Chapter 9

Where To? Providing Fair Protection Against Long-term Care Costs and Financial Sustainability

For most individuals, it is difficult to foresee whether long-term care (LTC) will be required in the future, and if so, the type, the duration and the cost of that care. Over the next decades, public expenditure in most OECD countries is expected to grow rapidly, in most part because of the expected increase in age-related expenditure, such as public pension, health and LTC services. Generally, given current tax mixes and levels, expected revenues are set to grow at a slower rate than expenditures, with the potential risk of shifting their cost to future generations. The policy challenge can thus be framed as providing fair protection against the financial risk associated with long-term care, while ensuring that the way LTC revenues and expenditures is sustainable in the long-run. Targeted universalism and a forward-looking set of collective financing policies have the potential to help striking a reasonable balance between these two competing priorities. This is what this chapter will examine.

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

9.1. Why provide financial protection against long-term care cost?

For most individuals, saving enough money to meet the financial uncertainty associated with dependency is unattainable. Whether public or private, risk pooling mechanisms – that is, financial mechanisms to share the responsibility for financing long-term care (LTC) cost across a "pool" of individuals – provide them a means to obtain coverage against that risk at a lower cost. Despite improvements in coverage of LTC cost over time (see Chapter 7), formal LTC cost can still be high and represent a significant burden on users in several OECD countries. This chapter starts by arguing that there is a need to provide for a basic protection for all against the risk of LTC. Fair protection refers to the notion of ability to pay relative to the level of care needs.

The chapter then suggests that a universal policy design does not prevent the targeting of higher benefits and services to those who need it the most. In fact, the main challenge for LTC services and systems will be how to ensure that financing of the system is sustainable in the longer run. Fiscal sustainability refers to the extent to which a given set of fiscal policies for LTC does not shift too large a financial burden on future generations (*i.e.*, intergenerational fiscal equity) and ensure that "ends meet". OECD countries use several mechanisms to align LTC revenues and expenditures. Yet, in the longer run, a set of forward-looking fiscal policies can help promote a fair sharing of LTC financing within and across generations.

While the policy challenge differs depending on how comprehensive existing LTC systems are, finding the right balance between fair protection and financial sustainability will ultimately depend on countries' views on an efficient and fair allocation of resources among the population and across generations.

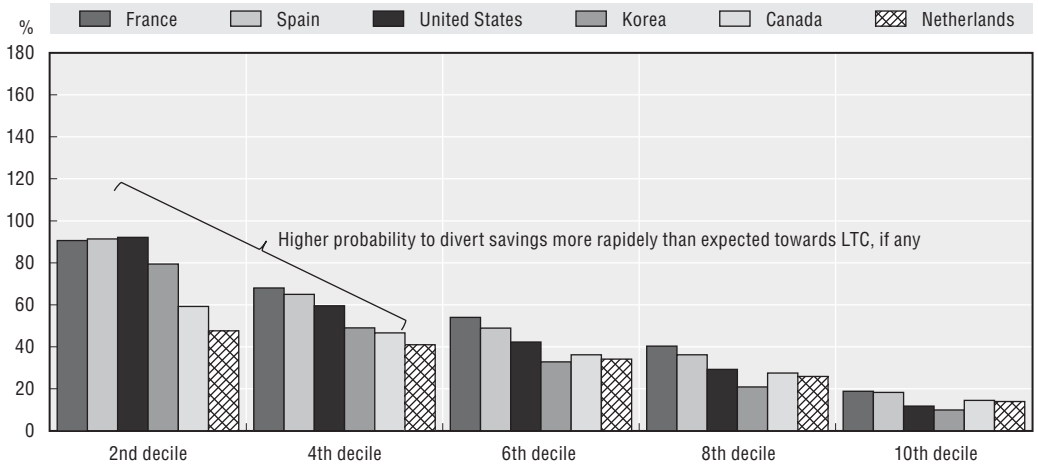
9.2. Improving protection against catastrophic care cost calls for universal LTC entitlement

On both *fairness and efficiency grounds*, there is a rationale for providing some basic universal coverage for personal-care services regardless of individual financial means. This is why many countries have opted or are moving to universal coverage. But, as observed in Chapter 7, within the confine of universalism, there are many ways to target/direct support where the need is the highest, and thus ensure both fairness and value for money. Hereafter this concept will be generally referred to as *targeted universalism*.

Taking *fairness and access* first, the expenses associated with even relatively low care needs (*i.e.* ten hours per week) can exceed 60% of a senior's disposable income for low and moderate-income individuals, up to the fourth deciles (Figure 9.1).[1] In addition, these households typically have no or little savings to spend down on LTC. For those requiring a larger range of LTC services (*i.e.*, 25 hours a week), the expenses associated with care can exceed 60% of the disposable income for those up to the 8th income deciles (Figure 9.2). Even for relatively higher income seniors, high-intensity LTC cost represents a significant burden requiring a rapid run-down of their savings. For most individuals with severe

Figure 9.1. **The cost associated with low-care need is significant for low-income seniors**

Share of adjusted disposable income for individuals 65 years and over in different income deciles, mid-2000s



Note: Low-care need is defined as 43.33 hours of care per month, at the prevailing rate per hour, excluding public subsidies, in each respective country.

Source: OECD Secretariat calculation based on the *OECD Income Distribution and Poverty Database* (*www.oecd.org/els/social/inequality*).

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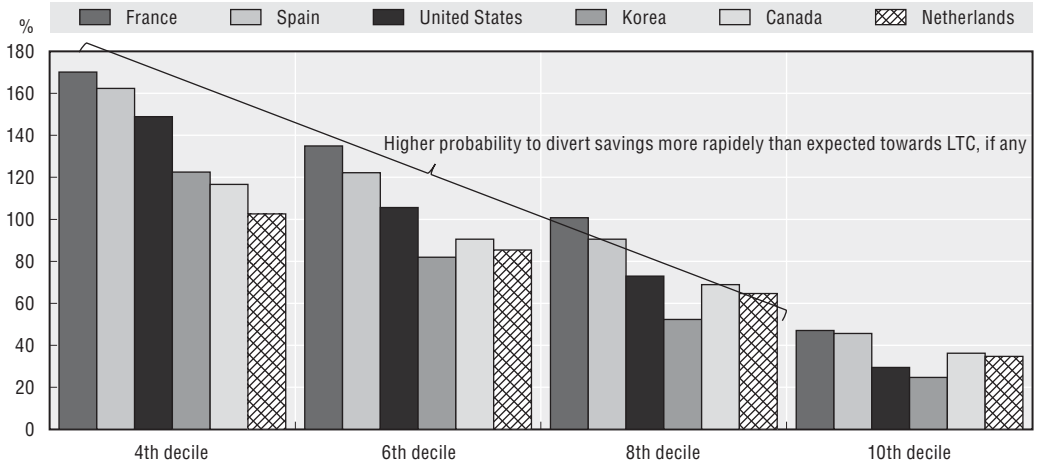
Figure 9.2. **The cost associated with high-care need is significant for most seniors**

Share of adjusted disposable income for individuals 65 years and over in different income deciles, mid-2000s



Note: High-care need is defined as 108.33 hours of care per month, at the prevailing rate per hour, excluding public subsidies, in each respective country.

Source: OECD Secretariat calculation based on the *OECD Income Distribution and Poverty Database* (*www.oecd.org/els/social/inequality*).

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functional limitations, long-term care cost can lead to a significant impoverishment and/or an overreliance on family carers or friends.

There are also good reasons on *efficiency grounds* for basic universal coverage of LTC cost. Delivering LTC benefits as part of welfare programmes or programmes of "last resort", where entitlement to coverage is subject to a "means" test, may have unintended effects such as shifting the allocation of benefits towards LTC/health services where public coverage is provided (*e.g.*, nursing homes or hospitals) as well as leading to potential abuse

requiring additional administrative cost *(e.g.,* in the case of assets planning to quality for care in means-tested eligibility systems).

These are the main reasons why across the OECD there is some movement towards universal or more comprehensive coverage. As discussed in Chapter 7, most are moving away from solely delivering personal-care services through a means-tested eligibility programme. For instance, in the United States, the proposal to implement the Community Living Assistance Services and Supports Act (CLASS Act, which is discussed in more details later in this chapter) reflects efforts to provide broader coverage for the financial risk associated with LTC outside its welfare system, Medicaid.

9.3. Universal care does not exclude targeting: What benefits and for whom?

While some degree of universal entitlement *for care costs* is warranted, universality does not mean that there is no room for targeting benefits on the basis of care need. In fact, as OECD countries age, the trade-off between "fair" protection and fiscal sustainability is likely to become more difficult to bridge. Although views on the allocation LTC benefits *(e.g.,* to which disabled people, for what services or how much) differ among countries, *targeted universalism* has the potential to help striking a reasonable balance between these two competing priorities. Using the same framework for analysis of LTC coverage systems of Chapter 7, the targeting of benefits can take place on three fronts:

- the assessment/eligibility rules (entitlement);
- the basket of services covered (breadth of services covered); and
- the extent of cost sharing (depth of coverage).

Targeting of eligibility

There is a rationale to "target" universal benefits towards those with relatively higher care needs because of the significant financial cost LTC entails. But, in practice, targeting is not a simple matter. The concept of "need" involves a number of factors including physical or cognitive functional limitations, presence of a family carer or unique local circumstances (rural *versus* urban) and is inherently subject to interpretation. As a result, one of the main challenges of targeting is to establish assessment procedures that lead to a fair allocation of benefits across dependent individuals.

Defining the target

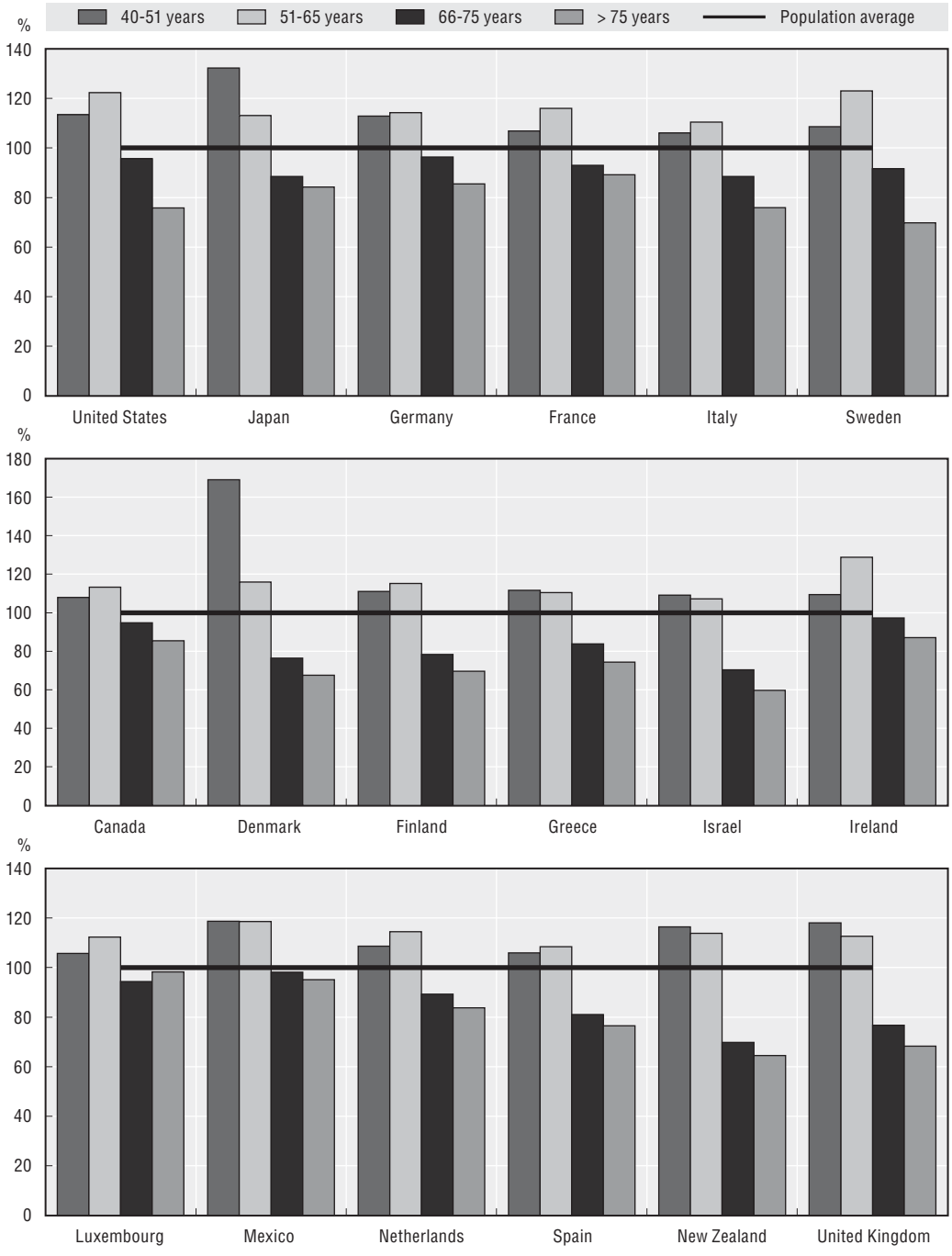
In the OECD, high-care needs are concentrated among the oldest age cohort, which is typically more likely to have severe or very severe functional limitations (Lafortune *et al.*, 2007). This means that in many OECD countries, the financial risk associated with LTC is generally the highest at a time when disposable income is typically the lowest over the lifetime (Figure 9.3). In 2008, about 50% of LTC recipients were older than 80 years old, of whom more than 75% were women who are also at highest risk of poverty.

Korea introduced in 2008 a universal LTC system for those aged 65 years and over.[2] With a view to containing cost, elderly Koreans with lower care needs are not eligible to LTC benefits unlike elderly living in countries with more comprehensive systems. Stringent assessment criteria are also in place in Germany, but not to the same extent as Korea (Campbell and Ikegami, 2010).

For countries that provide for "broader" universality, *better targeting within their universal system can represent an avenue to contain future expected cost*. For instance, Japan's

Figure 9.3. **Disposable income falls with age**

Adjusted disposable income of different age cohorts relative to the population average, mid-2000s



Source: Calculations from *OECD Income Distribution and Poverty Database* (*www.oecd.org/els/social/inequality*).

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public LTC system covers all individuals aged 40 years and older. As part of its 2009-12 planning cycle, and partly to mitigate future cost increases, seniors assessed with the lowest care needs have been moved to a prevention scheme with focus on encouraging healthy ageing (see Chapter 10). In 2010, Austria further targeted the allocation of benefits under their universal cash allowance (*Pflegegeld*) by increasing the minimum hours of help per

month required to become entitled to an allowance for those with relatively lower levels of care need (level 1 and level 2). In the mid-1990s, Sweden also targeted services and therefore public expenditure on LTC more closely on the most sick and disabled (OECD, 2005).[3]

Assessing care needs of the target

Assessment for targeting purposes typically takes into account physical and (at varying degrees of importance) cognitive limitations. As discussed in Chapter 7, measuring instruments and especially methods for assessing long-term care needs and required levels of care vary across countries even though many of the functional capacities which are measured are similar. When looking at targeting of eligibility, three main issues related to assessment procedures seem important.

The first one has to do with access, and how to *reconcile local flexibility with national consistency*. Local municipalities are typically the first point of contact and often responsible for the assessment. The rationale for local flexibility is that the environment where a dependent individual lives *(e.g.,* rural or urban area) affects his/her needs. On the other hand, too much local flexibility can lead to inconsistencies with respect to who is eligible for care and to what services. In the United Kingdom, local authorities are ultimately responsible for setting eligibility criteria. Despite national standards, this has led to what has been sometimes referred to as "postcode lottery", whereby people with similar assessment of needs are entitled to significantly different levels of care.

A second and related issue concerns the extent to which assessors or assessment tools provide room for interpretation and tailoring to *individual circumstances*. Most countries (but not Sweden) have at least one standardised national assessment tool for determining LTC needs, along with complementary guidelines for interpretation of the assessment grid. In Germany, the assessment grid is very detailed, yet the assessor may deviate from it if necessary. Japan, on the other hand, does not allow deviations from the guidelines of care provision,[4] and, like France, utilises automated computer programmes to compile responses to the assessment grid and help standardise the assessment. While enabling individual's care packages to reflect users' unique circumstances, tailoring can also make budget planning less predictable and lead to some inconsistencies in the level of benefits granted to individuals with comparable care needs. Similar issues arise when people are classified into groups that are homogeneous in the level of care they need – an approach used by many countries. When there is considerable variance of care needs within a given group, categorisation of recipients can still raise fairness considerations.

A third issue concerns whom to target. With the exception of Germany, assessment procedures and benefits systems differ depending on the age of the applicant, such that the level of support provided tends to be relatively higher for younger than for older dependent adults. Generally, this reflects the fact that for younger applicants, assessment instruments take into account ability to work, training capacity, and aim at reintegration into society. Most countries – such as the United States under the Medicaid programme or the Netherlands – provide for additional funding for working-age handicapped citizens. Yet it is difficult to develop standard assessment of such needs, and the approach used for this category of care recipients is often tailor-made (Ros *et al.*, 2010). In addition, age criteria may be perceived as unfair, particularly by those just below the age threshold *(e.g.,* 65 years of age).

The reliability and accuracy of LTC care assessment systems also needs to evolve over time to reflect the changing nature of dependency and identify the right target groups.

Need assessments are increasingly challenged to better address cognitive limitations, for example. While taking into account ADL limitations, the actual assessment and related funding for services may not address adequately the needs of a population with growing incidence of dementia and Alzheimer. In France, there is ongoing discussion about developing different scales to better capture cognitive performance and address more appropriately the needs of future LTC recipients.

Targeting of the benefit package

Universal coverage can apply to a broader or narrower basket of LTC services. However, decisions about what services to include in the package need to balance the need for flexibility and control for the user with concerns about cost and effectiveness of the services included in the package, with respect to coverage for domestic help and to the mode of providing benefits (cash or in kind).

Support for domestic care or practical help (IADL) provides an example of how difficult it can be to decide what to include in the package. In a number of OECD countries, public support for domestic care or practical help (IADL) is subject to less comprehensive coverage relative to health/nursing care and personal care (ADL). For example, while in Sweden, Denmark and Luxembourg service coverage includes home adaptation, assistive devices and IADL support, in-kind benefits in Belgium, Korea and New Zealand focus on support for ADL. Also, LTC care assessment mechanisms give a significant weight to the inability to perform ADL relative to IADL (see Chapter 7).

It is typically easier to define the set of basic personal-care services (in terms of type, length and frequency) needed by a frail or dependent person than it is to define how much support for domestic care should be required by the user. Determining the basket of domestic-care services generally involves a greater element of subjectivity *(e.g.,* over the frequency of shopping trips, where to and for how long). Support for IADL can also be more readily provided by family, friends or the community, since there is generally more flexibility with their provision. There is therefore a rationale for targeting support on nursing care and basic personal-care needs, since their assessment is less subjective and there are also cost-control considerations. To contain the growth in public LTC expenditures, support for IADL has for example been removed from the basic LTC coverage and devolved to municipalities in the Netherlands.

In practice, however, the distinction between personal and domestic help may not be as clear-cut as first suggested, especially for dependents with higher care needs, with cognitive limitations or with no or small family or community networks. The distinction can also be blurred by the fact that the services can be provided together by the same person or organisation (CIHI, 2007).

The inclusion of support for some IADL activities in the basket of services can also help delay institutionalisation or prevent a dependent individual with relatively high care need from moving to more expensive care settings. For instance, one of the main objectives of Denmark's LTC system is to encourage and enable the elderly to stay at home for as long as possible. To that end, support for ADL and IADL are generally available to all dependent individuals and not subject to co-payments.

Lastly, for the increasing number of dependent individuals with cognitive limitations, limiting the basket of services to support for personal care may not enable a recipient to live independently. But deciding the exact range of services needed and how this may vary over time can be very difficult. For instance, while a frail elderly with early stages of dementia might

be self-sufficient in relation to personal care, his/her ability to perform IADL tasks associated with memory and cognitive performance such as using public transit or handling personal finance might be poor (Avlund and Fromholt, 1998). In recognition of the complexity of assessing these users' service needs, the basket of LTC services in Germany covers support for some IADL activities and, since July 2008, includes an extra benefit for those with cognitive disease such as those with dementia (Heinicke and Thomsen, 2010). In Luxembourg the basket of services includes support for official paperwork (Alzheimer-Europe, 2009).

Also relevant to the discussion about targeting of the benefit package is the mode of benefit provision. As users with relatively higher care needs continue to live at home, defining the "right" basket of services that recognises each individual's unique circumstances – including the presence of a spouse or the availability of children for caring – can be challenging. An increasing number of OECD countries – the Netherlands, Austria, Germany, France, Italy and the United Kingdom as well as eastern European countries (see Chapter 1) – are now providing *cash entitlements* to care, giving individuals and families more freedom to make decisions on the care they need, while fostering competition among different LTC providers. Cash benefits give users choice and flexibility and can help address difficult arbitrage in determining the composition of a basket of services, for example between personal care and domestic support. Depending on the level of user direction and users' specific circumstance, these cash entitlements can typically be used towards other type of services than ADL services, such as meal preparation and housekeeping.

One of the challenges with providing a cash benefit is to strike the right balance between safeguarding its proper use and providing personal choice. For instance, in England, take-up of the Direct Payment, a cash-benefit scheme, has been relatively low (only 0.2% of the older population, compared to 4.2% recipients in institution in 2006-07). Restrictions on the use of the payment were identified as one of the barriers limiting their use (Comas-Herrera *et al.*, 2010). In addition, the way cash benefits are structured plays an important role in setting expenditure levels over time.

Eligibility for cash benefit schemes can vary according to age, need and income. For instance, the cash benefit scheme in France (APA) is targeted to those 60 years and older and is income-related. While cash benefits in the Netherlands apply to all dependents, the amount is also income-related (Da Roit and Le Bihan, 2010). Typically, benefit levels increase with care need and can be set to a fixed amount *(e.g.,* Austria, Italy, Germany), subject to national ceilings *(e.g.,* France) or set according to a number of hours of care needed at a prevailing rate of care per hour *(e.g.,* Netherlands, Luxembourg). In Germany and the Netherlands, cash benefits are typically set at a lower level than if provided in-kind. While there is ample flexibility in determining eligibility criteria and benefit structure, once set cash benefits take the form of an entitlement and are generally managed through open-ended budgets. As for any benefits, the introduction of a "new" cash benefit scheme can be subject to uncertainty with respect to its take-up rate, such that higher-than-expected take-up can lead to higher- than-expected global budget. This happened recently in the Netherlands with respect to the personal budgets for dependent people. With a view to remain within the global budget set for 2010, entitlements to new personal budgets were halted (with some exceptions) once the spending had reached the global budget set for the year.

Targeting of private contributions towards the cost of care

Lastly, targeting within universal systems can take place on the extent of cost sharing. As reviewed in Chapter 7, all public LTC coverage systems across OECD countries involve

an element of private cost sharing, albeit at significantly different levels. The rationale for using personal contributions can range from mitigating the risk of moral hazard, to recognising that ability to pay varies across users, and containing cost.

Private cost sharing can take the form of a flat cost-sharing formula (*i.e.,* flat percentage of LTC services cost). These are currently in place as part of universal public systems particularly in Japan, Korea and Belgium. One of the main objectives of flat cost-sharing formula is to provide a price signal such that demand for service is more likely to reflect the underlying need for that service (Finans Departmentet, 2009). It is also administratively simple. Nevertheless, flat cost sharing raises distributional considerations since lower-income dependent individuals as well as those with relatively higher need are typically required to spend a greater share of their income on those charges. In these countries, additional support is available through social assistance to compensate for the negative distributional impact of a flat cost-sharing scheme. In Japan and Belgium there are upper ceilings on the cost of care born by users.

Cost sharing can also be set as a given share (in some countries up to a given maximum amounts) of disposable income and/or assets. This is the case, for instance, in Finland, Ireland, the Netherlands and Sweden (see Chapter 7). The benefit of this approach is that it provides both certainty and predictability to individuals with respect to the maximum amount of resources they are expected to allocate towards LTC over time. Compared with flat cost-sharing schemes, they can be less regressive, especially for those with relatively higher LTC needs, but can be more complex to administer, since they require collecting information on income and/or assets and on how these evolve over time.

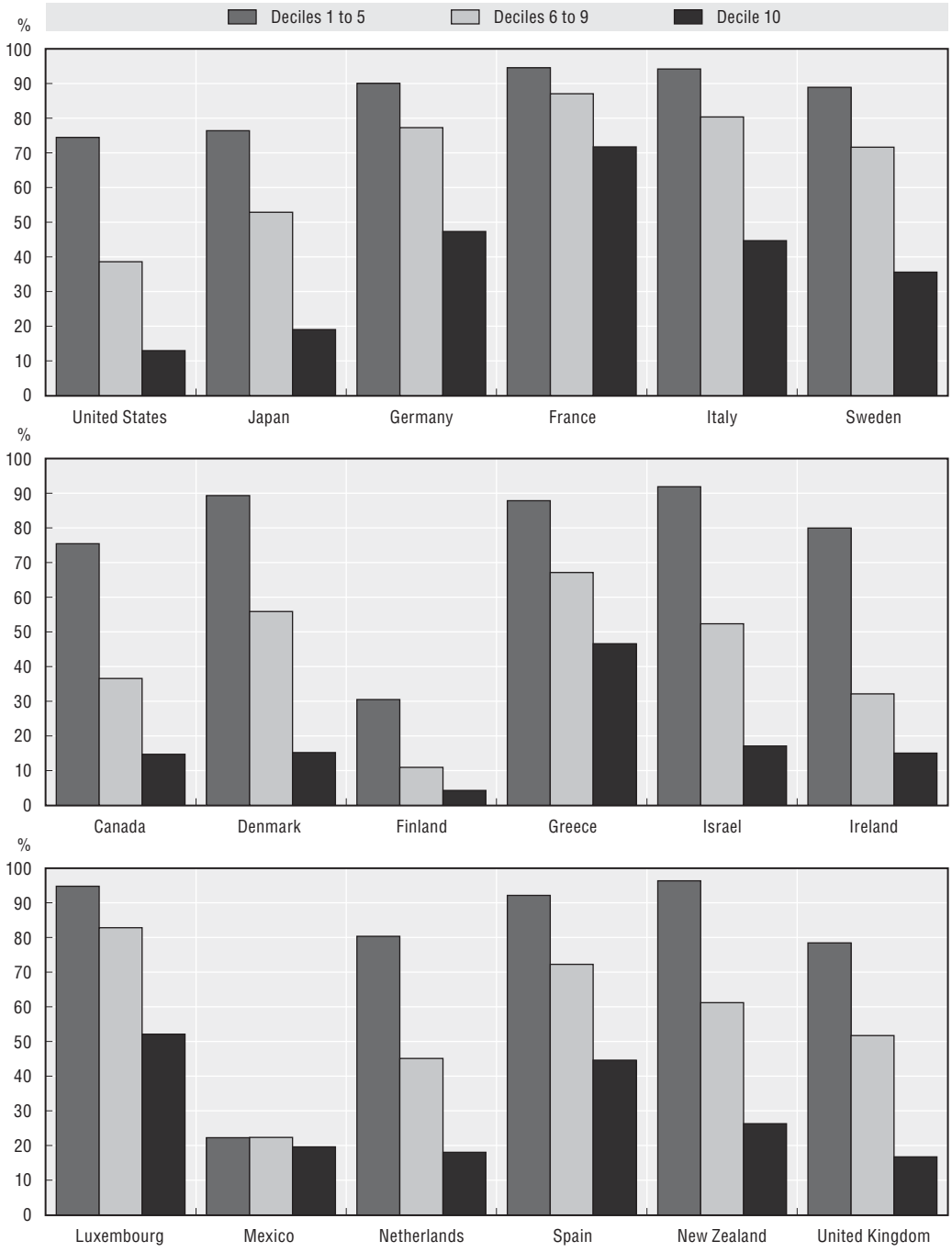
Cost sharing can also be set as a residual, if any, between the prevailing cost of LTC and the set amount of public coverage. In Germany and in the Italian disability cash benefit ("*indennita di accompagnamento*"), for instance, public coverage is a fixed support which depends on users' care need but not on users' income and assets and is subject to adjustments over time to reflect recent trends in LTC cost *(e.g.,* Germany in 2008). In Austria (combination of "Pflegegeld" and other LTC cash benefits) and France ("*Allocation personnalisée d'autonomie*"), on the other hand, the amount of support is capped but also varies depending on users' care level as well as income and/or assets. Although potentially more complex to administer, this approach can help control costs by capping benefits and increasing fiscal predictability for governments. It also takes into account ability to pay and is progressive. On the down side, it can leave users with uncertainty, especially for those with relatively lower income and higher care needs, particularly if the amount of public support does not keep track with the growth in LTC cost over time.

On equity and cost grounds, there is a rationale for requiring higher cost sharing from those with relatively higher ability to pay. That being said, the determination of the share of income and/or assets that should be allocated to LTC may depend on country's views regarding the balance between collective and individual responsibility for care cost and the notion of what constitutes "catastrophic LTC expenses" – for example whether LTC spending is deemed as catastrophic when it exceeds a given percentage of users' income and/or assets or a given maximum, or when it leaves a dependent individual with less than a minimum level of basic income and/or assets.

Potential interactions with targeted personal income tax measures and the structure of their pension systems also come into play. For instance, as shown in Figure 9.4, public transfers *(e.g.,* public earnings-related schemes as well as basic and resource-tested

Figure 9.4. **Public transfers provide the bulk of income in old age**

Public transfers as a share of the adjusted income of individuals 65 years and over, mid-2000s



Note: Public transfers include earnings-related schemes, basic and resource-tested benefits as well as minimum programmes. In Finland, mandatory occupational pension plans are included as capital income and are therefore not accounted as public transfer.

Source: OECD Income Distribution and Poverty Database (*www.oecd.org/els/social/inequality*).

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benefits) generally represent more than 75% of income for half of the elderly with the lowest income. For elderly with intermediate income levels (those falling in the 6th to the 9th deciles) public transfers can range between 30 to 80% of income. This suggests that for seniors, a significant share of private cost sharing towards LTC is paid out of public

transfers such that seniors' ability to pay for a share of LTC cost is related, in part, to the comprehensiveness of public pension systems.

9.4. Board and lodging costs in institutions are the main costs that LTC users face

A significant share of the costs associated with receiving care in a nursing home relates to board and lodging (B&L) costs. Depending on the standard and quality of accommodation *(e.g.,* number of beds in one room), B&L costs can represent more than 50% of the total cost of residing in a nursing home (Fédération Hospitalière de France, 2010).[5] This cost can be prolonged over a long period of time: on average, dependent individuals reside between two to three years in a nursing home. B&L costs can be high relative to the ability to pay of senior dependent people. In most countries, the lion's share of a dependent disposable income can be used to pay for these costs (*e.g.* 80 to 85% of one's disposable income in Australia, Ireland, Norway or Finland) and may need to draw upon their accumulated savings to pay for them.

In most OECD countries, this component of LTC cost is generally viewed as a social/housing risk and is typically not included in public LTC coverage. Assistance is generally targeted to low-income people as part of existing social-assistance or housing subsidy programmes, with the exception of a few countries with comprehensive LTC systems *(e.g.,* Japan and some Nordic countries), where cost sharing for B&L coverage can nevertheless account for a high share of residents' disposable income.[6] In Japan, the cost of B&L has been excluded from the insurance coverage since 2005, in order to ensure equity with people living at home.

High user charges or no coverage for the cost of B&L in a nursing homes contrast with the significantly lower charges paid for accommodation in hospitals or other short-stay acute care settings. The main rationale for the difference in cost treatment lies in the notion of what is considered as principal residence. Typically, for those receiving care on a temporary basis, either in a hospital or in a nursing home, one's principal residence continues to be the house or apartment. For those receiving care on a permanent basis in a nursing home, on the other hand, the former home or apartment is generally no longer considered as principal residence. In some countries, such as Norway and the Netherlands, the length of stay is taken into account to determine the level of private contributions towards the costs of residing in a nursing home.

In practice, moving into a nursing home is not akin to the usual accommodation choice within a community, since it is generally triggered by disability status. It is not only a difficult decision at the personal level but it also generally involves significant financial implications, at a time of life when disposable income is relatively lower, but accumulated assets can be high. This raises two main issues discussed below: first, how to calculate a "fair" level of cost sharing for B&L cost; and, second, how can policy makers help mobilise disposable cash (liquidity) to help users pay for the high cost of stay in nursing homes.

Settings cost sharing for board and lodging costs

It can be argued that all individuals should be required to pay at least for a minimum of their food and shelter-related expenses, regardless of the dwelling where they are living. It is also reasonable to expect that accumulated savings will meet some of the basic expenses related to food and shelter, including when a person move to a nursing home. The policy debate with respect to the B&L costs of a nursing home, then, is not on whether residents should pay for it, but *how much* and *what type* of expenses.

As board and lodging costs can be subject to significant variations depending on the standard and quality of the accommodation and services, a guiding principle may lie in ensuring that board and lodging cost reflects the market price of similar lodging and food services (Canada Healthcare Association, 2004). A difficulty, however, is that board and lodging costs often include the cost of other services, such as leisure activities provided in the home, or even the assignment of the capital cost associated with building or renovating a nursing home. As a result, board and lodging costs may be more akin to a "residence fee" consisting of the sum of all charges not publicly covered. This "residence fee" can represent a high burden for users and tensions may arise between them and the government on affordability grounds. Nevertheless, while public controls over residential charges and fees can help ensure their affordability – for both residents and governments – they may also have unintended impacts on overall investment decisions in the sector (National Seniors Australia, 2010).

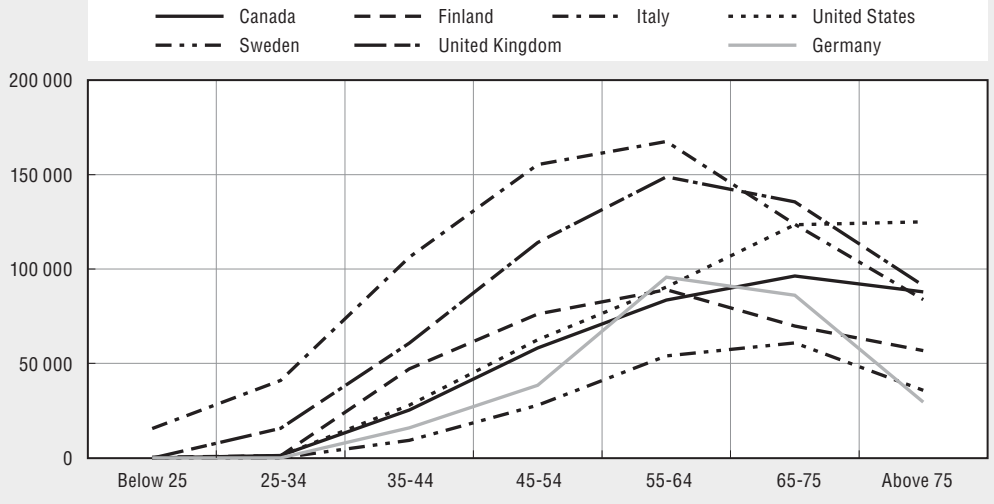
The main question then relates to how public support for the cost of board and lodging could be targeted. A number of countries (see Chapter 7) rely on both income and assets testing to determine the level of public support – and conversely private contributions – for this cost component. The rationale for including assets in the means test is that it better reflects the distribution of economic welfare among individuals, leading to a fairer allocation of public support. This is particularly important for older people who have relatively higher "net-worth" – which is the difference between total assets owned and total debt incurred – than young people (Figure 9.5 in Box 9.1). On the other hand, asset

Box 9.1. **Evolution of net-worth across age groups**

For OECD countries included in the Luxembourg Wealth Study,* the median net-worth profiles exhibit a hump-shaped pattern, albeit at different levels of net-worth, in most countries. Typically, the young have less, the middle-aged have the most and the older have less than the middle-aged but more than the young (OECD, 2008a). Net-worth is defined as the difference between total assets owned and total debt incurred.

Figure 9.5. **Median net-worth by age of the household head**

Net-worth, values in 2002 USD



Source: Luxembourg Wealth Study (LWS) *Database.*

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Box 9.1. **Evolution of net-worth across age groups** *(cont.)*

As shown in Table 9.1, the majority of household's total assets comprise of non-financial assets, in the form of residential real estate. On average, the principal residence represents between about 45 to 70% of total assets.

Table 9.1. **Household composition of net-worth**

Percentage of total assets

Wealth variable	Canada	Finland	Germany	Italy	Sweden	United Kingdom	United States	United States
	SFS 1999	HWS 1998	SOEP 2002	SHIW 2002	HINK 2002	BHPS 2000	PSID 2001	SCF 2001
Non-financial assets	78	84	87	85	72	83	67	62
Principal residence	64	64	64	68	61	74	52	45
Real estates	13	20	22	17	11	9	14	17
Financial assets	22	16	13	15	28	17	33	38
Deposit accounts	9	10	–	8	11	9	10	10
Bonds	1	0	–	3	2	–	–	4
Stocks	7	6	–	1	6	–	23	15
Mutual funds	5	1	–	3	9	–	–	9
Total assets	100	100	100	100	100	100	100	100
Debt	26	16	23	4	35	21	22	21
of which:								
Home-secured debt	22	11	–	2	–	18	–	18
Net worth	74	84	77	96	65	79	78	79

Note: BHPS = British Household Panel Survey; HINK = Swedish Survey on Household Finances; HWS = Household Wealth Survey; PSID = Panel Study of Income Dynamics; SCF = Survey of Consumer Finances; SFS = Survey of Financial Security; SHIW = Survey on Household, Income and Wealth; SOEP = German Socioeconomic Panel Study.
Source: Luxembourg Wealth Study (LWS) *Database*.

StatLink http://dx.doi.org/10.1787/888932401938

* The LWS is an international project to assemble existing micro-data on household wealth into a coherent database.

testing can be administratively more complex to implement and unduly punish those who carefully managed their budget over their lifetime. Given users – especially older people – attachment to their own home, there is resistance to inclusion of the value of the owned house into the assets test, even if this represents the core of older people net-worth (Table 9.1 in Box 9.1). There is also some evidence[7] suggesting that net-worth and disposable income are highly, albeit not perfectly, correlated. The distribution of disposable income may then represent a reasonable indication of the distribution of economic welfare or the base on which to allocate public support (Jantti *et al*., 2008).

On balance, there is a rationale for considering a broad definition of income when setting the level of user cost sharing on B&L cost. But there are also arguments for relying solely on income testing. Countries decisions can be informed by considerations about administrative simplicity and the notion of what is regarded as "fair" by society, although no system will be entirely immune from criticism. In addition, public support for board and lodging costs can be heavily influenced by the way support for ensuring access to basic necessities, such as housing, is provided for the population at large. Transparency on how charges are set and on the reasons for charging is important, so that users know that they

may incur significant B&L cost, even where there is "universal" coverage for personal care. These considerations also suggest that there is a role for governments to help mobilising resources to pay for what can rapidly become very high cost.

Delivering financial protection against board and lodging costs in institutions

Despite social assistance and other public support, moderate-income people residing in nursing homes are especially vulnerable to impoverishment due to high residential homes' cost. In addition, high nursing-home charges or cost-sharing requirements can force users to sell their homes to pay for care. Home ownership can provide a number of avenues to mobilise additional cash to pay, in full or in part, for expenses associated with LTC, such as board and lodging. These range from obtaining a loan against this cost, to trading it down, renting or selling it. Interesting public and private-sector initiatives can be found across OECD countries.

Some nursing homes are making use of *bonds/equity release* or loan schemes. For instance, in Australia, individuals with assets above a minimum threshold may be asked to pay for an accommodation bond when moving into a low-care home or entering an extra service place (at high or low-care level), where the level of care provided is the same as that provided generally in aged-care homes. An accommodation bond is like an interest-free loan to the aged-care home and by law it must be used by the aged-care home to improve building standards, and the quality and range of aged-care services provided. The aged-care home is allowed to deduct monthly amounts, called "retention amounts", from the bond for up to five years and up to a prescribed maximum amount (Australia Department of Health and Ageing, 2010a). Similar schemes are also used by some retirement homes in the United Kingdom (Collins, 2009). The benefit of those schemes is that they may foster a greater sense of ownership for residents. Nevertheless, they target those with relatively higher income and assets.

The ability to keep their own home and not have to divest it in order to pay for LTC is a sensitive matter for frail senior people. Measures to facilitate the mobilisation of non-financial assets towards some of the private cost associated with LTC, particularly B&L cost in nursing home, are especially relevant to people immediately above asset-testing threshold for public support.

Given the administrative complexity in valuing the stream of income stemming from an asset owned, especially with respect to non-financial assets such as a principal or secondary residence, asset testing typically takes the form of an asset cut-offs, which applies to the total value of assets owned at a given point in time. Typically, if an individual's total value of assets exceeds the given asset cut-off, s/he is not eligible for public support. For seniors having to move into a nursing home, the use of asset cut-offs to allocate public support can have important repercussion on their ability to keep their home. For instance, the inclusion of the principal residence[8] in a means-test may prompt a care-home resident to dispose of it to realise the property's capital and allow them to finance their care-home charges (Gheera, 2010).

While *private reverse-mortgage schemes* (see Chapter 8) may offer an avenue to mobilise cash to pay for care, these can be fairly complicated and expensive and not provide the necessary flexibility to keep one's home after moving into a nursing home. This is because private providers generally require the loan to be paid back once both spouses have moved out of the home for a given period of time. To date, such schemes have met with limited success.

Rather, governments in some OECD countries have set in place *public measures to defer payment* of nursing-home costs. These can provide greater flexibility to dependent individuals and their survivors to determine the composition of inheritances, which may include a dependent's home, while providing a means to meet immediate needs. For example, under the Irish Fair Deal Scheme introduced in October 2009, residents receiving care in a nursing home pay 5% of the value of any assets per annum in user fees. The value of the principal residence is included in the financial assessment, but only for three years. With respect to non-financial assets, such as land and property, the 5% contribution can be deferred to the time of residents' death. This provides individuals with the flexibility of not selling assets, such as their home, during their lifetime, in order to pay for their care. During the duration of the loan, preferential interest charges, equivalent to the consumer price index, apply. Since its introduction, about 15% of new nursing-home residents have taken advantage of this option (O'Regan, 2010).

In the United Kingdom, eligibility for public support for the cost of residing in a nursing home is subject to an asset test, which can take into account the value of users' principal place of residence (unless a partner or child still lives in the house). For those individuals who would meet the asset test if they did not own their home, some local councils provide a scheme that allows them not to sell the home immediately, and to move all or part of the nursing-home fees through a deferred-payment agreement. No interest generally applies on deferred payments over the period of the agreement and until a given number of days after the death of the resident. At that point, the deferred amount must be reimbursed or the residence sold. The New Zealand government also provide for interest-free Residential Care Loan to assist those not eligible to a residential care subsidy because of the value of their own home, but with limited cash or other assets, to pay for their care (New Zealand Ministry of Health, 2009). Similarly, in US Medicaid system, the value of a principal place of residence is generally excluded from the asset test, but can be subject to an estate recovery after the death of the resident, equivalent to the amount of support provided by Medicaid.[9] In essence, this is equivalent to a deferred payment scheme.

Deferral schemes have the virtue of permitting LTC users to keep their home, even if they have to move into a nursing home, although they can still raise considerations as to their impact on a dependent's inheritance to their survivors. Depending on the size of the deferred amount, the repayment or the recovery from users' estate after death can be perceived by survivors as a punitive inheritance tax targeted to the unfortunate few who required public support for paying for expenses associated with long-term care. However, it can be argued that, once a principal residence is no longer needed by the recipient, the recipient's spouse or a child, its equity should be used to cover some or all of expenses associated with LTC, such as board and lodging costs (US Department of Health and Human Services, 2005).

Private-sector initiatives, such as the combination of life and LTC insurance policies, can provide individuals with the opportunity of deferring (for some indefinitely) the decision of having to sell their home in order to receive the care they need. Typically, such hybrid policy provides for cash advances from the death benefit in the event that the policy holder requires long-term care for an extended period of time. For elderly dependents, this feature provides a way to mobilise additional liquidity thereby enhancing their flexibility to decide the type of assets that they intend to leave to their survivors. To date, these schemes still have limited diffusion, although life insurance is certainly a more diffuse product that LTC insurance in most OECD countries.

Board and lodging costs are high and will very likely remain high in the future. These costs can represent a significant share of the relatively low disposable income of the elderly. Nevertheless, elderly people typically have relatively higher level of assets and a portion of those should be used to help pay for basic necessities such as board and lodging. Most of elderly assets, however, take the form of non-financial assets *(e.g.,* a house), and decision to turn this asset into cash can be more difficult. While some private initiatives, such as the combination of life and LTC insurance, can help mobilise additional liquidity towards the cost associated with LTC, their diffusion remains limited to date. Recent public initiatives, such as the one implemented in Ireland, suggest that governments can play a larger role in facilitating the conversion of non-financial assets into cash for residents receiving care in a nursing home.[10] Akin to public student-loan programmes, such public schemes can be designed to mitigate conversion costs through preferential transaction and interest rates. This type of public intervention could also help foster greater flexibility to dependents in determining the composition of assets that they would like to leave behind while providing a means to meet immediate needs.

9.5. Matching care need with finances: Policies for the future

OECD countries' experiences with matching LTC cost to funding point to public LTC systems being currently financed on a "pay-as-you-go basis". However, as a result of population ageing, public expenditure is expected to grow more rapidly than revenues over the next decades. Especially in the case of age-related spending such as LTC, it is important to build a set of financial policies that are more forward-looking, taking into account the potential impact on future generations.

Public LTC financing systems in OECD countries match cost on a year-by year-basis

With the general exception of countries with a dedicated social-insurance arrangement for long-term care services *(e.g.,* Japan, Korea, Germany, the Netherlands), LTC financing typically represents a subset of a larger spending category such as health and/or social services.[11] In some cases, LTC financing cuts across different levels of governments. Comparing levels of LTC revenue and expenditure is a difficult exercise for countries relying on general revenue to fund LTC, typically requiring a broader fiscal perspective.

Countries use an array of mechanisms to ensure that revenues match the cost of LTC systems. In Japan and Korea, but also in Switzerland and Slovenia, for instance, *contributions are generally raised to match* expected expenditure of the LTC system.[12] In Japan, the process of matching revenues with expenditure takes place over a three-year cycle, while it takes place on an annual basis in Korea. As in Japan, a portion of the revenue raised is allocated to a financial stability fund, which can be used by municipalities to cover shortfalls arising because of inability to collect the premia or unexpected increases in utilisation. In Germany, while the contribution rate was kept fixed for several years, it was raised in 2009 to match growth in LTC cost.

In a number of countries – such as Belgium, Norway or Ireland – budgets for LTC services are set within larger *global-budget envelopes* that are set annually. In some cases, specific spending targets may apply to LTC expenditures, for example in France, New Zealand, Portugal and Slovenia. Generally, budgeting controls exist in most OECD countries, although many allow overshooting.

Another mechanism that has been used is to control entitlements. This can take the form of maintaining the value of LTC benefits over time or fixed pre-determined LTC entitlements (*e.g.* Austria, Czech Republic, Switzerland, New Zealand, Poland, Slovenia, Germany until 2007-08). All OECD countries also aim at controlling the demand for LTC care services to a specific target group of individuals, which is generally done through the assessment system.

Last, a number of countries contain LTC cost by exerting direct control on the supply of care services, either through the negotiation of salaries and fees paid to providers *(e.g.,* nursing homes, workers) or by controlling the number of subsidised beds or available workers. For instance, the Australian Government controls the supply of subsidised aged-care places through a provision ratio and determines the rate of residential care subsidy paid to approved providers for each person in their care, based on their assessed care needs. Belgium and other countries control the number of beds in nursing homes. In Japan, the number of LTC workers is indirectly controlled by requiring care workers to pass qualifications exams.

Each mechanism can have unintended impacts, for instance, most countries will face upward limits in their ability to raise revenue over time. Maintaining the value of LTC benefits can put some individuals at a greater risk of facing economic hardship, while controlling for the number of beneficiaries or the quantity of services provided may result in waiting times. This is why most countries currently use a combination of these mechanisms to ensure that LTC revenues are aligned with expenditures.

In line with general government budgeting processes, thus far the focus has been on matching LTC revenues and expenditures on a year-to-year basis. While such an approach is desirable to maintain public accounts in balance, it does not provide information on its potential impact on future generations. While still a relatively low share of GDP, evidence in some countries suggests that LTC cost is already exerting fiscal pressures on public budgets. In Japan, Korea, Germany, the Flemish government in Belgium and Luxembourg, LTC contributions have risen significantly since the introduction of public LTC coverage systems. For instance, contribution rates have about doubled in Germany from 1% in 1995 to 1.95% for people with children and 2.20% for people without children in 2009, while Luxembourg increased in 2007 its contribution rate from 1.0 to 1.4%. In France, central governments have reduced their respective share of LTC financing relative to local governments, while in the Netherlands the provision of IADL services was moved out of the public LTC insurance and devolved to the municipalities. Some administrations are attempting to reduce LTC spending as part of budgetary consolidation in response to the recent economic crisis. For instance, a number of states in the United States are cutting back on medical, rehabilitative, home care or other services needed by low-income people who are elderly or have disabilities, or are significantly increasing the cost of these services (Johnson *et al.*, 2010). Similarly, in New Zealand, some district health boards have been cutting hours of home help.

Promoting a fairer sharing of financing across generations

While ultimately an ethical concept, the notion of intergenerational equity has come to the forefront of policy discussions on LTC financing as a result of the expected reduction in the size of the working-age population compared to the elderly population (see Chapter 2 on demographic projections). Concerns are often raised with respect to the funding of age-related expenses, such as LTC, by requiring a relatively smaller future generation to pay

for a portion of the care of a relatively larger previous generation (that is, on a pay-as-you-go basis). This concern can be examined, in part, using the concept of fiscal sustainability.

Fiscal sustainability is a multi-dimensional concept that incorporates an assessment of solvency, stable economic growth, stable taxes and intergenerational fairness (OECD, 2009). While not acting as target, the concept can help guide future changes to a given set of fiscal policies (*i.e.*, expenditure and revenues) by informing the extent to which it may transfer liabilities to future generations in the long run. For illustrative purposes, if no change were made to the current set of fiscal policies, the gross-debt-to-GDP ratio for the 27 EU Member States would increase by about 80 percentage points and reach about 140% in 2030 (European Commission and the Economic Policy Committee, 2009). Similarly, for the United States, a no-policy-change scenario would result in the debt-to-GDP ratio to increase by about 50 percentage point and exceed 110% of GDP over the period of 2025 and 2040 (US Government Accountability Office, 2009). Those results suggest that the current set of broad fiscal policies is shifting a considerable amount of liabilities to future generations.

While the size of estimated fiscal-sustainability gaps[13] varies significantly across countries, most OECD countries have gaps typically arising as a result of both an unfavourable fiscal starting position and of the projected increase in the cost of ageing (European Commission and the Economic Policy Committee, 2009). For most OECD countries, the recent financial and economic crisis has deteriorated estimated fiscal gaps. In the case of OECD-EU countries, demographic ageing alone accounts for about half of the estimated fiscal gap[14] (European Commission and the Economic Policy Committee, 2009). Most of the projected increase in the cost of ageing arises from public pension and health expenditures. Nevertheless, on average, the increase in LTC expenditure is expected to contribute about 25% to the overall projected increase, with contributions above 40% in Sweden, Denmark, Italy, the Netherlands, Finland and Poland.[15]

The important contribution of age-related spending, including LTC, to fiscal sustainability gaps suggests that, in a number of countries it will be important to take a closer look at the way expected future expenditures and revenues are structured. The following section examines potential adjustments to help promote a fairer sharing of LTC financing within and across generations. While not all adjustments will be applicable or relevant to all countries, a menu of possible options is outlined.

Fostering intergenerational equity through pre-funding

One of the strategies that could be adopted to address the fiscal-sustainability gap includes the introduction of pre-funding, which essentially means building up assets to fund future ageing-related cost pressures, such as LTC (OECD, 2008a). There are a number of benefits associated with pre-funding, such as mitigating sudden increases in contribution and/or tax rates (also referred to as "tax-smoothing") in order to finance a stable set of benefits or services over time, as well as mitigating the risk of shifting obligations to future generations in the form of higher taxes or debt. The introduction of a pre-funding element would thus seek to extend the budgetary horizon to better take into account foreseeable LTC spending pressures.

In practice, pre-funding requires government to sustain budget surpluses over a given prolonged period of time, which can raise important political-economy issues since any surplus is typically subject to competing claims over funding alternative policy priorities,

including tax reductions. Such political economy issues can be overcome by tying pre-funding to specific age-related costs (OECD, 2008a). For instance, some OECD countries (Japan, Switzerland, Sweden, Canada, France Ireland, New-Zealand and Norway) have introduced public pension reserves to pre-fund future public pension's obligations (Yermo, 2008). Although different circumstances apply depending on each country LTC funding system, consideration could be given to establishing similar public reserves with respect to LTC expenditures and to the appropriateness of moving towards partial or full pre-funding.[16]

The notion of pre-funding better applies to countries which finance its LTC expenditure from dedicated revenue sources, either as part of a LTC-coverage systems – such as Germany, Japan, Korea, the Netherlands, Luxembourg, France, and Belgium with respect to the Flemish LTC insurance (Chapter 7). Currently, most of these plans are financed on a "pay-as-you go" basis, with contributions and/or benefits typically adjusted to match revenue over pre-determined short-term cycles of typically one year (three years in Japan). In Germany and Luxembourg, the public LTC insurance scheme is mandated to accumulate a small reserve. In Germany, a small stock of savings of at least 50% of the monthly benefit spending designated in the budget must be withheld (Heinicke and Thomsen, 2010). In Luxembourg, the reserve has to represent at least 10% of annual LTC insurance expenses. In 2008, the reserve was equivalent to about 50% of annual LTC insurance expenses (ministère de la Sécurité sociale, 2009). Elements of pre-funding could also be introduced in countries which finance LTC as part of broad social-security systems, such as Belgium. For instance, in Germany, considerations are being given to financing reforms that would include an element of pre-funding through the introduction of a capital-based branch in the social insurance scheme. The objective would be to better ensure sustainable financing in the area of long-term care and take into account intergenerational equity. One shortcoming with this approach, however, is that unless accumulated funds are earmarked to LTC, it does not guarantee that some of the accumulated assets originally meant for LTC could not be diverted to larger expenditure posts, such as health or pension (Yermo, 2008).

For countries financing LTC from general revenues, such as the Nordic countries, Canada or Australia, the notion of pre-funding is a broader concept more akin to building a favourable fiscal position, generally through lower debt-to-GDP ratio. While savings in the form of public-debt reductions foster future fiscal flexibility, they may end up being used for other future outlays than for ageing-related expenses. Still, for these countries, the benefits associated with better taking into account future expected budgetary fiscal positions remain.

An outstanding question concerns what desirable degree of pre-funded for financing LTC – that is whether or not there could be full pre-funding in LTC insurance. The experience with premium setting in private LTC insurance can be of interest in this respect. As indicated in Chapter 8, in principle, private LTC coverage is fully funded as premium setting involves the establishment of reserves. Private LTC insurance is a lifelong contract over which the insurance provider guarantees a premium rate schedule. Typically, given a subscriber's age, gender or previous health conditions, the premium is set to cover future expected LTC benefit pay-outs, taking into account the income generated from accumulated premia (Riedel, 2003). In Germany, private LTC insurers have established an ageing reserve ("*Alterungsrückstellung*") for insurees to pay for the expected growth in LTC benefits due to ageing. Similar reserves, or "provisions constituées", are accumulated by France's assurance providers. In 2009, a total of EUR 2.6 billion (below 10% of France's

public LTC spending) had been accumulated in reserves by French LTC insurance providers (FFSA, 2010). One lesson learned from the American LTC insurance industry, however, is that trends in the onset of dependency, the costs of providing a unit of care or the projected returns from invested reserves are all subject to high uncertainty. This can result in important year-to-year variations in premiums, with implications for the ability to fully fund a private LTC insurance scheme.

Under a public system, the move to a full-funding approach would not only be inappropriate due to uncertainty about the future need for LTC, but also be challenging to implement. It would raise fairness considerations in the way past unfunded LTC benefits of the current older segment of the population would be paid for. Potential ways to pay for past unfunded LTC benefits can range from a drastic increase in the level of contributions of the older segment of the population, which most would not be able to afford, to significantly reduce the level of LTC benefits provided to the older segment of the population in line with their level of contributions paid over their lives, or to require younger contributors to pay higher contributions to cover for both their and older people LTC benefits. Rather, the establishment of pre-funding could primarily aim at stabilising and/or minimising LTC contributions over time instead of ensuring the full-funding of the scheme (Office of the Chief Actuary, 2007). This could be achieved through partial pre-funding.

Under a partially funded LTC scheme, individual's LTC contributions would cover a portion of their expected future LTC benefits. Contributions and investment earnings would partially fund the scheme (Office of the Chief Actuary, 2007). One of the main advantages relative to full-funding is that it would be less sensitive to changes in the projected rate of dependency, the costs of LTC or the earnings from investment of reserve and thereby more conducive to stabilising contribution rates in the long run (Plamondon and Latulippe, 2008). The level of partial-funding depends on a number of variables, including the country's objectives in setting the level at which contribution/taxation rates should stabilise at as well as its age structure.

While the introduction of an element of partial pre-funding remains desirable to foster intergenerational fairness and stabilise contributions/tax rates within a public LTC scheme, its introduction may still be politically difficult because it would require individuals to pay an additional contribution/tax over the initial years of the financing scheme (*e.g.*, 15 to 25 years).[17] To mitigate such concerns, the required increase in contribution/tax effort could be phased-in over a given period of time. Alternatively, other adjustments to the LTC financing model could be considered.

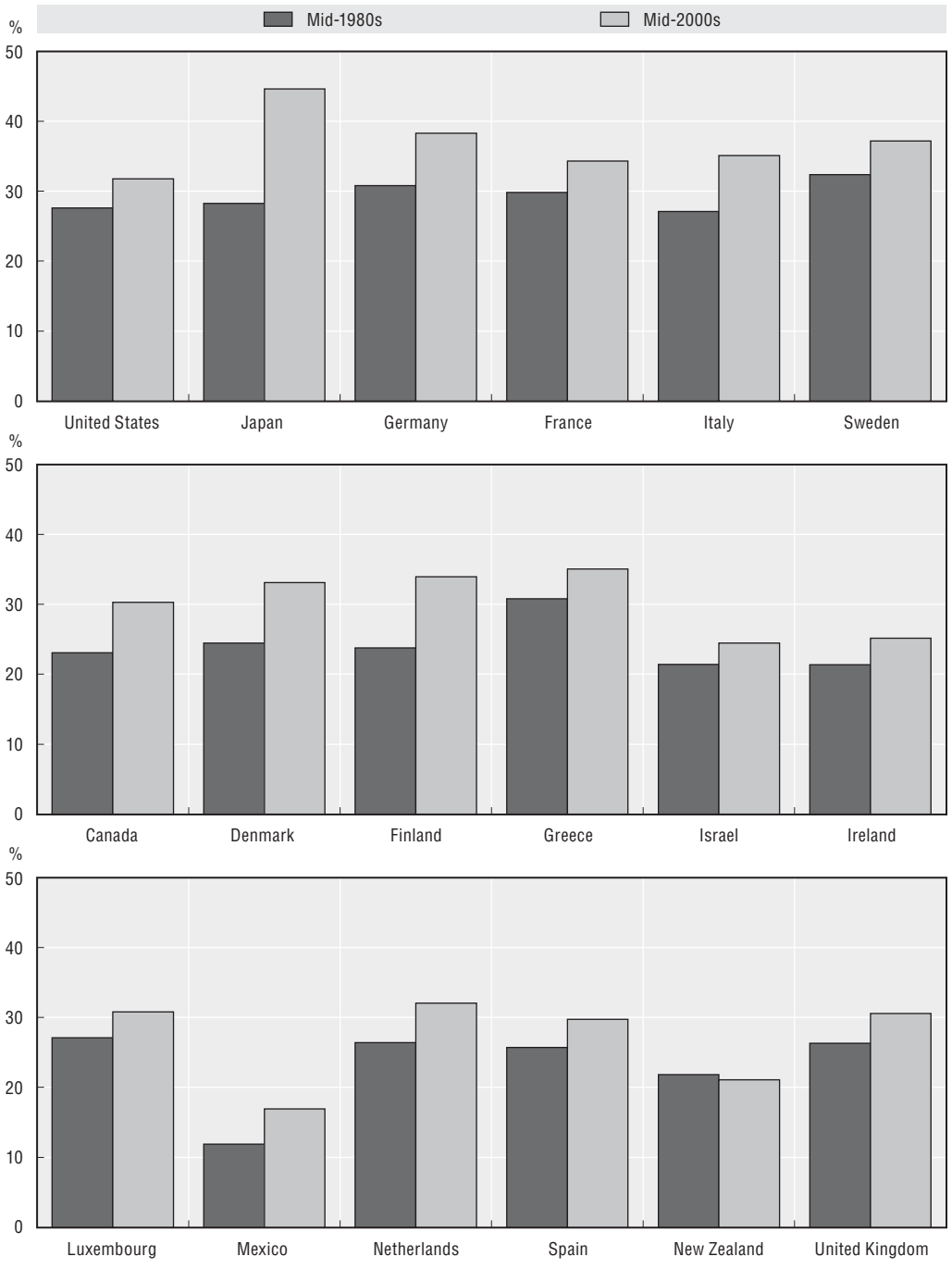
Who should pay?

Across OECD countries, the size of older cohorts will generally be larger than younger cohorts. This inverted demographic-pyramid structure challenges financing models primarily relying on the working-age population to support both the young and the old. As societies age, an increasing share of total disposable income will be in the hands of an older segment of the population (Figure 9.6),[18] mainly in the form of pension and capital income (Figure 9.7).[19] These demographic and economic trends suggest that the sustainability of LTC financing models could be fostered by either requiring LTC financing from more generations and/or through tax broadening.

The benefits of pooling the risk associated with LTC over as large a population as possible are well documented. But the inverted demographic pyramid can involve

Figure 9.6. **Increasing share of income in the hands of the older segment of the population**

Population aged 51 years and over



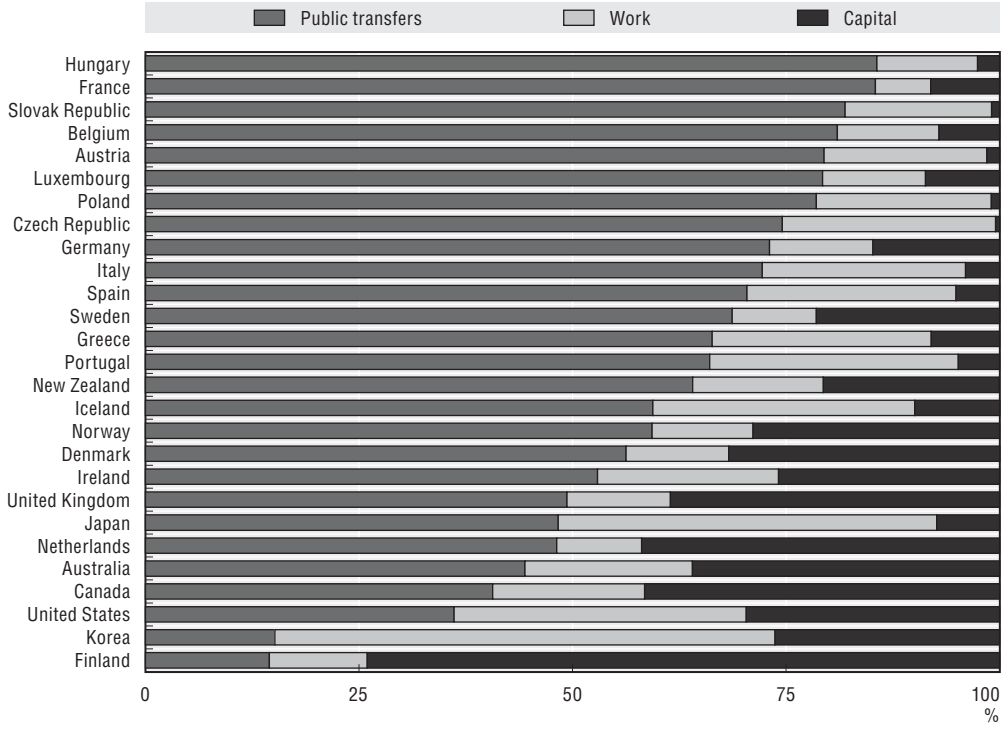
Source: OECD Secretariat calculations based on the *OECD Income Distribution and Poverty Database* (*www.oecd.org/els/social/inequality*).

StatLink http://dx.doi.org/10.1787/888932401767

significant cross-subsidisation of this risk from a relatively small younger cohort to a relatively larger older cohort of individuals. Therefore, on inter-generational equity grounds, one way to mitigate this cross subsidisation is to introduce intra-generational pooling (St. John and Chen, 2010) by introducing a contribution starting from a certain age

Figure 9.7. **Elderly people's disposable income mainly consists of pension and capital income**

Percentage share of adjusted disposable income, individuals 65 years and over, mid-2000s



Note: Income from work includes both earnings (employment income) and income from self-employment. Capital income includes private pensions as well as income from the returns on non-pension savings.

Source: OECD Secretariat calculation based on the *OECD Income Distribution and Poverty Database* (*www.oecd.org/els/social/inequality*).

StatLink http://dx.doi.org/10.1787/888932401786

of an individual or by requiring all people to contribute to LTC over their entire lifespan (LTC financing from more generations).

Complementary to introducing intra-generational pooling, is the concept of broadening revenue sources to look beyond revenues earned by the working-age population and include the retirees (tax broadening). Solely relying on social payroll contributions to finance LTC runs the risk of overly increasing the tax wedge on workers in the future. Large tax wedge would not only result in shifting the burden onto future generations but could also have negative impacts on employment. This is a main concern particularly for systems which rely on social insurance to cover LTC costs.

Japan's LTC financing system includes an element of intra-generational pooling and broadens revenue sources. In Japan, funding sources for the LTC insurance system are mixed. Of the overall budget, 10% is financed through user co-payments. The remaining 90% is equally shared between taxes (of which 25% from the central government and 12.5% each from prefectures and municipalities), and premia levied on the over 40 population. Setting aside cost sharing, 20% of the total LTC cost is covered from premia collected by the elderly and 30% from those aged 40-65.[20] Premia collected from retired people are income-related and those for individuals aged 40-65 are based on wages. Germany is also an example of extending LTC financing over more generations. Since 2004-05, pensioners

have been required to pay the contribution entirely from their disposable income and no longer receive a contribution subsidy from the pension funds (Arntz *et al.*, 2007).

Other OECD countries complement social payroll contributions with alternative sources of revenues either to specifically finance LTC insurance expenditures or more broadly to finance social security systems as a whole. In the Netherlands, while premia are laid only on the working-age population, LTC insurance is financed partly from general taxation. This share accounted for a fourth of the total budget of the Dutch AWBZ in 2008 (Schut and van de Berg, 2010). Similarly, in Belgium, the social security system is no longer solely financed through social payroll contributions and is partly financed through global budgets.[21] The financing of the Flemish long-term care insurance in Belgium provides for an alternative broad financing model. Of the overall budget, half is financed by a specific contribution paid by every adult resident[22] and the rest is financed by general taxes. LTC funding in France also comes from a mix of different revenue sources, most notably about two-thirds of the cash-for-care allowance (*Allocation personnalisée d'autonomie*) is generally financed from local property taxes.

In the case of LTC systems financed from general revenues, the same considerations apply, but more broadly. Tax broadening or adjustments to the composition of taxes can provide a way to extend financing of LTC over more generations, while maintaining the benefits associated with risk pooling. For example, this could be achieved by shifting the composition of tax revenues from taxing wages and employment to taxing general consumption (*e.g.*, value-added taxes), recognising the inherent distributional impacts of such a shift.

Lastly, it could be argued that one of the central social functions of the family involves intergenerational transfers of time and resources (Osberg, 1997). For instance, as shown in Chapter 3, children represent a main source of family care to frail elderly. For parents, children provide a broad network of support, ranging from emotional to financial help, thereby potentially delaying a move into more expensive care setting such as a nursing home.

In Germany, the presence of children affects individuals' level of contribution to the public LTC system. Following a decision from Federal Constitutional Court, an additional premium of 0.25 percentage points has been required from childless people since 2005. In 2009, the level of contribution paid by people without children was equivalent to 2.20 percentage points compared to 1.95 for people with children. The rationale for the additional premium is that childless people are expected to receive higher benefits from the social LTC insurance relative to people with children (Heinicke and Thomsen, 2010). This situation may arise because of the higher likelihood of dependent people with children to opt for cash instead of in-kind benefit. In Germany, LTC insurance cash benefits are set at a lower level than in-kind benefits.

Similarly, different generations can also share income within the family. In some OECD countries, social-assistance systems include an obligation for children to contribute towards their parent's expenses associated with long-term care, such as board and lodging. This obligation is often referred to as the concept of "filial obligation". This is the case for instance of Germany, Portugal and France[23] (Casey, 2010). Under such system, the income and assets of a dependent individual's children are taken into account to determine the level of public support.

These provisions recognise the role and duties of family carers. However, the notion of family responsibility varies widely across countries and similar requirements may be regarded as unfair by childless households, or as impinging upon bequests of adult

children. A simple and effective way to recognise the support of family carers is then by supporting them directly (see Chapter 4).

Considering partnerships and innovative approaches

Some recent initiatives or policy discussions have considered novel approaches to finance LTC, such as through forms of public-private partnerships, and automatic enrolment schemes.

Ideas of partnerships between the public and private sector have shown appeal in a few OECD countries. Public-private partnerships can mean different things depending on who are the "partners" of the public sector. For instance, as part of discussions currently held in France, considerations range from encouraging the take-up of voluntary private LTC to serve as a complement to the existing public LTC pillar, to moving towards compulsory private LTC insurance that would eventually replace the existing public scheme. At the time of writing, there is still uncertainty regarding how such public-private partnerships could be worked out in practice. Among the ideas proposed are introducing tax incentives to encourage voluntary private LTC insurance take-up, a targeted subsidy to compensate for the cost of compulsory private LTC insurance or encouraging combinations of private insurance and reverse mortgages (Le Bihan and Martin, 2010; Commission des Affaires Sociales, 2010).

In the United States, public-private partnerships have met with limited success, although the partnership in the United States applies to the co-ordination of private voluntary LTC coverage with means-tested public coverage (Chapter 8). Other ideas that have been floated for example in the United Kingdom regard partnerships between the public system and individual users, where public payers would match individuals' payments (Wanless, 2007) or the introduction of a mandatory social insurance system in which people would pay a single premium at a given age, for instance at age 65 (Barr, 2010). While the idea of partnership is attractive, making it work in practice can be challenging, and the jury regarding how best to structure partnerships is still out.

An interesting example of recent financing innovations from the United States is the so-called CLASS Act. The recently enacted federal health care reform legislation in the United States (the Affordable Health Care Act) creates a privately financed (there are no public subsidies), publicly provided, and voluntary insurance scheme that would pay a cash benefit to eligible dependent individuals to pay for long-term care services and support. Many of the specific features of the CLASS Act remain to be finalised and will be designated by 1 October 2012 (see Box 9.2).

The CLASS Act borrows some financing features from the private LTC insurance but the insurer is the government, enrolment is open for eligible individuals, and not subject to underwriting based on pre-existing conditions. Coverage – which is targeted to working-age individuals – is automatic for employees whose employers opt into the programme, but individuals have the option of opting out. Premia are generally set according to enrollees' age, regardless of income and health status, and include an element of pre-funding through the accumulation of reserves.

Automatic enrolment with the option of opting out – a feature that is akin to the Singapore Eldershield programme (see Chapter 8) – enables the government to signal the importance of individual planning for the financial risk associated with long-term care, while maintaining an element of individual responsibility. Relative to purely voluntary risk-sharing arrangements, automatic enrolment has the potential to provide for broader

Box 9.2. **United States: The Community Living Assistance Services and Supports (CLASS) Act**

The Affordable Health Care for America Act that was signed into law by President Obama in March 2010 includes the so-called Community Living Assistance Services and Supports (CLASS) Act. The CLASS Act is a national voluntary insurance plan that will be managed by the Department of Health and Human Services and solely financed through monthly premia paid by voluntary payroll deductions or payments made directly from individuals. The main goals of the Act are: *i)* to help dependent individuals maintain their personal and financial independence in order to live in the community; *ii)* to establish an infrastructure that will help address the needs for community living assistance services and support; *iii)* to alleviate burdens of family carers; and *iv)* to address the institutional bias by providing cash rather than in-kind benefits.

Eligible participants

Eligible participants in CLASS must be at least 18 years of age and earn a minimum level of earnings. For workers whose employers choose to participate in the programme, enrolment would be automatic through payroll deductions. For the self-employed, those with more than one employer or those whose employer does not elect to participate, an alternative enrolment procedure will be established. For the purposes of the opting-out option, annual enrolment and disenrolment period will be set. For those meeting the eligibility criteria, no underwriting test will apply.

Premia

Premia will vary by age, so that younger enrolees will pay lower premia than those choosing to enrol at older ages, but will not vary by medical condition, income or other factors. However, people whose income does not exceed the poverty line and working students younger than age 22 years old will pay a maximum of USD 5 per month (indexed over time).

At the age of entry, premia are set to remain level, unless, an increase in premium is necessary to ensure the solvency of the plan (calculated over a 75-year horizon). In this event, only the premia of those who have attained age 65 that have paid premia for at least 20 years and are not actively employed will not be subject to the increase. Premia will also increase if there is a lapse in payment of more than three months and the person wishes to reenrol. Premium payments will be placed in a "Life Independence Account" on behalf of each beneficiary.

Eligible beneficiaries

To receive benefits, enrolees will have to maintain enrolment in the programme by paying their monthly premia. In addition, before being eligible to benefits, premia must be paid for at least five years. Insurees will also be required to have worked for at least three years during the first five years of their enrolment into the plan. A person stopping to work after having met the three-year work requirement would still be enrolled in the scheme, as long as he or she continues to pay premia. The latter criteria implicitly exclude retired population. Those who did not pay premia for more than three months will need to pay premia for at least 24 consecutive months in order to be eligible again to benefits.

Eligibility will be based on care need. Eligible beneficiaries are those with a functional limitation expected to last for at least 90 continuous days and certified by a licensed health care practitioner. The limitation could be the inability to perform a minimum number (either two or three) of activities of daily living (ADL) without substantial assistance, or a substantial cognitive impairment requiring substantial supervision to protect the individual from threats to health and safety. Participants must continue paying premia to continue receiving benefits.

Box 9.2. **United States: The Community Living Assistance Services and Supports (CLASS) Act** *(cont.)*

Benefits

Eligible individuals will receive a cash benefit according to the degree of disability or impairment. The average level of benefits will be at least USD 50 a day. Between two to six benefit amounts could be designated. The benefit amount will be indexed to general price increases. There is no time limit on the number of years a participant can receive benefits.

The benefit will be put in a debit account available for withdrawals. It will be possible to use the benefit in a flexible manner, for example to purchase non-medical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice *(e.g.,* nursing home or assisted living). Support and services can include home modification, assistive technology, accessible transportation, home help, home-maker services, respite care or personal-assistance services. Any surplus left at the end of the month can be rolled over to the next month, but not from year to year.

Tax treatment of the scheme

Premia and benefits of the programme will be treated in the same manner as tax qualified long-term care insurance, making the premia deductible, while, as for medical expenses, the benefits will generally be non-taxable.

Combination with other LTC programmes

The CLASS Act would operate as a complement to Medicaid and Medicare, without changing their eligibility rules. When a dependent individual will be eligible to benefits under both the CLASS and Medicaid, CLASS benefits could be used to reduce the costs of Medicaid. Specifically, 95% of the CLASS Act benefit could be used to cover the cost of a Medicaid beneficiary admitted to an LTC institution, with the beneficiary retaining 5% of the CLASS benefit. Those who receive home and community-based services may retain 50% of their CLASS benefits, which could pay for additional services and supports.

CLASS will help reduce the risk of (high) out-of-pocket payments and it could would reduce Medicaid payouts, while at the same time provide a new means for people to pay non-medical expenses and remain independent in their homes.

Source: Patient Protection and Affordable Care Act (enrolled as agreed to or passed by both House and Senate), Section 3201 to Section 3210. Richards and Walker (2010); O'Malley Watts (2009); Wiener *et al.* (2010).

access to private LTC coverage at a lower price by pooling risks across a broad group because of inertia. It continues, however, to be vulnerable to adverse selection (low-risk insurees choosing to opt out of the insurance pool) which could put upward pressures on premia (or create downward pressures on benefits) in order to maintain the viability of the plan.

Age-related premium structures can encourage early subscription into the plan by requiring late-comers to pay more. They also discourage participants from gaming the system through enrolment and disenrolment because individuals wishing to re-enrol into the plan would face higher premia, reflecting his/her age of re-entry. However, under age-related premia, low and moderate income individuals are generally required to allocate a relatively larger portion of their disposable income on premia in order to maintain coverage.

Evidence from the Eldershield programme with automatic enrolment (Chapter 8) is promising, but the voluntary nature of CLASS creates significant uncertainty with respect to the participation rate as well as the composition of the participants in the pool,

especially over the initial years. Akin to private LTC insurance, the risk is that certain assumptions over enrolment rates might not materialise, translating into significant changes in premium levels.

Despite its limits, the CLASS Act has the potential to broaden access to some basic LTC protection, in a fiscally sustainable manner (the Act requires actuarial soundness for at least 75 years) while encouraging intergenerational equity. While benefits may not be sufficient to cover all the cost associated with dependency, such as board and lodging cost, the CLASS benefit will provide for a basic level of protection to all qualifying participants. By implicitly excluding the current cohort of retirees, CLASS is also in a position to avoid paying significant benefits early into its existence, therefore providing for a window of opportunity to accrue experience over the management of the plan.

9.6. Conclusions

This chapter discussed policies to address the challenge of providing fair protection against the financial risk associated with LTC in a fiscally sustainable manner. As most elderly dependents with relatively high care need likely face catastrophic LTC expenses, fair protection involves an element of universality of eligibility to care, which can be seen as a basic protection floor against LTC risk that potentially all citizens could face. Still, within the confines of a universal protection, important "arbitrages" remain with respect to targeting eligibility, a specific basket of services or the extent of cost sharing.

There is a rationale for targeting protection to the older segment of the population, those with lower ability to pay and those facing severe dependencies. Targeting the basket of services is a difficult exercise because it needs to address users' legitimate requests for users' choice, with appropriateness and flexibility over time. A special challenge will be posed by the growing number of users with cognitive dependencies, who may need a different package of services, relative to recipients with physical limitations, in order to support independent living. Assessment systems typically based on inability to perform activities of daily living may not adequately identify those with cognitive limitations. To address these difficult arbitrages in setting the basket of services and to enhance user choice, including between a formal and a family carer, a number of countries are providing services in the form of cash benefits.

Different considerations apply to board and lodging, a significant element of cost, which, strictly speaking, is not a "care" expense. For frail and disabled people living in nursing homes, expenses associated with board and lodging can be very high and rapidly force users to deplete all their accumulated income and assets. These costs are often not covered by public LTC coverage, or are subject to significant cost sharing where they are covered. While there is a rationale for the elderly dependents to pay for a share of these expenses, users with low and moderate income but accumulated assets may still find it difficult to turn some of these assets *(e.g.,* a house) into cash in order to pay for such expenses. There is therefore a potential role for governments to facilitate mobilisation of cash to help users pay such cost. While outside the scope of this chapter, housing is a major issue for elderly, especially in a context of elderly preferring to live at home instead of moving in a nursing home (Haberkern, 2011). In fact, the supply of suitable housing for the elderly will be central to the development of future housing policies. This is an area that will deserve closer attention in the future years.

As showed in Chapter 7, the way a public LTC system is financed – through dedicated social contributions or through general taxation, has little implications on the way LTC benefits are ultimately structured. In fact, financing mechanisms generally build on existing institutional arrangements or reflects political considerations in raising additional public revenues. Existing institutional arrangements are also reflected in the division of responsibilities between central and local authorities, and the way these arrangements are set can have important impacts on the provision of public LTC services across a country.

Once a basic LTC protection has been designed, the question becomes how financing can be fiscally sustainable over the long-run. All OECD countries have budgeting mechanisms to align LTC revenues and expenditures, but focus is often short sighted, often going from one year to the next. These systems may also have unintended consequences – such as waiting times – or leave unmet needs. Given the expected increase in age-related spending, a set of forward looking financing policies could include elements of pre-funding, extending payments to more generations and broadening of the revenue sources. A number of countries have made progress in this direction, while an innovative approach recently enacted in the United States involves element of pre-funding and the accumulation of reserves.

As OECD countries age, addressing the trade-off between providing for "fair" basic universal coverage and fiscal sustainability will become more urgent. While the allocation of LTC benefits and its financing are subject to differing views and judgment, convergence towards targeted universalism on the benefit eligibility side and broad collective financing on the revenue side have the potential to strike a reasonable balance between these two competing priorities.

To conclude, this chapter focused on structural aspects of designing an LTC system on the benefit and the financing side. Nevertheless – while not neglecting the importance of policies to support and encourage family carers – the expected growth in demand for more and better care call for greater attention to policies to achieve value for money within formal LTC coverage systems. Chapter 10 provides an overview of different approaches.

Notes

1. Figure 9.1 shows the share of disposable income accounted for by a low-care basket of services (*i.e.*, ten hours a week at the prevailing rate per hour of LTC services), excluding public subsidies.
2. Individuals below 65 years of age with age-related (geriatric) disease are also covered under Korea's universal LTC system.
3. See detailed information on eligibility rules in Chapter 7.
4. Assessment includes a physician's report, which provides some personalised information to complement the computerised assessment.
5. For instance, in 2004-05, average board and lodging costs were estimated at about EUR 10 600 in Belgium, EUR 13 700 in France and EUR 21 000 a year in Luxembourg (Hartmannn-Hirsch, 2007). In Belgium, more recent data for 2009 (2nd quarter), points to board and lodging costs being about EUR 14 200 a year (*http://economie.fgov.be*). In Australia, as of July 2010, basic daily fees for residential aged care were set up to about AUD 14 100 a year (Australian Government Department of Health and Ageing, 2010). In Canada, British Columbia, basic client rate is income-related and varies between about CAD 10 750 and CAD 35 200 a year (BC Ministry of Health Services, 2009).
6. See Chapter 7 for details on cost sharing in OECD countries.
7. From the Luxembourg study discussed in Box 9.1.

8. Typically, the value of the principal place of residence is not considered as an eligible asset if the residence is still occupied by a spouse/partner or a child under 16 years of age (*e.g.*, in the United-Kingdom and some states in the United States).
9. Medicaid estate recovery practices vary across US states.
10. As part of its Draft Inquiry Report, the Australian Productivity Commission also recently supported the introduction of a government-backed equity release scheme to cover the costs associated with LTC (Productivity Commission, 2011).
11. In Korea, while the long-term care social insurance covers care services separately, coverage for medical and rehabilitation services remains under Korea's national health insurance system.
12. In 2011, LTC insurance contribution rates will not be subject to an increase.
13. Fiscal-sustainability gap is an estimate of the adjustment needed to a country's primary budgetary position (*i.e.*, revenue minus non-interest expenditure) in order to keep a county's debt level on a sustainable path until some future dates.
14. The sustainability-gap analysis uses the projected changes in age-related expenditure from the European Union 2009 *Ageing Report*. The analysis includes the following spending categories, pensions, health, long-term care, education expenditures as well as unemployment benefits.
15. OECD calculation based on the European *Union Sustainability Report 2009*.
16. Contrary to the pay-as-you go approach, under which younger generations typically pay for the LTC benefits of older generations, full-funding would translate in each generation paying for its own LTC benefits.
17. In Luxembourg, the 2007 increase in the contribution rate from 1 to 1.4% allowed for the building of a reserve, as revenue raised in 2007 and 2008 exceeded expenses incurred by the plan.
18. As shown in Figure 9.6, over the last 20 years, the older segment of the population's share of total disposable income increased in all OECD countries. This reflects both the relatively larger size of this group as well as the relative increase in their level of income compared to the mid-1980s, especially for those aged between 51 and 65 years old.
19. As shown in Figure 9.7, public transfers and capital income, mainly from private pension, represented the bulk of disposable income for those aged 65 and over, in the mid-2000s, with the exception of Japan and Korea where work is an important source of old-age income.
20. These shares are subject to change over time, mainly as a result of changing demographic structure.
21. In Belgium, alternative financing comes from a share of its value-added tax.
22. The contribution is set at a lower amount for persons qualifying for lower co-payments in the compulsory health insurance system.
23. The administration of social assistance falls under the responsibility of the local governments ("Départements"), and the application of the filial obligation (obligation alimentaire) varies among them.

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