

Long-Term Care Financing: Models from Abroad

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Summary

Achieving a long-term care system that meets individual needs and distributes costs equitably will require fundamental reform of long-term care financing and a substantial commitment of federal resources. So concludes the National Academy of Social Insurance's study panel on long-term care in its report, *Developing a Better Long-Term Care Policy: A Vision and Strategy for America's Future*.

Many other developed countries are further along the aging curve than the United States and have already made reforms to their long-term care systems. Some have adopted a universal approach to providing public long-term care insurance, while others use means testing. Their experiences illustrate different ways to balance public financing that spreads risk with personal responsibility through cost sharing, as well as methods of targeting benefits, controlling costs, and supporting caregivers. This brief highlights and updates the findings of a comparative analysis prepared for the Academy's study panel. The full analysis, which also highlights parallels with long-term care programs in the U.S. and issues in evaluating different models, is available on the Academy's website at www.nasi.org.

Types of Public Long-Term Care Programs

Some public long-term care programs cover most or all of the population, providing benefits to anyone meeting a test of disability. Others serve only people whose income and assets are below certain levels. In most countries, both local and national governments are involved in financing long-term care. In virtually all cases, beneficiaries share responsibility for their long-term care by paying premiums or cost-sharing. Private long-term care insurance is quite rare in other countries.

Social Insurance

Austria, Belgium, Germany, Israel, Japan, Luxembourg, and the Netherlands offer social insurance for long-term care. Social insurance programs cover all or most of the population and have a dedicated funding source. The German program, established in 1995, covers long-term care through the same organizations that provide health insurance (but with entirely distinct funding). The contribution rate is 1.7 percent of income (up to a ceiling), divided equally between workers or retirees and employers or

pension funds. Starting in 2005, childless employees pay a supplementary contribution of 0.25 percent; the differential contribution rate acknowledges that raising children is one of the pillars of the long-term care insurance system, since children will be paying contributions in the future. High-income people may opt out of the social insurance system by purchasing equivalent or better private coverage. As of January 2005, the social insurance system covers 70 million Germans, and the private system covers another 9 million high-income workers and civil servants.

In Japan, everyone aged 40 and over participates in a social insurance program operated by municipalities. Half the program cost is covered by contributions or premiums, and half is covered by payments from the central, prefectural, and municipal governments. For covered workers, the contribution rate is 0.9 percent, split equally between employers and employees. People aged 65 and over pay an income-related premium. The Japanese program dates from 2000.

Social Democratic Model

The Scandinavian countries provide universal coverage through public services. Everyone is entitled to long-term care services through municipal programs funded primarily by local and regional tax revenues. The central government covers roughly 30 percent of costs in Finland and 15 percent in Sweden. The Danish central government makes no fiscal contribution. While coverage is universal, benefits or required cost-sharing may vary according to local ability to raise funds. Differences in the proportion of the population served, the level of benefits, and the level of charges have been especially high in Sweden and Denmark.

Means-Tested Systems

Australia, New Zealand, the United Kingdom, and many other countries rely primarily on means-tested programs financed from general taxation. In the United Kingdom, the National Health Service covers nursing care in the community and in nursing homes. Non-medical long-term care is furnished by localities on a means-tested basis (except that there is no means testing for personal care in Scotland). Funding comes primarily from the central government, however, but also partly from local taxation and user charges.

Hybrid Systems

A simple dichotomy between universal programs and programs aimed at the poor does not adequately characterize some systems. A universal program can cover everyone but vary benefits according to income. France's personalized independence allowance (APA), or autonomy pension, provides cash payments to be used for long-term care services for people age 60 and over. A maximum benefit amount is specified for each of four levels of disability. The benefit is reduced according to a sliding scale based on income: the highest-income participants receive only 10 percent of the maximum benefit for their disability level. The central government and the elected councils in each department jointly fund the benefit, which took effect in 2002.

Similarly, a means-tested program may have standards so generous that much of the population is eligible. Israel's social insurance program provides full benefits to aged people who meet disability tests and whose income is no higher than the average wage (or, for a couple, 1.5 times

the average wage)—a test met by many pensioners. A single person with income more than 1.5 times the average wage or a couple with income more than 2.25 times the average receive no benefits. In 2004, 113,500 Israelis received long-term care insurance benefits, compared to 722,000 old-age pensioners.

Finally, some countries have both a universal social insurance program and a means-tested social assistance program. In Germany, people who cannot meet the cost-sharing requirements for nursing home care are helped by local means-tested programs, which are financed by the states. Austria and Belgium have similar systems.

In Canada, each province runs its own long-term care system, with federal funding in the form of a block grant shared with health and education programs. Home care tends to be a universal entitlement, while provinces vary in the extent to which they impose means-testing for institutional services.

Controlling Spending

No nation offers a public long-term care program that provides an unlimited entitlement to services without a strategy for managing costs. Some countries limit benefits on a per person basis. Others stay within a fixed budget by adjusting eligibility thresholds, limiting services, or establishing waiting lists.

Limited Entitlements

Germany and Japan provide services (or, in Germany, an optional cash alternative) up to a fixed amount per person based on level of disability. These programs are limited entitlements whose costs are fairly predictable in the short term. They may incur higher spending if more people participate, but not because people use more costly services than expected.

France's autonomy pension is an example of a limited entitlement that actually faced budget overruns because of unexpectedly high participation. Costs turned out to be nearly 50 percent higher than estimated, and the government responded by tightening eligibility and lengthening the waiting period before benefits are available.

Budgeted Systems

The Scandinavian long-term care systems nominally provide an entitlement to all appropriate services to everyone who needs them. In practice, however, the local governments that operate the program adjust the criteria for eligibility to fit available finances. Implicit rationing may also arise if services are covered but unobtainable. For example, at the start of the German program, 30 percent of the home care budget could not be spent because there was no one to provide care. The Organization for Economic Cooperation and Development (OECD) reports that the Netherlands has waiting lists for both home and institutional care.

Budgeted systems may also ration informally. In England, where localities provide services under fixed allocations from the central government, there are no set eligibility or benefit standards. Needs are assessed and services doled out on an *ad hoc* basis; people cannot be certain what kind of help they might receive.

Cost Sharing

Beneficiaries must usually contribute to meeting the cost of both home care and institutional care. This requirement retains a measure of personal responsibility for long-term care and holds down costs by deterring utilization.

For home care, many countries impose some form of fixed payment per visit—often amounting to some 10 percent to 15 percent of cost and subject to income-based exemptions or sliding scales. In the Japanese social insurance system, beneficiaries pay only 10 percent of the costs irrespective of their income. Germany does not impose explicit co-payments but has implicit cost sharing, since the amount of home care provided at each level of benefit falls short of the estimated need. France’s disability-based cash allowances are reduced by a fixed amount based on income; this financial participation is not linked to service use or expense.

Cost-sharing tends to be larger for institutional care than for home care, partly because people in institutions have fewer additional demands on their resources. Some systems, such as the U.K., have spend-down regimes for nursing home care comparable to that in the U.S. Others, such as Belgium, Finland, and Sweden, impose cost-sharing that consumes a substantial fraction of income. Many countries expect nursing home residents to pay the costs of accommodation—rent, meals, utilities, housekeeping, laundry, and other ordinary expense of living—unless they are receiving social assistance. In some cases, the accommodation charge is related to the level of the public pension.

Evaluating Need and Targeting Benefits

Both public and private long-term care programs must have a way of determining who is sufficiently disabled to qualify for benefits. Programs that vary cash or service benefits by level of care must also have ways of classifying participants; these systems vary in the number of benefit tiers used and the range of benefits for each tier. To determine eligibility or care level, some systems use explicit criteria, such as requiring assistance with a given number of activities of daily living (ADLs) or needing a certain number of hours of care. Others allow more discretion to decision-makers. Entitlement programs tend to use explicit criteria, while budgeted programs are more likely to rely on discretionary judgments, which can be adjusted to meet funding targets.

Explicit Criteria

Systems using fixed criteria vary considerably in their stringency. The German social insurance program is relatively strict. To be eligible for the lowest level of benefits, a person must need assistance at least once a day with two ADLs and require at least 90 minutes of assistance per day. To receive the highest (third) level of benefits, a person must need continual assistance averaging at least five hours a day. For the French autonomy pension, needing assistance with three ADLs is the minimum standard of eligibility. The highest (fourth) level of benefits is reserved for those who have lost both physical mobility and mental acuity.

In contrast, Japan offers a minimal benefit to people who need as little as 29 minutes of care a day and provides six different levels of benefits. For in-home benefits, an automated program considers 73 individual characteristics (including ADLs, instrumental ADLs, and cognitive

measures) in assigning applicants to one of six care levels. Furnishing supportive services to less disabled individuals is specifically designed to slow deterioration and prevent premature institutionalization.

Discretionary Judgments

To avoid replacing informal care, some programs combine disability standards with consideration of the availability of family supports. Someone who is highly disabled but living with family members might require services only intermittently, while someone living alone might need help even with a less severe disability. Under such a system, budgetary pressures may result in shifting burdens to family caregivers. In Sweden, for example, municipalities rarely furnish assistance to elderly women who must care for their husbands.

Although most countries with social insurance for long-term care have explicit criteria for eligibility, the Netherlands relies on a rather subjective assessment. Eligibility for benefits is determined through “holistic” evaluations by teams that may include nurses, social workers, and other professionals. The team considers the level of disability, the home environment, and the availability of informal care. There is no uniform instrument for these assessments, and the teams have a high degree of professional discretion.

Home-Care Benefits

Increasingly, public long-term care programs are providing more paid home care, with the goal of allowing people to remain in the community and avoid costly institutionalization as long as possible. Home care programs vary along two dimensions. The first is the *degree of consumer direction or autonomy*—from systems in which an agency or care manager makes all decisions to systems in which individuals decide what they need and where to get it. The second is the *type of benefit*—ranging from provision of formal services from recognized providers, through service budgets that may be used to pay formal and informal providers but may not be retained as income, to unrestricted cash grants.

Under traditional programs that pay for in-kind services, agency-selected providers furnish services under an agency-approved care plan. This arrangement can apply either in a social insurance program (as in the Netherlands) or in a means-tested program (as in the UK).

At the other extreme, exemplified by the French autonomy pension and a similar cash option under the German system, the individual receives funds that may be used to pay anyone for any service or that may be retained as income. Under the German social insurance system, participants may choose between in-kind benefits and a cash grant. The in-kind benefit allows substantial autonomy; benefits may be obtained from licensed providers of services up to specified monetary limits. Alternatively, people opting for a benefit in cash may use it to pay family caregivers or in any other way they see fit. The cash benefit is set to equal about half the benefit in kind for a given disability level.

Between these two poles are programs that pay only for services but give the consumer some discretion in what services will be provided or by whom. In the Japanese social insurance system, for example, after the municipality determines the needed level of care, a care manager

draws up a care plan. Beneficiaries may acquire services from approved providers in an amount up to the budget ceiling for their level of care. In the Netherlands, following reforms in 2003, new home-care users have been offered the option of a consumer-directed budget in place of direct services. In Denmark, beneficiaries may choose providers but do not receive a service budget.

Supporting Caregivers

Throughout the world, relatives, friends, and other unpaid caregivers provide a substantial amount of long-term care. In part to hold down spending on more costly forms of care, several countries have recently adopted policies to support informal caregivers, including the provision of cash allowances, respite care, and pension credits.

The German and French cash benefits may be used to pay family caregivers. In addition, the German system furnishes up to four weeks of in-home respite care or short-term institutional care to provide relief to informal caregivers. Training is made available for unpaid caregivers, and the long-term care insurance funds may make public pension contributions on their behalf.

Several countries, including Australia, Canada, Ireland, Sweden, and the United Kingdom, have introduced payments to caregivers to make up for some of their foregone earnings. The U.K. offers a Carer's Allowance to people who spend at least 35 hours a week looking after someone who is receiving or has applied for certain benefits based on disability. People receiving a Carer's Allowance for an entire year also receive credits under the U.K.'s earning-based supplemental pension as if they had annual earnings of £12,100 (\$21,900).

Conclusion

Analysis by the Organization for Economic Cooperation and Development finds a growing number of countries with universal public plans for financing long-term care. Public protection, the OECD reports, does not imply the absence of private obligations, such as cost sharing and out-of-pocket spending, nor does it imply unlimited services or exploding costs. Rather, it aims to strike a fairer balance between public and private financing—relating personal contributions to ability to pay and targeting benefits to the population in greatest need.

Many of the public long-term programs discussed in this brief and analyzed by the OECD are relatively new or have been recently modified. As experience accumulates, further analysis would be useful to find out how well these programs are working, how much they are spending, how many people they are serving, what changes are being considered, and what additional guidance they may offer in developing a better long-term care policy for the United States.

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