Building systems to address functional decline and dependence in ageing populations

The Hague 25 and 26 April 2013

Background paper

Financing long term care

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Preface

This paper was commissioned to review existing literature on long-term care financing models, definitions and taxonomies and describe the barriers and opportunities to encourage global discussion on LTC financing especially among low and middle income countries. The review is not meant to be exhaustive. Any feedback is greatly appreciated and can be sent by email to Chek Hooi Wong. (wong.chek.hooi@alexandrahealth.com.sg)

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Table of contents

Summary

The ageing of any population is accompanied by changing health care needs. In particular, the increasing demands for long term care (LTC) services. As a result, countries are exploring financing arrangements to ensure that their populations are not denied access to LTC because they cannot afford it. The purpose of financing is to make funding available to ensure individuals can access effective LTC services. In addition to making funds available, setting the right financial incentives are also important. For example, inadequate support for social care may lead to an increased use of more expensive acute care hospitals for LTC purposes. Financing mechanisms can be used to encourage the integration of services, improve responsiveness and avoid cost shifting in health systems.

Effective financing is important in providing universal health coverage (UHC) to all individuals with LTC needs. Within the current tight fiscal environment, UHC provides a framework for an equitable and sustainable health financing strategy. Current models of LTC financing are analysed using the proposed dimensions of universal health coverage: proportion of population covered, the range of services made available and the proportion of costs covered. Financing functions in allocation of funds and purchasing, revenue collection, and risk pooling financing functions are also included to complete the overview into LTC financing to examine efficiencies and equity considerations.

There are also specific financing policy strategies for low and middle-income countries (LMIC) to consider in the provision of LTC. Currently, there is a lack of coherent national policy responses in LMIC to meet the needs of LTC. Policy reforms are needed to recognize the importance of investing in LTC, aligning financing to the provision of LTC and building coherence towards the integration of LTC into the health care system. As the pace of ageing is gathering momentum in LMICs, these countries will also have to consider how fast to scale up their LTC financial resources and strengthen their service infrastructure.

1. Introduction

The demand for long term care (LTC) services is increasing worldwide as a result of population ageing and the epidemiologic shift from acute to chronic diseases. As a consequence, LTC demand and expenditure is expected to grow.[1] The aim of long-term care services is to help chronically ill and functionally disabled people maintain a good quality of life with the highest degree of independence, personal fulfilment and dignity by combining medical, nursing, and social care services.[2]

There are increasing debates on the development and dimensions of LTC financing as this directly impacts on how the health care system provides coverage for LTC. Current LTC programs and financing models are very heterogeneous, reflecting the differences in coverage and the mix of services, benefits, and schemes, and different stages of LTC services and financing development. Although the bulk of the literature on models of LTC financing is from high-income countries (HIC), there are increasing number of case reports and analyses on LTC financing from LMIC. This paper takes a systematic approach to LTC financing by analysing (i) the settings in financing LTC and LTC financing challenges in LMIC and HIC (ii) current LTC programs (iii) LTC financing using the framework provided in Universal Health Coverage (UHC) and specific financing functions to furnish efficiency and equity considerations, and (iv) financing policy strategies.

2. Setting the stage

2.1 Why develop LTC services?

Increased LTC needs from population ageing

Populations are rapidly ageing in low and middle-income countries (LMIC) (Figure 1). The number of people aged 60 years or over is expected to increase from 470 million in 2009 to 1.6 billion in 2050, where 80% of the world's older population is expected to be living in LMIC.[3] Health care needs of older people are different from younger people. Older people are more vulnerable to chronic non-communicable diseases

and experience higher rates of disability that may require help from others.[4] As a consequence; older populations have higher long term complex medical and social care needs than younger populations.

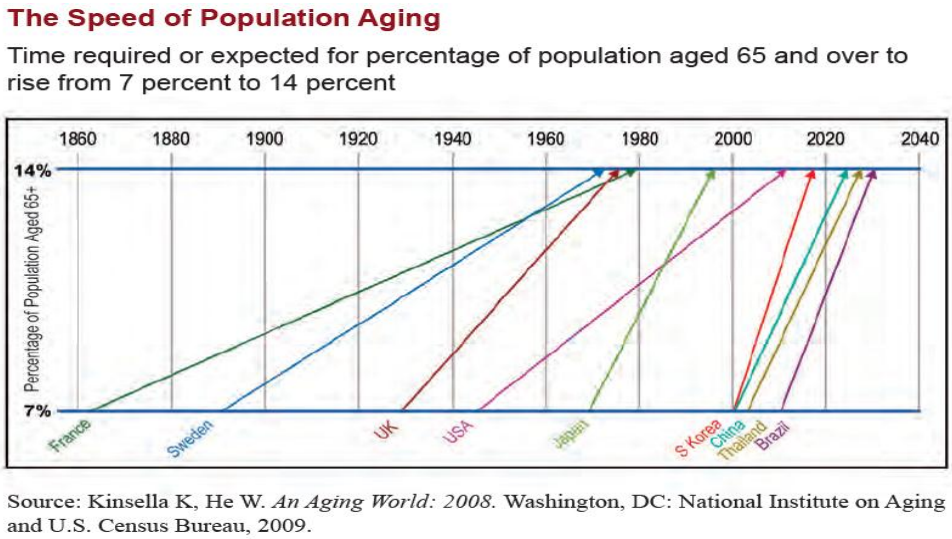


Figure 1 The pace of ageing in LMIC

Increasing demand for LTC services and LTC expenditure

Most long-term care needs of dependent older people are met informally by family members. However, the available pool of informal carers is likely to shrink due to dramatic falls in the proportion of younger adults compared to older adults and increasing mobility of the working adult population. The increasing relative proportion of older family members means fewer and fewer younger adults will share this burden. (Figure 2) This has led to a growing global consensus that countries must do more to support the increasing demand for LTC.[1] Population ageing is also expected to push up LTC expenditure. The direct financial costs of formal LTC can exact a heavy financial burden on older people and families. While estimates of spending on LTC have mostly been limited to high-income countries (HIC), there is an increasing interest to quantify LTC expenditure in LMIC. In Argentina, for example, the average LTC cost for women aged 60 years and above is estimated to be 52% of expected value per capita family income.[5]

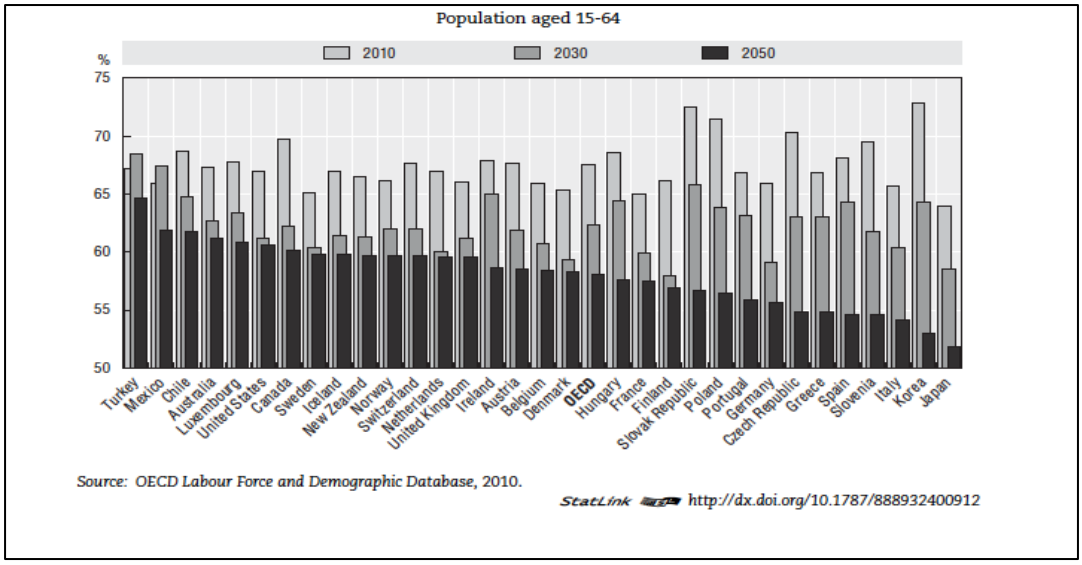


Figure 2. % share of working-age population decreasing (2010-2050)

Indirect costs to caregivers, families, society and health systems

While often perceived as "free", informal care is not without costs to caregivers, society and health systems. Indirect costs include lost income in reduced work hours, absenteeism from work, employability and productivity by family caring for older adults.[6] Since women bear most of the responsibility for informal care; this creates inequities for women experiencing opportunity loss from workforce participation.[7] Failure to meet long-term care needs also has consequences on health systems. In Japan, for example, unmet LTC needs resulted in the use of expensive acute hospitalization for LTC purposes.[8] Combined, these indirect costs are likely to have significant negative impacts at a societal level and at a macro-level in socioeconomic development. Consequently, more countries are starting to view LTC as a shared societal responsibility and public support should play a role in meeting the LTC needs of older people. For example, in 2011, China passed the China National Benefit Protection Law of Ageing Population to reaffirm that the state has a role in meeting the health and social care needs of older people.[9]

2.2 Why develop public LTC financing?

A rationale for countries to create long-term care financing schemes is that the cost of LTC is high and places a significant burden on low-income households or those

with high levels of dependency. In addition, there are uncertainties for older adults when they will need long-term care as well as the duration and intensity of care. Prepayment and pooling for LTC costs provide an answer to high uncertainty and costs by pooling risk and ensuring protection against potentially catastrophic long-term care cost. Financing of LTC enables access to services by offering compensation for the cost of services and, helping to prevent individuals from being deprived of necessary care due to lack of financial resources.[10]

2.3 Long-term care financing challenges*

The development of LTC financing is taking place differently in different countries and groups within countries (particularly urban-rural). The development of LTC financing is most advanced in high-income countries as their populations have been ageing for some time. Currently, populations in LMIC are ageing rapidly. The pace of ageing is also expected to be several times faster than the pace that has occurred in HIC. This means that LMIC will have less time to put in place the policies and infrastructure to meet the needs of their ageing populations.[11]

Low and middle-income countries (LMIC)*

Currently, LTC is not a priority in many low-income countries due to the current young population profile. Most low-income countries are already severely challenged to provide essential health services to their populations and to provide financial protection to the population. Faced with budget constraints and multiple health care needs, low-income countries need to get more value for their money in terms of efficiency and more equitable health outcomes. However, there is growing interest in the provision of LTC, particularly in community home care, due to the recognition of a more efficient and cost effective use of resources compared to hospitalization for chronically ill and dependent patients, for example, HIV/AIDS patients.[12]

*** LMIC** is from World Bank's classification of economies based on gross national income (GNI) per capita. The use of the term is convenient and it is not intended to imply that all economies in the group are experiencing similar development or that other economies have reached a preferred or final stage of development. Classification by income does not necessarily reflect development status.

In middle-income countries, rapid demographic and epidemiologic transitions would be a major challenge to their emerging health care systems and health financing. For example, China's older population over the age of 65 years will increase to 330 million in 2050 from 110 million today and India will increase to 227 million from 60 million.[11] LTC demand and costs are expected to increase as these countries are also facing challenges as family- or community-based informal support for older persons is under growing pressure from falling fertility rates, smaller family sizes, and changing cultural norms regarding caring for older persons. In general, most households in middle-income countries spend almost 40 percent of their total health spending out-of-pocket.[13] The out-of-pocket medical costs are predominantly concentrated at the end of life and at the same time, for countries without social security, poverty is also concentrated in older adults.[14]

Most public health care systems in LMIC are not designed to provide or incorporate LTC. Financing of public health care is also not aligned as current health financing benefits and payment systems in LMIC generally provide better coverage for acute episodes of care rather than the poorer quality or non-existent coverage for on-going chronic care and LTC. These challenges are also exacerbated by fragmented financing systems and inefficient purchasing arrangements.[13] Although some form of LTC service delivery may exist in LMIC, there is very little information and description on the scope and provision of LTC in the health system. In China, for example, there has been increasing developments of both public and private community care and nursing homes in urban centres like Shanghai. However, there is lack of a coherent development in the country's LTC system and financing to support this increasing need.[15,16] There are also increasing inequities in the accessibility of LTC between urban and rural centres.[17]

High-income countries (HIC)

Many HIC have started reforms in their social or national health insurance–based financing systems to meet the needs of their ageing populations. These countries recognized the need to promote increased risk pooling on grounds of equity, and financial protection for older adults by introducing public LTC insurance. In 1968, for example, the Netherlands started a LTC social insurance scheme (the Algemene Wet Bijzondere Ziektekosten), which covers the population from high costs in long-term

care and disability.[18] In general, the development of LTC financing and services in HIC remain fragmented from general health care services. LTC financing was developed in a later phase from health care financing and LTC services were based in different institutions (nursing homes, home care, and residential care) than general health care (hospitals, and primary health care). [18]

Effective LTC combines two inter-related services of social† and medical care. While most HIC finance some medical and nursing care components of LTC, there is less agreement on social care. Consequently, there are on-going debates on how best to finance social care. For example, social care benefits under the United Kingdom (UK) National Health Services (NHS) are covered for older people in Scotland, but in the rest of the UK only nursing care was covered.[19] HIC have started to recognize the inefficiencies and challenges of their LTC systems and have started the debate on reforming their LTC system and financing.

3. Current public models of long-term care programs

Although there are LTC services in LMIC, there is limited literature available on models of public LTC delivery programs. This section describes the current available programs based on scope of entitlement and coverage in HIC. The advantages and disadvantages of providing a wider coverage ("Universal schemes"‡) versus a targeted safety net program of limited coverage are highlighted. In general, the types of care services in LTC can include medical and nursing care, and social care. (Box 1)

† **Social care** has been defined differently depending on the context and purpose. Social care in this paper is defined as health-related social care in terms of Personal care for Activities of Daily Living (ADL) and Assistive care for Independent Activities of Daily living (IADL). (Box 1) In the National Health Accounts for health expenditure, social care is defined as community and occupational support whose primary purpose is not health-related but for social and leisure reasons.

‡ **"Universal schemes"** is a term defined by the Organization for Economic development and Co-operation (OECD) to describe the coverage of LTC program. This is in contrast to Universal Health Coverage where the goal is to provide both universally accessible access to care and financial protection to all individuals.

Box 1. Typology of formal care in LTC

Medical and nursing care described for LTC and home care are predominantly delivered by skilled medical doctors, nurses and paramedics and can include administration of medication, wound dressing, to more complex care in enteral tube, and urinary catheter. Some countries include preventive and rehabilitative services

Social care needs based on **Personal care** or Activities of daily living (ADL) including feeding, bathing, personal hygiene, ambulation) and **Assistance care** or Instrumental activities of daily living (IADL) including performing housework, preparing food, handling finances, taking transportation), care in day centres, and meals delivered at home is generally care delivered by low-skilled workers. The main aim is to help dependent older adults to remain at home and the package offered by different countries varies. At minimum most packages includes care in ADL. Assistance services or IADL are only covered as benefits in a limited number of countries.

OECD, Eurostat, WHO (2011). A system of Health Accounts, OECD Publishing

3.1 Current "universal" vs means-tested schemes

Wide coverage - "Universal schemes"

Universal schemes are programs that generally cover all of the population and provide benefits on the basis of assessed needs compared to means tested programs. These schemes can be financed from general taxation or social health insurance schemes and managed by National Health Systems or Social Health Insurance systems. These programs allow individuals to access services and all eligible individuals have a right to a standard LTC benefit.[10]

Although these schemes are labelled as universal; there are many features that are different from a Universal Health Coverage.[20] For example, most countries agree to

provide medical/nursing care services and ensure access to these services with a financing mechanism to avoid catastrophic spending. However, social care services are often not covered for the full cost or adjusted to a recipient's income by progressively increasing the share of the cost paid for by the public system as the income of the recipient decreases.[21] The extra cost can be met by a number of different arrangements including funding from social assistance and other income-support mechanisms (co-payment, medical savings account, supplemental private insurance). This segregation of social care from medical/nursing care services introduces complexity in LTC as frail older people may require both types of care. It disrupts the continuum of care and requires the set up coordinating mechanisms to help users navigate the system. The segregation in benefits could also increase cost shifting across medical/nursing and social care benefits in LTC. Country examples include Japan, Germany, South Korea and the Netherlands.[10]

Advantages of current "universal" schemes

- More equitable offering LTC services based on needs (predominantly for medical/nursing care)
- Wide coverage (predominantly for medical/nursing care)
- Reliable source of dedicated revenue from general taxation or social insurance
- People are willing to contribute if entitled to benefits (Social insurance)

Disadvantages of current "universal" schemes

- May not fully cover social care and requires additional income supporting mechanisms to help cover costs.
- Separation of purchasing and provision of social care from medical/nursing care benefits.
- Disrupts the continuum of care and requires the set up coordinating mechanisms to help users navigate the system
- May lead to cost shifting between social care providers and medical care providers.

Limited targeted coverage – Means-tested schemes

Under means-tested schemes, LTC coverage is provided through safety net programs targeted to older people based on personal/family income and/or asset tests and/or availability of informal carers to be used as eligibility to publicly funded care. Only those falling below a set threshold of income/asset/availability of informal carers tests are entitled to publicly funded LTC services or benefits. Countries set different thresholds and assessment methods for eligibility through case managers and can be administratively expensive. The basic argument for means testing is that government acts as a payer of last resort for those unable to provide for themselves. However, means testing may create inequities[§] and increase incentives to use more expensive acute health care (where universal healthcare is available) for LTC purposes.[10,21] In most means-tested schemes, elderly and disabled people are only eligible for care when they become impoverished (income and/or asset). Means tested plan do not generally have a dedicated revenue source, because it may be politically impossible to impose a visible tax on people who may not have a chance in qualifying for benefits. Country examples include the United Kingdom and the United States.[10]

Advantages of current means tested schemes

- Safety net to target those with highest care needs.
- Budgeted and costs are maybe more predictable.

Disadvantages of current means-tested schemes

- Need to set income/asset threshold for eligibility for public care.
- Poor coverage and requires elderly to be "impoverished" before being eligible for care.
- May increase incentives to use acute health care.
- Could be administratively expensive and inefficient.
- No dedicated revenue source.

§ In addition, when older adults are required to sell their homes before being eligible to public coverage, it may be seen as unfair given older adults' attachment to their family homes.

4. Financing long-term care

Although there is no recommended framework to examine LTC financing, the approach to the principles of LTC financing is conceptually similar to health system financing. It is a process with the following functions: funds are collected, accumulated in fund pools, and services purchased from various providers (Figure 3).[22] These financing functions can be undertaken by different organizations or by one or more organizations in different combinations. Hence, the specific form of financing schemes may not be as important since a combination of insurance schemes may be necessary to accomplish the goals of financing, for example, to ensure all individuals have access to effective services and financial protection for older people.[13]

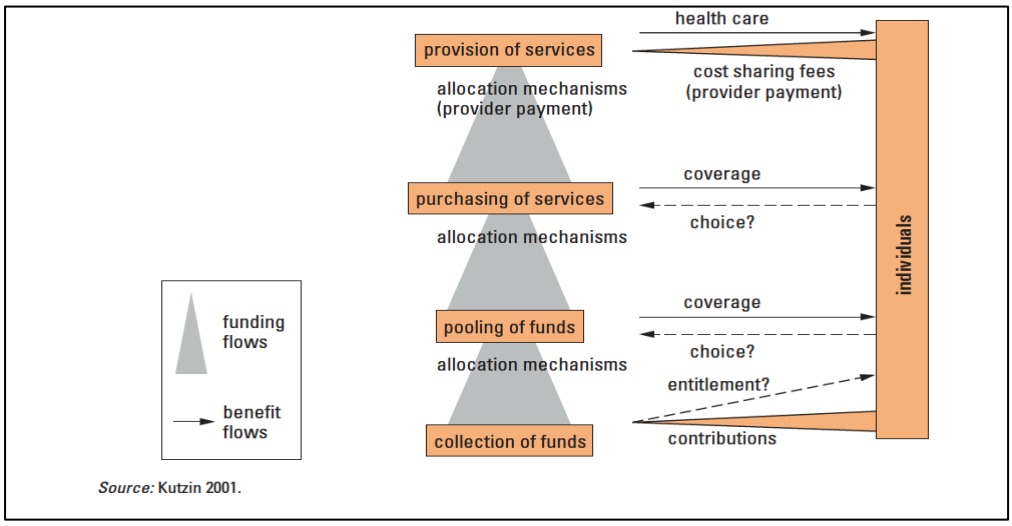
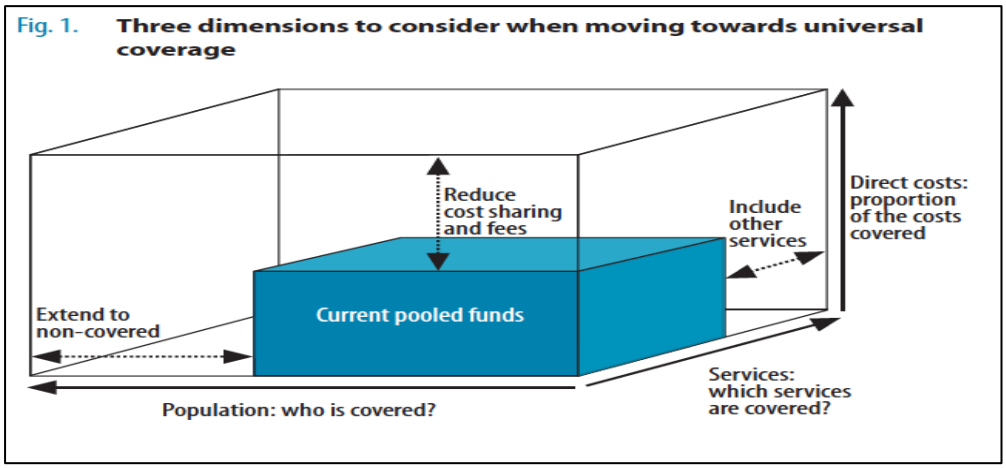


Figure 3. Framework of health financing functions

4.1 Goals of financing and universal health coverage

An important goal of financing is to ensure older people are not denied access to long –term care because they cannot afford it. This is consistent with the aims of Universal Health Coverage (UHC) to provide coverage to all individuals with health care needs while ensuring that the use of these services does not expose the user to financial hardship.[20] Within the current tight fiscal environment, UHC can also provide a framework for an equitable, and sustainable health financing strategy. Current LTC financing systems are analysed and evaluated for potential trade-offs

using the three proposed dimensions of UHC: the proportion of population covered, the range of services made available and the proportion of costs covered (Figure 4). Financing functions in allocation of funds and purchasing, revenue collection, and risk pooling financing functions are included to complete the overview into LTC financing to examine efficiencies and equity considerations.[23]



Source: WHO

Figure 4. Three dimensions to consider when moving towards universal coverage

4.2 Eligibility: Who is covered?

Public LTC financing have eligibility rules based on assessments using physical or cognitive disabilities (dependency) help LTC financing programs target care needs by considering level of disability, the home and environment, current availability of informal care, and likelihood that this care will continue. In means tested schemes, there are additional income/asset tests that assess eligibility to public funds.

Which levels of dependency and disability to target?

Decisions about qualifying disability and dependency levels partly reflect financial concerns, as well as, the different goals for long-term care programs. Austria and Japan offer benefits to a larger number of elderly people, while Belgium, France, US and Germany use much stricter criteria to restrict individuals who are eligible for benefits.[10,21] Targeting and providing supportive services to less disabled people may slow deterioration in function and prevent premature institutionalization.[8] On the other hand, targeting people whose impairments are severe enough to qualify them

for nursing home admission may shift the burden from available informal carers to institutionalization benefits or what is known as the "woodwork effect".[24] One way of overcoming this effect is to combine dependency standards with some 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 more help even with less severe disability.[24]

4.3 Depth of coverage and cost to users

The coverage and benefits provided by countries with LTC health-care systems to older persons vary considerably. The differences reflect not only the human and financial resources made available for older persons, but may also reflect societies' norms regarding the appropriate balance between individual and collective responsibility in caring and financing for older people.

Debates centre along social care component in LTC

Most public LTC systems require users to share part of the cost of the health-related social care support they are entitled to but countries differ markedly in method and extent of public/private mix. In the South Korean National LTC insurance system, beneficiaries must pay 20% of total costs in institutional care and 15% of total cost for home-care services.[10] Based on a means test on household income and assets, low-income recipients may pay half of the standard personal contribution rates. Either explicit or implicit cost sharing (using co-payments and deductibles) not only reduces the government share of costs for each service but also deters excessive utilization. Although cost sharing may be regressive, it could be mitigated by income-based reductions. Exemptions from co-payments or direct payments can be used to increase utilization rates by certain groups or for certain services for example, social assistance recipients are exempt from cost sharing arrangements.[10,21]

4.4 Purchasing of services: Type and nature of services

There are differences in the types of LTC services provided by countries. The two main forms of formal** long-term care are institutional care and home-based†† care. Institutional care can include long-term hospital care, nursing home care and residential home care. Home-based care can include a wide variety of packages of care, including help with personal care or ADL services and assistance care or IADL services, care in day centres, and meals delivered at home. (Box 1)

Greater emphasis on home-based care

Historically, efforts in LTC in LMIC have been directed at institutional care for poor older people. However, there is an increasing effort in LMIC countries to balance between institutionalization and home-based care. Many LMICs, for example Nicaragua and Thailand, have started to pursue policies that have the intended effect of maintaining as many elderly people as possible in their own homes and develop home-based care service[18] as part of a continuum of different types and levels of care, as called for by the Madrid International Plan of Action on Ageing.[25] These countries are placing greater emphasis on home-care services and to support and build the skills of family caregivers.

Appropriate benefits package affects financing efficiency

It is important to focus on designing appropriate benefit packages for covered populations as these packages affect the efficiency of risk pooling, the level of financial protection, and allocative efficiency.[10] Specifying benefits also helps in monitoring the total expenditure, feasibility and quality, and define what essential services to cover. (Box 2)

** **Formal care** comprises care provided by individuals formally employed as carers. Formal care services can include education and support to informal carers and older adults. Informal caregivers should also have access to supportive services, including information on and assistance in securing help, training, and respite care.

†† **Home-based care** may be provided exclusively in the home or combined with care in the community (such as in day centres, or respite care). People who require home-based long-term care may also need other services, such as acute physical or mental health care and rehabilitation, together with financial, social, and legal support.

Box 2. Need to specify and design basket of benefits

Argentina's Programa de Atencion Medica Integral (PAMI) was a public health insurance program set up in 1971 to provide medical care for older adults. PAMI had a large benefits package and a complex purchasing and organization of services including medical, specialist services, and day care services benefits also included recreational and leisure activities. The program suffered a major financial setback, as the benefits were unsustainable. The example from Argentina highlights the need for LTC services need to be defined and the challenges of a fragmented LTC delivery of medical and social care services.

Sherlock PL (1997). Healthcare provision for elderly people in Argentina: The crisis of PAMI. Social Policy & Admin.,31(4):371-89.

Appropriate stakeholder involvement in designing benefits

An appropriate level of stakeholder involvement can improve the process of defining and monitoring the benefit package. The participation of health care providers and insurers is important to ensure that the composition of the package is both technically appropriate and financially feasible. The participation of consumer or patient organizations is important, as they will monitor the quality of services and provides information about needs and preferred treatment alternatives.[1]

Nature of services (in-kind home care services or cash grants)

The nature of long-term care benefits can range from payment for formal in-kind home care services from recognized providers, to service budgets (that may be used to pay formal and informal providers) and to cash grants. The amount of benefits is generally determined by classifying participants according to level of care needs established at the same time as the initial eligibility assessment and subject to periodic reassessment. The Netherlands favours providing in-kind home care services (by approved formal provider agencies) and limits on the number of visits or hours of care a beneficiary may receive.[24]

For cash grants, the individual receives funds that may be used to pay anyone for any service or may simply be retained as income. Cash options or programs with a

high degree of consumer direction may have some advantages. It may be easier to set a budget than to specify an entitlement to a fixed scope of services. Individual participants' needs may also be met at lower cost, if consumers can pay family members or find other less expensive alternatives to formal agency services. Cash grants have been implemented in countries with limited LTC resources including Hungary, Slovakia, and the Czech Republic, which can be used to compensate family carers and pay for a share of LTC cost[26] and may have the potential to improve health outcomes with a relatively modest administrative cost in LTC. However, this may not translate into lower costs overall, because cash programs may have higher take-up rates than in-kind service programs. The payment and use of informal providers may also raise concerns about quality, patient safety, or fraud and abuse.

4.5 Allocation of funds and purchasing

The segregation of funds allocation and the inefficient purchasing structure of medical/nursing care and social care services can lead to health system fragmentation.[18] In many HIC, users of LTC experience difficulties finding appropriate services or need to repeat their story to multiple providers. In addition, providers may be unable to offer the quality due to multiple handovers and administrators cannot attain maximum efficiency due to multiple administrative procedures from separate funding sources and providers. In an effort to reduce fragmentation, many countries are introducing better efforts in care coordination and smoother transitions of care. The US, for example, favours bundled payments and transfers a fixed budgeted amount per participant to an independent public or private agency; the agency is then, expected to cover medical, nursing and social care services using these fixed bundled payments.[10]

4.6 Pooling of funds

Policy makers must assess the most appropriate mechanism to pool health risks and provide financial protection to older people. The challenge to countries is to direct the high level of out of pocket spending into either a public or private pooling

arrangement. The choice in risk pooling in LTC should consider the development of LTC financing in terms of equity, efficiency and sustainability. Four main health financing methods to pool risk are[13]

Voluntary

- Voluntary or private health insurance
- Community-based health insurance

Mandatory

- State funded systems through ministries of health or national health services (NHS)
- Social health insurance (SHI)

Both voluntary and mandatory pooling mechanisms in LTC financing have been used in HIC. Voluntary pooling mechanisms are available in LMIC. For example, private health insurance, are available on a large scale in countries like Brazil, Chile, Namibia and South Africa,[27] and community-based health insurance are available in countries like the Democratic Republic of the Congo, Ghana, Rwanda and Senegal.[28,29] However, there is a paucity of literature on their use for LTC financing in LMIC. For mandatory pooling mechanisms of social or national health insurance systems, we explored the considerations for integration with pre-existing general health financing systems.

4.6.1 Private LTC insurance

As a pooling mechanism, private LTC insurance has the potential to help individuals and family manage the risk of catastrophic spending better than out of pocket. There are essentially 2 types of private insurance policies. [30] Reimbursement insurance policy which provides for a reimbursement, in whole or in part, of eligible LTC expenses incurred and indemnity insurance policy which provides for a fixed indemnity (cash benefit) paid to eligible recipients once they become dependent, regardless of whether LTC services are received.

In the Organisation for Economic Cooperation and Development (OECD) countries, the private LTC market remains small accounting for less than 2% of total LTC spending.[30] Private LTC insurance is also commonly arranged around countries' public LTC systems, either to complement available public coverage (to cover potion of LTC cost not covered) or to supplement additional benefits where there is no public coverage.[10,21,30] This is because relying primarily on private insurance for LTC has multiple challenges. These include the following:

- Private insurance is expensive and reaches mostly wealthier populations. According to a 2005 survey in the United States, more than 70% with private LTC insurance had reported income of more than USD 50 000 a year and total liquid assets of USD 100 000 and over.[31]
- Subject to market failures, such as adverse selection and moral hazard where those with high-perceived LTC need would purchase private insurance and the insured would use more services than required as they are covered. To mitigate adverse selection, private insurers usually limit eligibility for coverage to those with no pre-existing health risk associated with dependency.[30]
- There is a long time lag between the moment a person buys cover and the moment benefits are paid out. This poses challenges in long term risk projections for insurers as future trends in onset of dependency are unknown and there are uncertainties in costs of care.[32] As a consequence, there is a tendency for insurers to set relatively higher premium or pay lower benefits.[33] Similarly, individuals are not able to project on a longer term their own financial risks associated with dependency and do not buy private LTC insurance until an older age when they face high premiums.[30]
- Insurers allow premiums to fluctuate and increase if the overall level of risk shared within the pool increases. This causes volatility in premiums.[30]

Regulating private LTC insurance

The challenges associated with private markets can be addressed through regulations to protect individuals who purchase LTC insurance and to ensure the quality of the insurance products. For example, in many OECD countries, there are limitations on the insurer's ability to use pre-existing health conditions to impose

exclusions on coverage or to set premiums.[30] However, the regulations may be difficult to implement and enforce.[13,34] Other innovative strategies to improve the quality of LTC insurance is in designing specific programs. For example, Singapore's private LTC insurance (Eldershield) is designed by the government but managed, priced and sold by private insurers. The program ensures a larger pool of insured individuals and risk sharing with an opting-out option. Enrolment into the program is automatic for individuals aged 40 years and above (except for those who are already severely disabled).[35] In France, the use of group insurance for working-age individuals is another way to broaden the coverage and risk pooling by encouraging early subscription into private LTC insurance.[36] Other innovations include reverse mortgages where homeowners are able to use to convert their home equity into cash to pay for private LTC insurance.[30] However, these innovations have challenges in the availability of a large formal work sector and would primarily serve populations with higher income and accumulated assets.[37] There is little information on the use of private LTC insurance in LMIC but the complexity of private LTC insurance raises questions of feasibility, equity and accessibility to services in LMIC.

4.6.2 Community-based health insurance

Community-based health insurance was the precursors of many social health insurance systems including Germany, Japan and Korea. (Figure 5) They are not-for-profit prepayment plans that are controlled by community that has a voluntary membership. However, they are often not able to raise significant financial resources and the pool is usually small making it difficult to pool risk. There are usually problems with efficiency and sustainability which governments can assist through more formal financing arrangements.[13] However; there is little information on the feasibility of Community health insurance specifically for LTC.

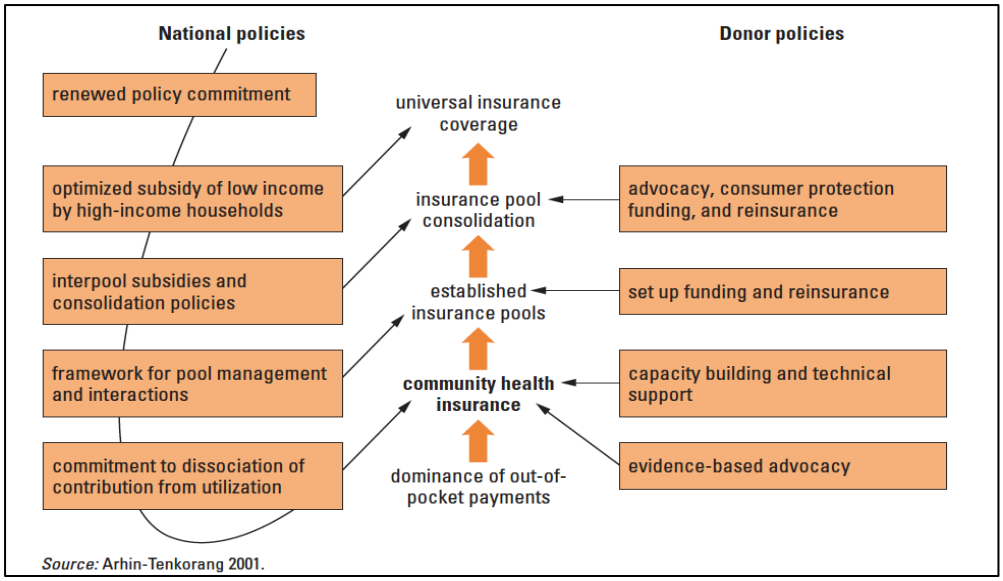


Figure 5. Stages of financial protection and supporting policies

4.6.3 Mandatory pooling mechanisms

Mandatory pooling mechanisms differ from private LTC insurance in two respects. As membership is mandatory, it is possible to break the link between premium and the risk and uncertainties in dependency and cost of care. Secondly, protection can be given against risks that private insurance cannot insure well and increase access to care.[38] In Nordic countries, funds for LTC are available principally from general taxation and in countries like Germany; Japan and Korea finance using available social health insurance systems and participation is mandatory for the whole or a large section (for example, those aged 40 and over in Japan) of the population. [10]

Segmentation of LTC funds from general health

A common strategy in most countries is to manage funds for LTC programs separately from pre-existing general health programs. For example, Austria, Germany, Israel, Japan and the Netherlands have adopted special laws to create separate funds for long-term care.[10] The advantage of maintaining a separate fund for LTC from general health is that the resources cannot easily be diverted to serve other purposes. It may also be easier to manage the funds transparently (which may increase people's willingness to pay) and to apply specific policies – for example, eligibility criteria is applied to long-term care programs, but not to general health

care schemes. However, the segmentation of funds for long-term and general health care respectively makes it less easy, though not impossible, to cross-subsidize and pool the different types of care and risks.

Need to equalize risk and benefits of a larger funding pool

People with LTC needs and chronic long-term conditions are considered high-risk or high-cost patients. Hence, there should be a capacity to improve risk equalization to control risk selection. Similarly, a tax-based multiple fund system of decentralized funds with a relatively high number of chronic patients and no proper compensation scheme, will not be able to offer the same quantity or quality of services as funds with lower-risk groups. The absence of compensation for the increased costs associated with chronic patients will function as an incentive to apply risk selection.[10,21] Historically, funding and management of LTC was segregated as LTC was developed at a later phase than general health financing in high income countries. However, for LMICs setting up health financing systems, there could be opportunities to design and pool LTC funds into the general health funds from the beginning. With the inherent risk equalization of a larger pool, the process may increase equity.

4.7 Collection of funds: Revenue

Most public universal long-term care systems in HIC operate on a pay-as-you-go basis. This means that current workers are paying for current users for service and are not pre-funding their own future services.[28] Younger workers may already feel that they are paying into social insurance systems from which they might never benefit and may resent an additional levy. For example, Japan's system provides a partial solution by asking only people aged 40 and over to pay additional contributions. Older adults are more willing to contribute as they may be more conscious of their own long-term care risks and are also likely to be more able to pay.[10,21] The willingness of younger workers to finance older adults also reflect the inter-generational solidarity that exist in that country and may reflect the importance in balancing policies and burdens for both generations.[39]

Can current wage earners save for their future healthcare needs?

Prefunding, for example, medical (health) savings account may be a good way to encourage current generation of wage earners to save for their healthcare needs in old age. The good news is that countries with emerging economies are still experiencing rapid economic growth with a relatively young population. During this narrow period of "demographic dividend" countries may have the potential to boost medical-related savings.[40] While a fully prefunded LTC system may not be justifiable or equitable given the uncertainty surrounding future LTC needs, there could be a possible role for prefunding of selected services in LTC in middle-income countries.[30]

5. Strategic LTC Financing Policy Considerations

Measuring demand and burden of costs of LTC in LMIC

Currently there is very little quantitative data on demand for LTC in LMIC. Although the OECD uses age 80 years and above[30] threshold to project demand of LTC, the use of a specific age threshold may not be appropriate for LMIC. Studies in the United States and England showed that, in general, older people in lower socioeconomic status may be more at risk of poor health and dependency at younger ages when compared to people of higher socioeconomic status.[11] Indicators based on dependency and need for LTC could be better than the use of chronological age. There is also a lack of reporting on direct and indirect costs of LTC in LMIC. Indicators to estimate the microeconomic impact in costs to family and households from reduced productivity, work loss, increased health care consumption, reduced savings and increased care giving are mainly from HIC. For example, the United States estimated the indirect costs of informal care to be $450 billion in 2009.[41]

LTC and universal health coverage

Consideration based on needs of individuals throughout their life course would require the provision of LTC from the health system. (Figure 6) Discussions on the provision and financing of LTC, based on the goals of UHC to develop accessible health systems and financial protection for populations, could be used to systematically build coherence to health policies, systems and financing. There is potential in using UHC as a unifying goal in integrating LTC into a country's health

system development. China, for example, has introduced policies to legislate the State's responsibilities in the provision for LTC. [9] Although the policy recognized the need for LTC, it did not provide for a strong national framework of on the implementation of LTC. In addition, the policy did not include a coherent integration of LTC into the health system and financing.[15]

Investing in long-term care

Current health financing benefits and payment systems in LMIC generally provide better coverage for acute episodes of care rather than on-going chronic and long-term care. LMIC would need to redesign health care systems and align health financing to meet the changing burden in LTC. A principle in financing health systems is to seek optimal health outcomes with the least costly mix of interventions.[42] As a middle income country, Slovakia has embarked on a substitution policy in trying to achieve a good mix of home care and institutional care with acute care hospitals. LTC can be seen an investment into the current health system.[43,44]

In addition, if older people's LTC needs are not met, they will look to fulfil their needs in other parts of the health system leading to inappropriate use of resources and cost shifting. This is both expensive and an inefficient use of health care resources. For example, in Japan, the government started to develop LTC financing, triggered by the need to support families take care of dependent older people and the increased use of expensive acute hospitals for LTC purposes.[8]

Integrate‡‡ the provision of social care with nursing/medical care services

Providing LTC requires combining medical, nursing and social care services. The challenges associated with the different levels of organization and divisions of responsibility, as well as differences in demarcating the boundary between the medical/nursing care and the social care are increasingly being debated. Although a recent review of programs done in HIC indicated that a full structural integration is not necessary, the report acknowledged the integration is not a "one size fits all", and dependent on settings and contexts.[45] The case for a more comprehensive

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‡‡ **Integrated care** is defined as the management and delivery of health services so that clients receive services, according to their needs over time and across different levels of the health system. The complexity in fragmentation of medical/nursing care and social care can be alleviated by better coordination of care.

integration in LMIC could be more compelling as their health services infrastructure is weak. The need to optimize existing resources and purchase resources effectively could become an additional motivation for pursuing a more comprehensive approach in LMIC.

There is very little literature on the integration of care in LMIC but there are case reports from Africa, the Americas and Asia on the role of community health workers in some form of LTC service delivery.[2] For example, in lower-income countries like Myanmar, there are few paid health workers, and local volunteers (village level) often provide rudimentary health care. These volunteers perform a number of tasks, such as providing advice to family, distributing drugs and supplies, and referring patients to health care services. Volunteer, village and community networks could support most of the care to older adults, and families when given appropriate training to provide long-term care. This could be more sustainable while ensuring availability and access, continuity of care and minimize over-servicing in lower-income countries with restricted resources.[2]

Align allocation of funds and purchasing with the integration of LTC

There is the possibility of integrating provider systems while maintaining a separate financing structure for medical/nursing care and social care by better coordination of services. However, the separate allocation of funds and purchasing structure for medical/nursing and social care in LTC could lead to inefficiencies in allocation and purchasing of services and also potentially lead to cost shifting between social and health care providers.[30] For example, Slovakia put in place policies to integrate the provision of social care and nursing/medical care in LTC in 2005 but had challenges in implementation. Funding of Slovak LTC was from two sources, health care component of LTC from health insurance with no co-payments and social care from regional and local taxation and cover only two-thirds of social expenses. In 2010, despite agreements between the Ministry of Health and Ministry of Family, Social Affairs and Work, there were no providers with fully integrated care.[43,44] However, there is a lack of research on the strategy of financial integration. A recent review on LTC programs from HIC, found tentative but not robust evidence on health outcomes and cost effectiveness on the integrating financing for medical/nursing and social

care. In addition, the effectiveness of such an approach may not be transferable to the different settings in LMIC.[45]

5.1 Aligning health financing for life course

Development of integrated care packages

Countries could look to finance LTC either narrowly as a group of services for dependent chronically sick individuals or by having a broader system-level definition. An interesting development in attempting to overcome efficiency problems caused by fragmentation is in the development of integrated care packages. In Germany, for example, the disease management programs integrate curative with rehabilitative services. Disease management programs in Germany were cost effective but the lack of integration on LTC was seen a potential efficiency problem.[18]

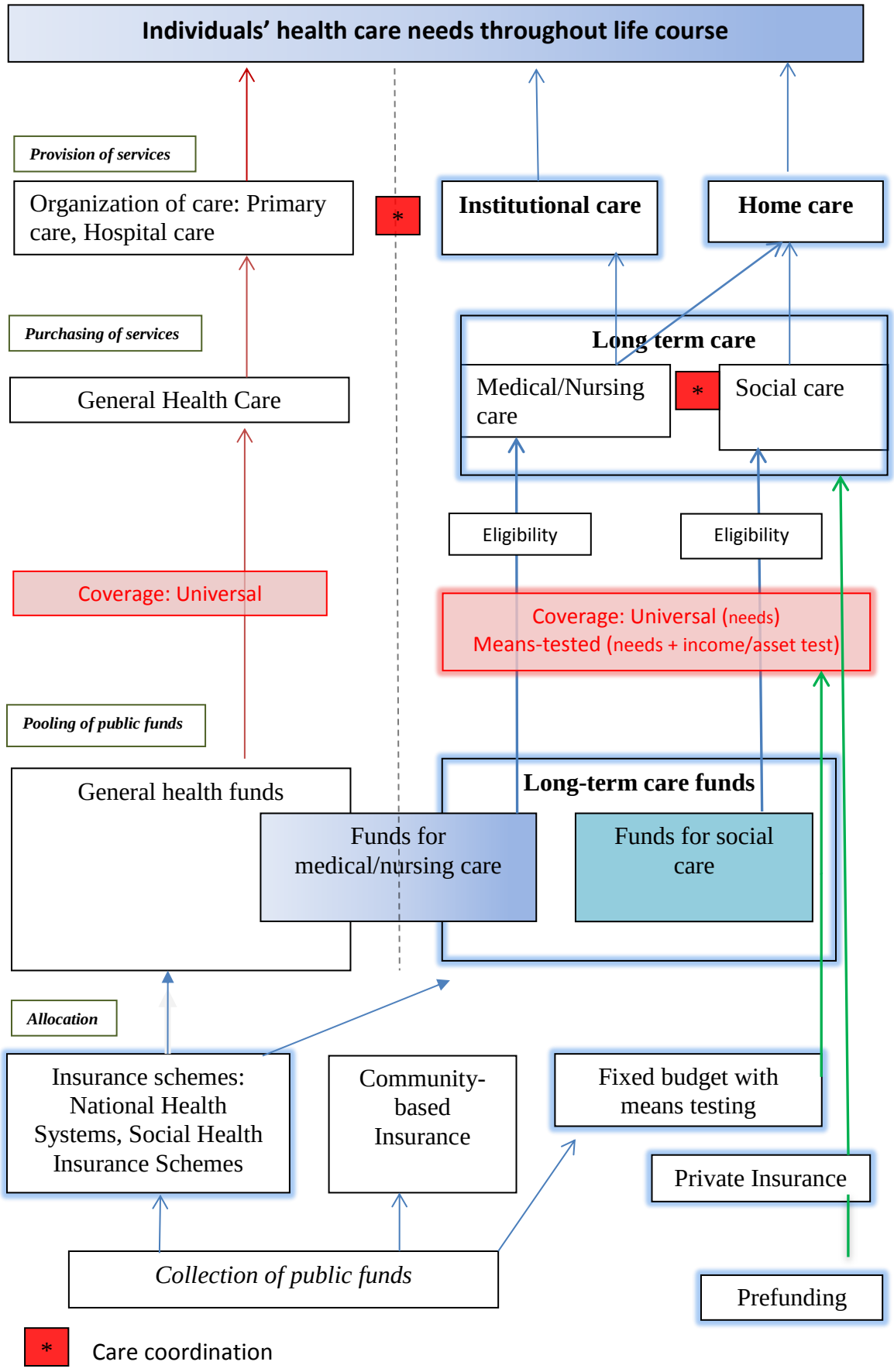
LTC is not only about end of life care

Countries are beginning to view LTC broadly as a continuum of care from prevention, rehabilitation to end of life care. This can include improving function and preventing falls for frail older adults, improving adherence to treatment, rehabilitation and encouraging healthy behaviour over the life course rather than simply concentrating on providing services for an individual who is already severely disabled. There is also potential in controlling the demand and costs for care of dependency in older adults by increasing the focus on prevention of functional decline, and health promotion programs. When taken in a continuum, LTC programs can be cost-effective and produce cost savings elsewhere in the health system due to their ability to provide secondary prevention.[18] High income countries are considering the notion of a 'care continuum', including elements of other public health policies such as preventive measures, active ageing, autonomy promotion and empowerment, social assistance, healthcare and end-of-life or palliative care.[33] LTC financing can be commensurate with longer-term investment in needs in the health system resulting from the epidemiologic transition.

5.2 Sustainable development and timing

It is important to consider the level of sophistication in financing, and infrastructure needed for LTC within the context of a country's economic development and the underlying structure of the health and social services, as well as available human resources[46] to achieve equity, efficiency and sustainability. There is also a prevailing view that LTC systems should be kept as simple as possible and incrementally strengthened to ensure their long-term sustainability especially in LMIC.[46] Creating adequate fiscal space and revenue is important in lower income countries as traditional donors are geared towards short-term investment costs. Voluntary and community-based financing schemes could serve as tests for lower-income countries before they seek to expand the role of prepaid health coverage schemes. However, the timeframe for many middle-income countries to consider financing reforms and investment into LTC is shorter than lower-income countries due to their earlier demographic transitions. These countries have to consider how fast to scale up their LTC financial resources and service infrastructure for LTC based on the current and future projections of LTC needs of their older population.

Figure 6. Health financing in general health and long-term care



6. Questions

Why should countries finance LTC?

1. How should countries quantify the costs and benefits for financing LTC? What should be used as measures of direct and indirect costs?
2. Should the provision of LTC be an essential part of the health care system?
3. If yes, should financing for LTC be the responsibility of families or should LTC be seen as a shared social responsibility with public support in financing?
4. How should countries measure and project demand for LTC services?

How should countries finance LTC?

1. What are the advantages and disadvantages of current LTC financing systems?
2. How should countries balance between adequacy of coverage and financial sustainability for governments?
3. Could we use the Universal Health Coverage (UHC) framework to design for an equitable and sustainable health financing strategy and to assess trade-offs in LTC?
4. Should countries look at funding LTC services separately from general health care or as a continuum of care needs?
5. Which pooling mechanism should countries consider for LTC – voluntary, mandatory mechanisms or both? What are the barriers and opportunities?

Where can we look for efficiencies in LTC financing?

1. How should countries define and fund essential LTC (medical/nursing and social care) benefits?
2. Who should be covered and which level of dependency to target?
3. Could countries gain efficiencies in allocation and purchasing of LTC services?
4. Where should countries consider funding for LTC – Home care, Institutional care or both?

Financing policies

1. What are the policies needed to build a coherent integration of LTC into a country's health systems and financing?

2. Where should countries concentrate on providing LTC – Prevention, Rehabilitation, End of life care or provide a whole continuum?
3. How fast should countries scale up resources for LTC? What are the other considerations in financing LTC in low-resource countries who may already be challenged with providing essential health services?

7. Glossary

Activities of daily living (ADL): include bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom. They are often referred to as "personal care".

Adverse selection: occurs when individuals with low expected losses drop out of an insurance pool, leaving only high risk individuals with high expected losses. Adverse selection can make it difficult to sustain private insurance markets.

Cash (or cash-for-care) benefits: include cash transfers to the care recipient, the household or the family caregiver, to pay for, purchase or obtain care services. Cash benefits can also include payments directed to carers.

Cost sharing: requires individuals who are covered to pay part of the cost of health care received. Cost sharing maybe in the form of deductibles, co-insurance or co-payments.

Formal care: includes all care services that are provided in the context of formal employment regulations, such as through contracted services, by contracted paid care workers.

Home-based care: may be provided exclusively in the home or combined with care in the community (such as in day centres, or respite care).

In-kind benefits: are those provided to long-term care recipients as goods, commodities, or services, rather than money. They may include care provided by nurses, psychologists, social workers and physiotherapists, domestic help or assistance, or special aids and equipment. They might also include assistance to family caregivers such as respite care.

Informal carers: is a terminology used often to refer to “unpaid” family carers.

Instrumental activities of daily living (IADL): include help with housework, meals, shopping and transportation. They can also be referred to as “domestic care or home help”.

Market failure: In health care, market failures arise when an individual has a lack of information on quality and efficiency of care or when health care cannot be paid even though it would be society’s interest to provide it.

Medical savings accounts: are designed to help participants pay for medical and healthcare expenses by allowing them to save for those expenses in a tax-sheltered environment.

Moral hazard: for a given health status, individuals use more health care services insured when not insured or paying for themselves. This raises the possibility of over consumption or inappropriate consumption.

Out-of-pocket payments: Payment collected directly from individuals at point of using the health service. Out-of-pocket payments are also called **user fees.**

Private LTC coverage arrangements: they are primarily distinguished from public coverage programmes by their funding through voluntary non-income related premiums, as opposed to taxes or compulsory social security payroll contributions. Typically, private insurers promote and sell the products on the market.

Revenue collection: the process by which the health system receives money from households and organizations, as well as donors.

Reverse mortgage: it is a special type of home equity loan under which one can receive cash against the current value of a home minus outstanding home-secured debt. The loan does not have to be repaid as long as the borrower continues to live in the home and it generally becomes due when the borrower dies, sells the home, or permanently moves out of the home.

Social health insurance: health insurance mandated for a designated population and generally organized by government. Eligibility requires the enrolee to have paid the premium for a minimum period.

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