflicting time commitments or live a distance away. Moreover, private long-term care insurance has not shown itself as a credible primary mechanism for funding long-term care services. However, in a limited number of countries (and most notably in France) a significant number of individuals have purchased private voluntary insurance products in order to complement the state offer of support (25).

Economic theory provides a variety of explanations for the limited reliance on such insurance coverage, such as a low risk perception by younger people, low willingness to pay for insurance coverage, difficulties in calculating the costs of long-term care dependency and a preference for family-provided care (26–28). Moral hazard, whereby individuals alter their behaviour in the knowledge that future support is available to them, and adverse selection whereby only those consumers who perceive that they have a high risk of needing long-term care enrol in insurance-based schemes, are challenges that have to be faced by both market and (non-compulsory) state solutions.

Market failures also characterize the market for care services. An unregulated care market mechanism may lead to undesirable outcomes because of the problem of information asymmetries (where one party has advantages in the transaction owing to better information), which in turn raises challenges for quality assurance (29).

Improving solidarity and equity

Different funding models imply different charges at the point of use, and individuals respond to different charges by altering their consumption patterns. In other words, funding arrangements do not just impact on “who pays for what service” but also on “who gets what service”, and have therefore equity as well as efficiency implications. Cross-subsidization of funding across the population, depending on the degree of coverage and intensity of collective support, can increase the sense of solidarity and social cohesion in society.

Collective funding solutions can make sure that enough protection is provided for those in greatest need and/or with the least ability to pay. Means-tested care systems, for instance, are implemented with the aim of targeting state support to those individuals least able to afford services. If, however, they

exclude significant proportions of the population they may be seen solely as a system for the poor, which in turn might undermine the personal dignity of service recipients, and reduce service take-up. Universal funding schemes that provide equal levels of support regardless of wealth, albeit more expensive, may maximize the sense of togetherness in society. The existence of universal schemes may, however, mean that individuals alter their behaviour, for instance by taking greater financial or personal risks.

Avoidance of catastrophic costs

The lifetime costs of long-term care services can be substantial. The costs in most countries of long-term care services provided in residential facilities will deplete the assets of all but the richest service users. Estimates in England, for instance, suggest that costs for people reaching the age of 65 exceed £30 000 (30). A US-based study suggested that the average value of lifetime long-term care expenditures for people turning 65 in 2005 was approximately \$47 000, with 28% of individuals having costs in excess of \$100 000 (31). Given the risk of such catastrophic costs, governments will want to consider putting in place a collective social care funding system simply because by doing so they will limit the risk that members of society are faced with catastrophic expenditures due to their care needs. All collectively funded long-term care systems provide a degree of insurance against the risk of very high social care costs, by sharing the payment of care expenditures among a large pool of contributors.

What criteria can be used to assess the equity, efficiency and sustainability of funding arrangements for long-term care services?

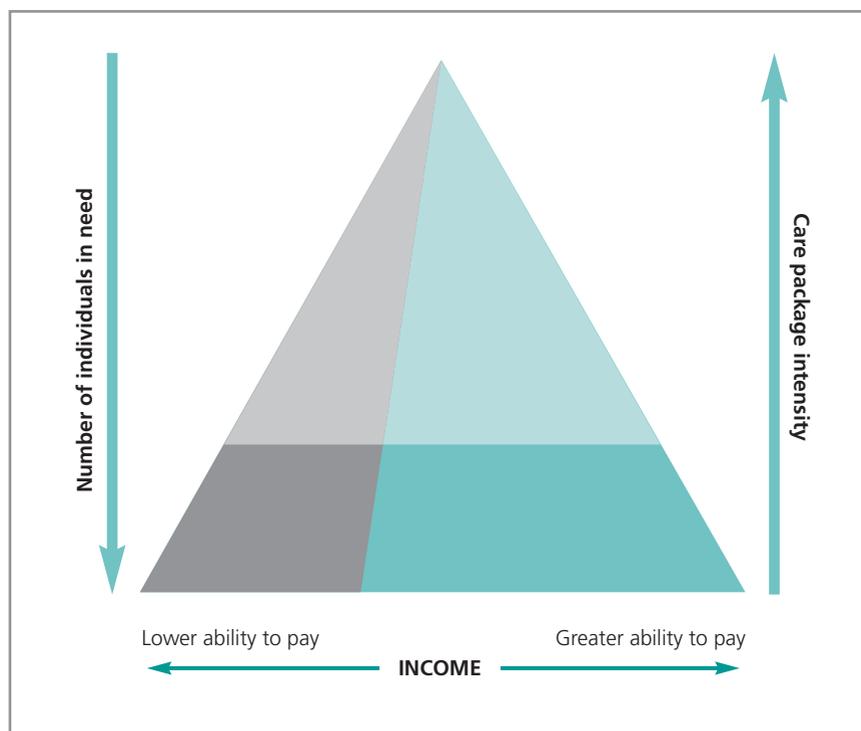
What criteria can policy-makers use to help them determine which option to choose when considering long-term care funding mechanisms? There may be a multiplicity of objectives associated with long-term care, much of which will vary dependent on national context.

Equity considerations

One consideration is the extent to which any funding mechanism should promote *horizontal* and *vertical equity*, by ensuring respectively that individuals with equal needs (and perhaps ability to pay) receive equal levels of support, and that individuals in greater need receive greater support. In practice, different systems will define “need” differently, but typically this will include the impacts of physical and mental health status on the ability to perform activities of daily living (ADLs), such as washing, feeding and eating and, in some settings, on the ability to undertake instrumental activities including light housework, shopping or preparing meals.

The emphasis placed on equity together with the definition of need applied will

Figure 2. The pyramid of needs



significantly affect demands to be met by long-term care services. As illustrated in Figure 2, the number of people covered by the system increases exponentially as the concept of need is relaxed. The total number of service users is determined by the joint effect of need and financial eligibility criteria.

If, as in most social care systems, service users are asked to contribute to the costs of services at the point of need, policy-makers need to consider the extent to which charging policies should protect the dignity of service users, by making sure that they are left with enough resources to afford their normal daily expenses. Many means-testing systems for instance, exclude a certain level of wealth and assets, from the assessment process.

Another key criterion for policy-makers to consider is the extent to which the system promotes a partnership between personal, family and state responsibility. For instance, policy-makers should consider whether charging rules inappropriately penalize individuals who have saved prudently for their

retirement. There is often a public outcry in situations where older people, having behaved prudently, are required to contribute most or all their savings in order to pay for the costs of their care. This problem is particularly acute in means-tested systems in which public support is targeted exclusively at individuals with very low means. Any collective funding system will be denied valuable resource if individuals, in an attempt to avoid what they see as unfair and punitive long-term care charges, deplete all of their financial resources, for instance, by transferring them to relatives.

The way in which a funding system recognizes and values the role played by unpaid family caregivers is also important. Deciding the extent to which funding rules take into account informal support is, however, difficult and requires judgements to be made more broadly as to the optimum balance of responsibilities between the family, the community and the state. If family carers feel that they are taken for granted as a free resource without entitlement to support, then this may reduce the willingness of future generations to provide informal care (32, 33). In *instrumental* caring models, formal services treat carers as co-workers, entitled to state support, with funding also made available for services aimed at reducing informal caregiver stress, such as day and respite care. Carers might even be seen as co-clients of services. Making entitlements to services *carer-blind*, in the sense that they do not take into account the availability of informal support, minimizes the implicit demands from the system on informal caregivers. On the other hand, providing the same amount of formal care to someone with no informal support as to someone with equal needs but with significant levels of family support might not be regarded as unequivocally fair. Most insurance-based long-term care funding systems, such as the French, Japanese, Austrian and Spanish systems, provide levels of support on a carer-blind basis.

The final equity-related criteria for policy-makers to be aware of relates to *transparency* in eligibility rules for financial support. Means-testing systems, in particular, tend to be complex. Clear and transparent rules help facilitate public auditing of the allocation process. Moreover, if eligibility rules are widely understood, easy to interpret, and make explicit the level of state support they can expect, this allows individuals to plan better for their long-term care needs. It can be a misconception in some European countries that long-term social care is provided on the same basis as health care support.

Economic efficiency

Given the resource constraints faced by all European countries, it is important that policy-makers consider the impacts of different charging arrangements on the efficiency with which available health and social care resources are used. The impacts on efficiency will depend on the nature of the *incentives* that charging arrangements generate on service users and professionals in the social

care and allied sectors. For instance, they will depend on the extent to which they promote the use of an ideal mix of social and health services.

In some means-tested systems, for instance, the value of a user's house might be taken into account when calculating the level of personal contribution to residential care charges, but not included in the calculation of care charges for community-based support. This generates an incentive in favour of institutional care from the point of view of the state, but from the service user's point of view provides an incentive to request community-based care. The implications of incentives on the demand for services need to be carefully considered, as indeed does their use as a way of encouraging the use of cost-effective preventative measures.

The funding system should also support *diversity in the supply of services*, to ensure that a range of services are available to cater for different circumstances, wishes and preferences of services users. In that respect, the means by which resources are distributed (directly as cash allowances, through service vouchers, or as care packages in kind) will affect the size and nature of the care market, the degree of competition and the prices of services. Policy-makers should balance the benefits of more "competitive" markets against the cost implications of the monitoring and regulatory framework required to ensure quality in the supply of services.

Funding arrangements can also be used to encourage the efficient interaction between public services, such as between health and social care services. In many countries, funding rules for health and social care services are different, with typically much higher private contributions required for social care services (34). In addition to creating a cliff-edge effect, whereby individuals with very similar needs are charged very different amounts for their care depending on whether they are classified as "belonging" to the social care or health care system, differences in the funding of the two systems can lead to service retrenchment and to cost shunting, usually to the detriment of the weaker, social care, partner.

Promoting sustainability and acceptability of funding arrangements

Ensuring that any funding system is sustainable is another key criterion. This will be affected by at least three factors: the degree to which the system enjoys public support, its affordability and its capacity to be flexible in adapting to changes in circumstances.

The degree of public acceptability will depend in part on the extent to which individuals believe that the system will provide them with adequate support should they ever need it. Such expectations will be shaped by the level of contributions requested (greater expectations for greater contributions) as well

as by factors such as whether the system is fully funded (linking lifetime contributions to expected payments) or operates on a pay-as-you-go basis (with resources collected in a given year used among the current population of service users). Social preferences about the optimum degree of intergenerational cross-subsidization will be important.

Public confidence in the system will also be influenced by the extent to which the system targets resources to the “right” people, and for the “right” care. Individuals’ willingness to co-finance the care of others in society will be greater if resources are seen to be targeted towards the provision of vital services, such as assistance with key activities of daily living, to individuals with significant needs and limited ability to pay.

To be sustainable the system also needs to be affordable. At the individual level, the sense of affordability is likely to be affected by whether or not financial contributions are spread over a lifetime and across the entire population, rather than being demanded at the point of retirement. Willingness to increase contributions might also be helped by maximizing transparency in the revenue raising process, for instance by ring-fencing of a tax for long-term care.

Not all of the objectives of these criteria can be maximized simultaneously; policy-makers thus need to weigh up the relative merits of different funding mechanisms so as to yield a “preferred” combination of impacts on equity, efficiency and sustainability, given the specific national context. For instance, in countries where transparency in the allocation process is paramount, eligibility for services might be determined through highly explicit rules. In turn, this might reduce the system’s capacity to match resources flexibly to the specific circumstances of individuals in need of support, which might therefore be at the cost of increased inefficiencies in the targeting of services.

What alternative approaches to funding long-term care might be considered?

We now turn to look at three potential alternative approaches to funding long-term care. Differing national contexts such as the importance placed on the formal long-term care sector, societal values, reliance on family care and resource constraints will all play a role in determining which funding mechanism is adopted. Differences in social values will affect, for instance, the distribution of support between users with and without informal carers, and whether the state concentrates on providing a safety net for those unable to afford care charges, or whether it offers equal support to all.

Historically, different countries have shown a predilection for different broad families of funding models (see Tables 1 and 2 for detailed descriptions of six countries). More universal systems, for instance, have been located typically

among Nordic and more recently other northern European countries. In southern and eastern European countries, in contrast, services remain very fragmented and public social care systems have been based around the concept of a safety net, whereby public support is selectively targeted on those in greatest need and with lowest financial means (12).

Provision of a minimum safety net

One policy option for consideration is the provision of a system that minimizes state intervention and concentrates support on one population subgroup: those individuals lacking the financial ability to pay for the cost of services. Examples of this approach include the long-standing systems in operation in countries such as Australia, Cyprus, England, Ireland, New Zealand and the USA (35, 36). In safety-net systems public resources available for long-term care are cash-constrained and do not necessarily change with needs. Thus they can be very effective in controlling state expenditure. They are usually funded through a combination of general (central and/or local) tax revenue and user charges levied at the point of need, calculated on the basis of means-tested rules.

Maximizing efficiency in the targeting of the limited resources available is therefore a key policy objective, which often results in very tough need-eligibility criteria, with entitlements mostly limited to very high need individuals. Eligibility for financial support and calculation of user charges are typically determined by a combination of exclusion criteria, for instance having assets with a value above a maximum threshold, as well as rules defining “assessed income” such as level of earnings, pension income and returns on savings. A sensitive issue, particularly in countries where rates of house ownership are high, is whether housing assets are included in asset valuations.

Means-tested systems also tend to restrict the type of support provided to a limited core set of activities centred around personal care tasks (e.g. feeding, washing, eating, dressing). This can give rise to the polarization of the population in need of services into three groups: at one extreme, low wealth and high need individuals who receive services funded by the state; at the other extreme, wealthy individuals who are able to self-insure and fund services out of pocket; and a third group of moderate income dependent people, who struggle to afford the services they require, or simply go without them (18).

As a result, means-tested systems can generate significant unmet need. “Cliff-edge” effects, whereby governmental subsidies change markedly, following small differences in the users’ wealth or income are also a feature. As noted in our discussion of equity, efficiency and sustainability criteria, this system may be perceived as unfair to prudent savers and provide strong incentives for individuals to deplete their assets and, to a lesser extent, minimize their income, in order to increase the amount of subsidy they receive. Restricting public

support to people with low means can also lead to a stigma being attached to the use of state funded services, which as noted above might undermine the dignity of service recipients, as well as making them less likely to demand services. Such systems may also have high transaction costs, because of the need for an administrative system to apply the means-testing rules.

Universal funding systems

An alternative policy option is the development of a funding system that provides cover for the entire population. Such models imply significantly greater levels of state expenditure than means-tested systems. In exchange for this greater financial commitment by the state, universal systems should promote greater equality and social cohesion, by ensuring that all people in need of support can access services regardless of their financial status.

In tax-funded universal systems, exemplified by countries like Denmark, Sweden, Norway (36) and more recently Scotland, long-term care is funded by the public sector, with little or no co-payments at the point of use. Almost all social care state tax-funded systems are progressive in terms of the way in which they raise resources, albeit tempered by any contribution from non-progressive sources of revenue, such as sales taxes. This progressivity is reinforced because of the link between income deprivation and need for help and support (37).

Tax-funded systems can also employ expenditure constraints and have a degree of flexibility in how they match resources to needs. Eligibility criteria can be redefined or waiting lists used to help make the best use of existing resources. Formal assessments of need are also made, often based on local professional judgements by care managers.

In contrast to tax-funded programmes, social insurance systems are funded through earmarked contributions or premiums, usually levied through a payroll tax on earnings, supplemented by transfers from general government revenue for the rest of the population (for example, the self-employed or unemployed). Typically, eligibility is assessed on the basis of clear, algorithm-driven, written rules linking levels of disability to entitlement to certain levels of state support.

Algorithm-based entitlement systems have several implications for equity and efficiency in social care. They offer a more transparent allocation process than care-managed systems, and provide greater assurances about service users' rights to support. As a result, social insurance expenditure is needs-driven, rather than budget-constrained. On the negative side, entitlement systems can lack flexibility in the way they match care packages to individual need levels, because of the difficulties that exist in incorporating into entitlement rules important factors influencing the need for social care such as attitudes,

relational characteristics, and environmental factors. Partly for this reason, social insurance systems are generally carer-blind, and thus do not take into account the amount of informal support that individuals receive in order to estimate entitlement levels.

In theory, social insurance can cover the whole cost of care, but in practice this rarely happens. Instead, a co-payment is required from the service user, although this co-payment charge is normally means-tested. Where this co-payment is relatively large, these arrangements can be described as a (point-of-need) partnership between the individual and the state. The long-term care systems of Germany, Japan, Luxembourg and the Netherlands fall largely into this category (36). These “Bismarckian” social insurance systems are also characterized by the existence of an implicit social contract, with a tighter link between individual contributions and benefit levels than in the tax-funded models, in which funding is used on a pay-as-you-go basis and care levels depend on the resources available at the time.

Ultimately, whether the advantages of universal systems, including increased coverage and a greater degree of equity in entitlements, are worth the increased budgetary pressures on government is a political judgement. Despite the much greater levels of public expenditure required, there is widespread public support across Europe for some other universal entitlement systems such as for health care and education. One Europe-wide survey also suggests that the public may be in favour of supporting a similar commitment to long-term care (11). These attitudes may differ according to age: work in Scotland indicated that prior to the introduction of free care services there was a recognition among people aged under 50 that available resources should still be targeted at those in most need, whereas in the over 50s only a minority of those in one survey supported the use of means-testing for care (38, 39). It is also important to note that increased access to financial assistance to help meet the costs of long-term care could have positive collateral cost-benefits on other sectors. One English study, for instance, suggested that investments in long-term care services reduced the use of acute health care services (40).

Progressive universalism funding mechanisms

The third family of funding systems combines universal entitlement to state help with a means-tested element, which ensures that those in greatest financial need receive the greatest amount of state support. These systems, including those operating in Austria, Belgium, France and Greece (35), grouped under the banner of progressive universalism, aim to minimize state financial commitments while retaining an element of universality, in order to promote social cohesion and provide some insurance benefits to all, while limiting (relative to universal schemes) state expenditure.

The universal nature of support can increase public support for the system among those who would not qualify for entitlement to some benefit under the minimum safety benefit system. This support increases as the income of the potential care recipient decreases. As in the case of universal schemes, this can also have the effect of raising the profile of long-term care services, and reduce the stigma attached to the receipt of care in means-tested systems.

The Austrian long-term care system, for instance, builds on a universal component: all Austrian residents in need of long-term care are legally entitled to a cash benefit (long-term care allowance), irrespective of age, income, type of disabling condition (mental, physical or sensory) and regardless of the specific cause of the limiting condition. Recipients of this long-term care allowance are then free to choose how to spend the money (41). The long-term care allowance strengthens purchasing power but is not intended to cover the full costs arising from long-term care needs. In the case of care arrangements that rely partially or totally on formal care, means-tested components of public support come to the fore. In general, users are charged for social care services, but those who cannot afford user fees can apply for means-tested provincial social assistance. The different provincial authorities may also set a maximum price and/or subsidize services (42).

A second example of a progressive universalist approach can be seen in France, which introduced the *Allocation Personnalisée d'Autonomie* (APA) in 2002 as a contribution to the costs of long-term care for older people. The APA is a needs-assessed, means-tested universal entitlement, allocated according to national rules, and funded through general taxation. The benefit is defined in cash terms but the payment must be used to fund a care package agreed with social and health care professionals. Out-of-pocket contributions towards the cost of the care package vary depending on an individual's financial resources, with significant tax breaks available for co-payments and private expenditure for personal care and domestic help. Under French civil law, children are also obliged to contribute towards the costs of care for their parents, and must report their income to the "Aide sociale" when a parent applies for social assistance (36).

Funding models in practice

Although we have set out three broad policy options for long-term care funding, it is important to stress that, in practice, long-term care funding systems are highly heterogeneous; many borrow key parameters from different "families" of models. It is often the case, for instance, that means-tested systems which restrict receipt of state funding to a minority of low-income individuals are complemented by other state schemes that provide a degree of coverage for everyone.

In the four countries of the UK, for instance, the different systems of long-term care coexist with a universal system of disability-related cash benefits. Even the United States could be argued to complement its means-tested state controlled long-term care support system with more universal support options, such as state-run tax incentives linked to the purchase of voluntary private insurance.

There is little evidence, however, suggesting that these types of incentives have worked in the social care context. For instance, they do not appear to have increased the demand of private insurance in the United States (43), and do not exist in France, the European country with the highest proportion of older people holding voluntary private insurance policies. One of the reasons quoted for the lack of success of tax breaks is the fact that such incentives are likely to be modest for individuals with low incomes and in fact incentivize most strongly those individuals who would be most likely to purchase private insurance in the absence of any incentive (43).

This mixed picture of the long-term care funding landscape applies equally to other key parameters, such as the degree of local flexibility in funding arrangements. Although typically social insurance systems define national entitlements to social care, in some countries including Japan, for example, the national insurance system allows local authorities some freedom over the level of premiums raised.

Which key funding system implementation choices are likely to affect fairness and efficiency in the system?

What steps can be taken to aid in the implementation of different policy options for the funding of long-term care?

Building consensus on the roles of individuals and the state

Perhaps the most fundamental and difficult policy question implicit in the design of a funding system concerns the relative prioritization of groups in society, both in terms of who should contribute financially, for instance just people who are highly likely to make use of services, for example, older people or society in general; and in terms of who should be supported (e.g. degree of universality of support). These decisions will be shaped by societal preferences on issues like the role of the family in providing care, views on intergenerational transfer of assets and optimum levels of taxation.

In order to help build a consensus around any long-term care system, it is important to try and involve all sectors of society in a consultation process on the future shape of the system. This might involve a series of public meetings and the publication of consultative documents inviting different stakeholders to put forward their own views on the direction of the system.

Promoting a transparent and comprehensible funding mechanism

Implementation may be facilitated if the operation of the new system is seen to be transparent, fair and equitable in the way in which it uses resources. One such decision involves the choice of raising revenue mechanism – direct and indirect taxation, earnings-related social insurance contributions, private insurance premiums, and/or user charges. Different sources of revenue will generate different incentives, and will imply varying degrees of income redistribution. A tax on income is usually progressive but may not always ensure that contributions are collected from those who have non-waged incomes. In some countries, partly because of issues of tax avoidance, where there has historically been a reliance on sales and other consumption taxes, it might be more difficult to make use of general income tax to fund long-term care, but an earmarked tax might perhaps be more publicly acceptable.

One crucial issue will be to gain public support for the method of revenue collection to be used to fund any long-term care system. In particular, as we have noted, the inclusion of property in any means-testing system may be particularly contentious, given not only the growing amounts of wealth tied into housing stock in countries where the culture of house ownership is strong, but also because of families' strong emotional attachment to their housing assets. If housing assets are included in means-testing, one potential option to allow some release of capital without necessarily having to lose one's home may be equity release schemes offered either by the state or commercial bodies. In Ireland, for example, the proposed new system of long-term care funding explicitly addresses public concerns over this issue, by guaranteeing that contributions towards long-term residential care based on the value of a home will not exceed 15% of its value (7.5% if one person in a couple needs care and the other remains at home). Moreover these costs will be deferred until the settlement of the estate after death (44).

Regardless of the funding mechanism, public support for any system of long-term care can be aided if it is seen to be fair in the way it makes use of resources. This has implications for whether and how the system imposes user charges at the point of need. By avoiding a zero cost at the point of use, they act as a deterrent to demand, but to avoid being seen as unfair the reasons for any co-payments should be explained, and mechanisms put in place to allow for opt-outs from co-payments under certain circumstances. Ideally, eligibility and charging criteria should be seen as a way of targeting funding more specifically to those in most need.

Providing clear and accessible information on the long-term care system

As care systems become more complex, they can become a more bureaucratic administrative burden, which may undermine public confidence or

inappropriately deter individuals from seeking support if the process is seen to be too cumbersome. One important way of countering complexity is to ensure that adequate information, written in accessible language (and taking account of minority languages and visual impairments) is available, in addition to the provision of support for independent advocacy for individuals if and when they need it. Information might also be provided on any quality monitoring of long-term care services conducted. Maintaining high quality standards might also be conducive to greater public support for the system.

Such information needs critically to define precisely what is meant by long-term care. The somewhat ambiguous term can cover care provided within the home as well as that provided in residential facilities. It can range from support with personal care tasks such as washing and feeding, to activities linked to much broader concepts of well-being, such assistance with shopping, managing financial affairs, reducing social isolation and promoting leisure activities.

How long-term care is defined will of course have an impact on demand for services, and thus the cost of the system. In particular, demand is likely to expand exponentially as 'softer' objectives such as assistance with housework, or with broader well-being objectives are considered.

Systems may decide to provide different levels of financial support for different types of care and support. In particular, the state financial contributions might be concentrated on the costs associated with more acute needs, and in particular with the core personal activities of daily living. If so, it is critical that potential users are well aware of differences in user charges for different services. Both the free personal care system in Scotland, which concentrates on free support for personal care activities while charging for other types of support, and the soon to be introduced revised system of charging for long-term care in Ireland, have been accompanied by explicit printed and audio materials setting out entitlements (44, 45).

Balancing flexibility versus transparency in the matching of resources to needs

As a system is implemented, policy-makers also need to try and balance the need for flexibility in responding to individual needs while having an equitable and transparent entitlement process. Given the heterogeneity in the characteristics of people with long-term care needs, matching resources to needs is often complex taking into account a wide variety of circumstances (e.g. physical and mental needs, informal support, housing environment).

In means-tested, cash-constrained systems, eligibility rules are often implemented by front-line workers (case managers) with some discretion over actual service provision. Such a case-managed system as, for instance, seen in Estonia (46), allows front-line professionals to take into account a wide range

of individuals' characteristics, including some not easily amenable to measurement, such as the nature of the relationship between individuals in need and their informal caregivers. Overall costs can be contained more easily by continuously updating eligibility rules in line with available budgets. These systems, given their reliance on the skills of case managers, have been criticized both for a lack of transparency in their allocation decisions and for not providing individuals with a clear description of their entitlements to care.

Private or social insurance systems, in contrast, tend to have more explicit rules of entitlement, making use of algorithms to assess needs (see, for instance, the French, Austrian, German, Japanese and the new Spanish assessment models). While these systems provide greater transparency, as the rules for entitlement are more explicit, they are criticized for not taking into account all the subtle and often important characteristics of individuals in need. In particular, factors such as the nature and level of informal support, general frailty and the need for supervision, for instance, for people with cognitive impairments, are difficult to incorporate into formal algorithms of entitlement to support. However, a number of tax and social insurance based systems, including those in Austria and the Czech Republic, provide cash benefits which can then be used by consumers to purchase services that best meet their needs (14).

As with individual needs, wide local variations in most key aspects of long-term care within some countries have been well documented (47–51). Such variations have been subject to public criticism: in England the term “postcode lottery” is used to describe a situation where entitlement to support simply differs according to where an individual lives. The question is the extent to which such variability can be justified on the grounds of local accountability and responsiveness to local preferences and constraints, or whether it bears witness to significant variations in performance and territorial inequity (52, 53).

Localists have for a long time argued that variability born out of divergences in local preferences and constraints should be perceived as a positive rather than negative phenomenon (54). Research has shown, for instance, that variations in need, costs of staff and other inputs can have a great effect on the mix and intensity of services provided (40, 51, 55). Ultimately, some degree of local variability is likely to be needed to allow the system to adapt its offer to local characteristics and needs. Funding arrangements should allow for these variations, while providing individuals in society with clear and transparent information about the levels of service they can expect to receive.

Interaction with the informal care sector

In many countries, informal carers continue to provide the bulk of support for their loved ones and ideally they should be viewed as an important element in the process of providing care. However, formal care systems adopt a range of

attitudes towards informal carers. In terms of funding entitlements, the key issue is whether eligibility is reduced when informal carers provide support (as in England) or whether informal care activity is ignored (as in Japan). As already noted, not assessing access to informal care can significantly increase public costs to the state and lead to inequities in support between those with differing levels of informal care. However, supporting informal carers with their caregiving can help to reduce the need for full-time state sector intervention, and help carers to avoid becoming isolated from work and society.

To date, partly due to technical difficulties, and partly because they tend to conceptualize need for long-term care as a social risk, systems that use formulaic assessment processes are less likely to link entitlements to state support to levels of informal care received. In some cases, as in Germany, a reduced cash payment may be offered (instead of services in kind) in recognition that service users need to be able to compensate informal carers financially for the support they provide (56).

Improved coordination and partnership with other related systems

In setting funding parameters for long-term care, decision-makers ought to consider the implications they might have in other related systems, such as the health care, housing and benefits sectors. For instance, it is likely to be easier to implement social security schemes for long-term care in countries with pre-existing similar schemes for health care. In general, the degree of coordination between the health and social care systems will be affected by whether the same funding arrangements are used in the two systems.

The interaction between health systems free at the point of use and means-tested long-term care systems, for instance, can lead to situations where individuals with very similar needs (e.g. stroke and cognitive impairment) are provided with very different levels of state support depending on whether they are considered to have social or health needs. As indicated above, these cliff edges between different funding systems can also lead to cost-shunting and public dissatisfaction.

The need to coordinate intergovernmental activities might also influence the locus of control over the long-term care funding rules. Hence, it might make sense to locate responsibility for social care to the relevant body as with other public services, such as health and housing services. However, there may be a potential danger, given the relative difference in size of budgets, that the social care element becomes marginalized in the newly merged administrative structures.

Alternatively, funding-related incentives can be used to improve the coordination of health and social care activity. In countries like Sweden and

England, for instance, social care services have been made responsible for the cost of individuals who cannot be discharged from hospital because they do not have an appropriate social and long-term care support package. The use of such financial incentives appear to have contributed to a reduction in the number of delayed discharges in both countries, and are particularly relevant to tax-funded systems, as they involve the creation of joint budgeting mechanisms across elements of the two systems.

Interactions with social welfare benefits systems must also be considered. Most countries, in addition to having social and long-term care systems, also have mechanisms for the provision of disability related cash benefits. How will access to such benefits impact both on the income and needs of individuals? Means-tested social care systems may take such benefits into account when determining entitlement to services.

Summary

Across Europe data suggest that an ageing in the population, combined with changes in the availability of informal family support, increasing costs of care and raised expectations about the quality, intensity and flexibility of services may raise major challenges for policy-makers contending with maintaining or extending coverage and support for long-term care systems.

The case for public sector intervention for long-term care funding is strong. The lifetime costs of long-term care services can be substantial and may deplete the assets of all but the richest service users. State supported collective funding solutions can make sure that enough protection is provided to those in greatest need, and/or with the least ability to pay, and help avoid catastrophic costs. The private sector has failed to provide a sustainable insurance system that can cover a large proportion of the population, although in some countries it does provide a complement to state support. Nor is a continued reliance on family support possible for all; many dependent people have no living kin.

A number of different criteria can inform the development and public acceptability of long-term care funding mechanisms. They include the extent to which funding mechanisms are equitable and promote a partnership between personal, family and state responsibility. Another factor is whether systems are sufficiently transparent in how they define long-term care, rules on funding and entitlements to services.

Potential policy options include systems that seek simply to provide a safety net to those who cannot fund care, universal systems that, by and large, provide the same levels of entitlement to the whole population regardless of income, and incrementalist systems, which combine elements of safety net and universalist systems. Different approaches have differing effects on equity,

efficiency and impact on the public purse, all of which may require careful tailoring to specific local contexts and circumstances.

To be sustainable the system also needs to be affordable, fair and flexible. Measures to help facilitate any system of long-term care funding include public consultation to explore and exchange ideas and gauge public acceptance on the need for co-payments. As any system is implemented, adequate but accessible information should be made available in a variety of means. Support for advocates to help individuals in care package choices may also be needed. Steps to assure quality standards, provide support for carers and facilitate flexibility in care package choice can also help. Measures might also be taken to improve coordination between the long-term care and associated sectors.

Different long-term care systems are at very different stages of development across Europe. Much can be learnt from the experience of different countries, and international bodies such as the European Commission and World Health Organization, through information portals, policy dialogues and schemes that encourage cross-border partnerships may also be well placed to collate and diffuse knowledge, tailoring it to the specific circumstances observed across Europe.

Table 1a. Eligibility criteria in six countries

Japan	<p>Permanent residents of a municipality with a certified care need aged 40 or older:</p> <ul style="list-style-type: none"> • people aged 40–64 (restricted entitlement) • people aged 65+ (full entitlement). <p>Assessment of needs is income-blind and carer-blind.</p>
Germany	<p>Residents with an approved need for LTC regardless of age, income and availability of informal care who are covered by statutory health insurance and also belong to that fund's LTC insurance scheme.</p> <p><i>Social care services:</i> access to subsidized services may depend on receipt of care allowance (varies between states).</p>
Austria	<p><i>Care allowances:</i> residents with an approved need for LTC regardless of age, income and availability of informal care.</p> <p><i>24-hour care allowance:</i> LTC needs (level 3 or higher), income threshold.</p> <p><i>Social care services:</i> access to subsidized services may depend on receipt of care allowance (varies between provinces).</p>
France	<p>Residents aged 60+ with approved need of LTC, means-tested access.</p> <p>Family members often contribute – whether explicitly required to do so or not – to costs of residential care.</p>
England	<p>Residents with LTC needs.</p> <p>State support for social care services is restricted to those with limited financial means (income and assets).</p>
Denmark	<p>Residents with LTC needs regardless of age, income and availability of informal care.</p>

Table 1b. Entry threshold (need) in six countries

Japan	<i>Support level:</i> person lives independently but requires some assistance with IADLs.
Germany	<p>Those who need help with their personal care, nutrition or mobility at least once a day for at least two tasks in one or more areas, as well as assistance several times per week in performing household chores.</p> <p>Need care of no less than 90 minutes a day on average, of which more than 45 minutes must be accounted for by basic care.</p> <p>To be eligible an individual must have required frequent or substantial help for at least six months.</p>
Austria	<p><i>Cash benefit:</i> need of care for at least 50 hours a month, expected for a period of at least six months.</p> <p><i>Subsidized care services:</i> can be tied to the receipt of LTC allowance or a specific level of LTC cash allowance (regional variance).</p>
France	Inability to carry out at least three ADLs without assistance: unable to wash and toilet/dress unaided, unable to get up in the morning without help, but once up can move around inside the home.
England	Set locally.
Denmark	–

Table 1c. Care levels in six countries

Japan	If a person requires LTC he/she is assigned one of seven care levels: support level 1 and 2 (for light support); care level 1–5 (intensive services). This will determine the benefits in kind that he/she receives (care level 5 being the most dependent).
Germany	If a person requires LTC he/she is assigned one of three care levels and this will determine the benefits (in cash and/or in kind) that he/she receives (level 3 being the most dependent). The benefit that an individual receives depends on what care level they fall into, whether they are at home or in an institution, and whether they choose to take cash benefits or care in kind.
Austria	If a person requires LTC he/she is assigned one of seven care levels and this will determine the level of cash allowance he/she receives (level 7 being the most dependent). Access to 24-hour care allowance (level 3 or higher). Eligibility for institutional care can be tied to a minimum level of care allowance (regional variance).
France	If a person requires LTC he/she is assigned one of four categories in the national AGGIR (Autonomie Gérontologique – Groupe Iso Ressources) scale of dependency (category 1 being the most dependent).
England	Determined by needs assessment.
Denmark	Determined by needs assessment.

Table 1d. Assessment of need in six countries

Japan	<p>Need for LTC is assessed by the municipality; eligibility is based on a 79-item questionnaire which covers functional status etc. Responses are processed through a computer algorithm, which classifies the needs band that a person falls into.</p> <p>The results of the computer classification are assessed by an expert committee which makes the final decision, in some cases different from that produced by the computer.</p>
Germany	<p>A single national needs assessment tool is used. It is the health care insurance fund's Medical Review Board or, in case of private insurance, a Medical Review Board of the private insurance agency called "Medicproof" that verifies and assesses a person's need for care. The assessment is carried out by a physician.</p>
Austria	<p><i>Care allowance</i>: a coordinated assessment tool is used. Time budgets are allocated to 13 IADLs and summed up for those activities where support is needed. Total time of required support and – in case of higher levels of care allowances – type of care needs result in an assignment of care allowance.</p> <p>The assessment is carried out by a physician, if necessary professionals from related disciplines will be consulted.</p> <p><i>Care services</i>: some provincial authorities have their own assessment for care recipients who want to be cared for in care homes.</p>
France	<p>A single national needs assessment tool, the AGGIR (Autonomie Gérontologique – Groupe Iso Ressources) is used.</p> <p>This sets a maximum value for the care package.</p> <p>For domiciliary care, the assessment is carried out by one of a team of medical and social care staff responsible for assessments. In residential care, it is done under the responsibility of the supervising medic or an agreed doctor.</p>
England	<p>Social worker or care manager assesses need and develops care plan.</p>
Denmark	<p>LTC needs assessed by home care managers.</p>

Table 1e. Types of benefits in six countries

Japan	Services (up to financial limit), no cash alternative.
Germany	Free to choose cash, care in kind, or a combination of the two. The cash payment for home care is lower, but it can be spent on anything or paid to family members.
Austria	Untied cash benefit (i.e. recipients are free to choose how to spend the money); one exception: residential care (all but a small personal allowance is paid to the residential provider). 24-hour care allowance for people with high care needs (level 3 or higher); tied to the employment of up to two carers. Care services to be paid for by the users; some provincial authorities set a maximum price and/or subsidize the service.
France	Benefit defined in cash terms but payment must be used to fund an agreed care package. Funds can be used to employ a relative as a carer, but only for specific care plan tasks.
England	Means tested access to services. Tax free attendance allowance for people aged 65+ who need help with personal care.
Denmark	Services (access is not means tested).

Table 2a. Public sources of funding in six countries

Japan	<p>Compulsory public long-term care insurance system (LTCI):</p> <ul style="list-style-type: none"> • premiums (50%) collected by municipalities (for insurees aged 65+) or health care insurers (for insurees aged 40–64); • general taxes (central and local taxes) (50%).
Germany	<p>Compulsory public LTCI, based on premiums only.</p> <p>Tax-funded support for LTC service providers and service users in some provinces and communities (levels and modes of support vary between provinces).</p> <p>Tax-funded LTC benefits: those who cannot afford user fees for care services that exceed the amount of services covered by the LTCI can apply for a means-tested benefit ('Hilfe zur Pflege' – help with care) under the social assistance scheme.</p> <p>Medical home care: health insurance scheme.</p> <p>Tax deductibility of care-related expenditures.</p>
Austria	<p>Tax-funded long-term care allowances.</p> <p>Tax-funded support for LTC service providers and service users in some provinces and communities (levels and modes of support vary between provinces), financial contributions for institutional care facilities from provincial health funds.</p> <p>Tax-funded LTC benefits: those who cannot afford user fees can apply for means-tested provincial social assistance.</p> <p>Medical home care: social health insurance scheme.</p> <p>Tax deductibility of care related expenditures.</p>
France	<p>Tax-funded LTC benefits.</p> <p>Tax-funded LTC benefits: Those who cannot afford user fees can apply for means-tested social assistance.</p> <p>Tax deductibility of care related expenditures.</p>
England	Tax-funded.
Denmark	Tax-funded.

Table 2b. Individual contribution to public LTC systems in six countries

Japan	<p>Permanent residents in one of the municipalities aged 40 and older:</p> <ul style="list-style-type: none"> • residents between 40 and 64: premiums (percentage of income) are divided between employee and employer; • residents aged 65+: percentage of income; • premiums may vary between municipalities.
Germany	<p>Whoever is covered by statutory health insurance also contributes to that fund's LTC insurance scheme (percentage of income between a lower and a higher threshold; childless aged 23 and over pay higher premiums).</p> <p>Exemptions for dependent family members of the insured, unemployed and informal carers under specific circumstances.</p> <p>Social health insurance premiums (applies for medical home care only).</p>
Austria	<p>Taxes.</p> <p>Social health insurance premiums (for medical home care costs only).</p>
France	Taxes.
England	Taxes.
Denmark	Taxes.

Table 2c. User charges and co-payments in six countries

Japan	Mandatory co-payments (10% of total cost of services up to a ceiling/month; lower ceiling in case of income below a certain threshold).
Germany	Private out-of-pocket payments if service use exceeds the amount of services covered by the public long-term care insurance. User fees vary between provinces.
Austria	User fees for care services, reductions for low income service users. User fees vary between provinces.
France	A means-test, with national rules, determines the level of co-payment. The level of public assistance declines sharply with income as the co-payment increases from 0% to 90% of the value of the care package. The means-test accounts for income and some assets.
England	Almost all LTC services are subject to a means tested charge.
Denmark	Long-term home based care and palliative care free of charge. Charges for meals at home services. Income related contribution to costs of residential care.

Table 2d. Private long-term care insurance in six countries

Japan	Expenses caused by additional services are covered by optional private LTC insurance.
Germany	Partly mandatory (for those who opt out of the statutory health insurance scheme) and partly optional (those covered by the statutory LTC insurance scheme), 11% of the population hold a policy.
Austria	Optional private LTC insurance; 0.5% of the population hold a policy.
France	Optional private LTC insurance; 3% of the population hold a policy.
England	Not available.
Denmark	Not available.

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