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International Perspective on Long-Term Care

Key Points

- Developed countries finance LTC through different combinations of private and public programs, but all face the issues of aging workforces and declining fertility rates.
- U.S. public and private LTC programs provide varying degrees of coverage. Many beneficiaries will need to rely on family, friends, or community support.
- The Dutch established a universal LTC insurance program in 1968 that is available to all citizens. Austria's LTC system is a mixture of social insurance, social protection, and social assistance that provides a combination of cash benefits and in-kind services.
- Germany's public LTC system was once similar to the U.S. system, but the German government replaced its means-tested program with a universal, comprehensive social insurance LTC program.

Defining Long-Term Care

Long-term care (LTC) is health and personal care that is provided for people with chronic illnesses or disabilities. LTC includes support services and assistance for activities of daily living (ADLs), such as eating, bathing, and dressing. LTC can be delivered in the home, in a community, in assisted-living facilities, or in nursing homes.

Worldwide demand for LTC is expected to grow by as much as 400 percent in coming decades because of longevity increases and advances in medical technologies and treatment. While LTC isn't limited to supporting the elderly, the increase in older populations is the primary driver for expanding demand. Different countries vary in the current size and projected future growth of their elderly populations, but they need to design programs that will ensure relative comfort, financial security, and independence for their oldest citizens.

While the projected speed of aging in the Japanese and Korean populations, for example, is faster than that of other developed countries – a problem that is exacerbated by large declines in both fertility and mortality – most of the world is moving in the same direction. The proportions of octogenarians and of populations older than age 65 also are increasing rapidly (see Figure 1).

These trends will lead to mounting national LTC financial burdens. As populations age, LTC expenditures necessarily will grow as a percentage of gross domestic product (see Figure 2). Finding solutions to the looming LTC funding challenge is emerging as a major issue around the world.

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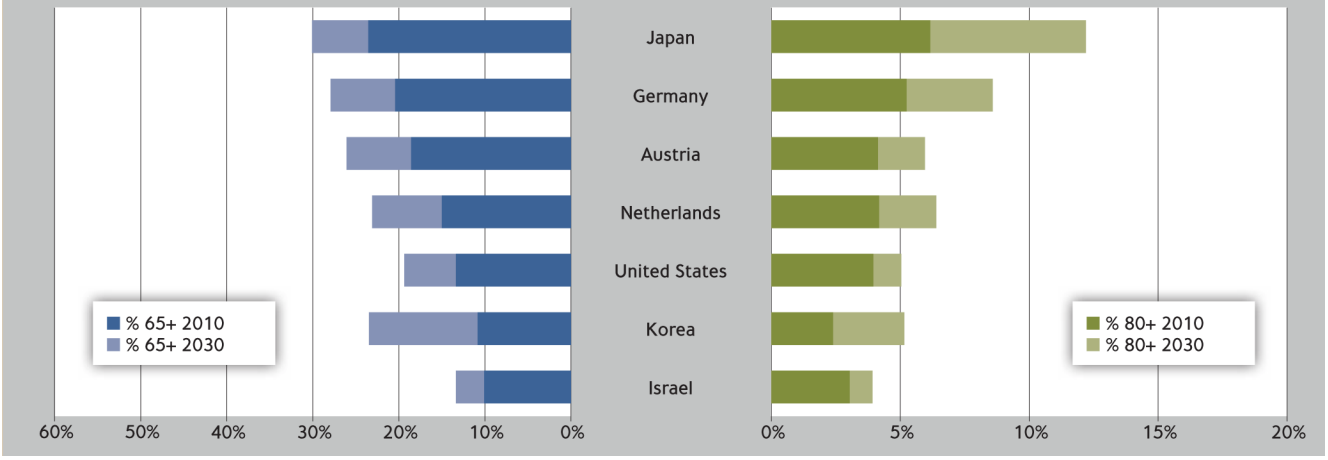
FIGURE 1

Shares of Population Age 65 and Older and Age 80 and Older



Source: U.S. Census Bureau, International Data Base

All existing national LTC systems are organized around varying levels of public and private cooperation. But public financing of LTC is complicated by the fact that declining fertility and an aging workforce are reducing tax revenues at the same time that the financial burden of covering LTC, pensions, and other senior needs is increasing.

Austria, Germany, Israel, Japan, Korea, the Netherlands, and the United States all face similar challenges regarding financing the care of their elderly citizens. While some of these nations have enacted LTC reforms over the past couple decades, their approaches have differed significantly. The American Academy of Actuaries' Health Practice International Task Force has developed this issue brief to explore the similarities and differences with respect to LTC reform in each of these countries.

Program Framework

United States

LTC is financed by a combination of public and private programs in the U.S. Public programs provide limited care, and many beneficiaries must turn to family and friends or rely on community support. Without proper planning, many individuals may find themselves with few options.

Medicare and Medicaid, the two public programs that pay for some LTC services, have different structures and benefit designs. Medicare operates at the federal level only, while Medicaid has both federal and state components.

Medicare is designed to cover acute care services and pays only for medically necessary skilled nursing-home and home-health services – generally for a limited time. Medicare doesn't pay for custodial LTC.

The primary payer of LTC in the U.S. is Medicaid, which has both income and asset eligibility requirements, is funded by a combination of federal and state monies, and is managed by the states. The disparity among states in both their budget resources and coverage decisions is reflected in different LTC services and spending across states.

Private LTC insurance covers a relatively small proportion of the U.S. population. In 2010, 7 million to 9 million people in the U.S. had private LTC insurance. However, private LTC insurance still remains cost prohibitive for many Americans.

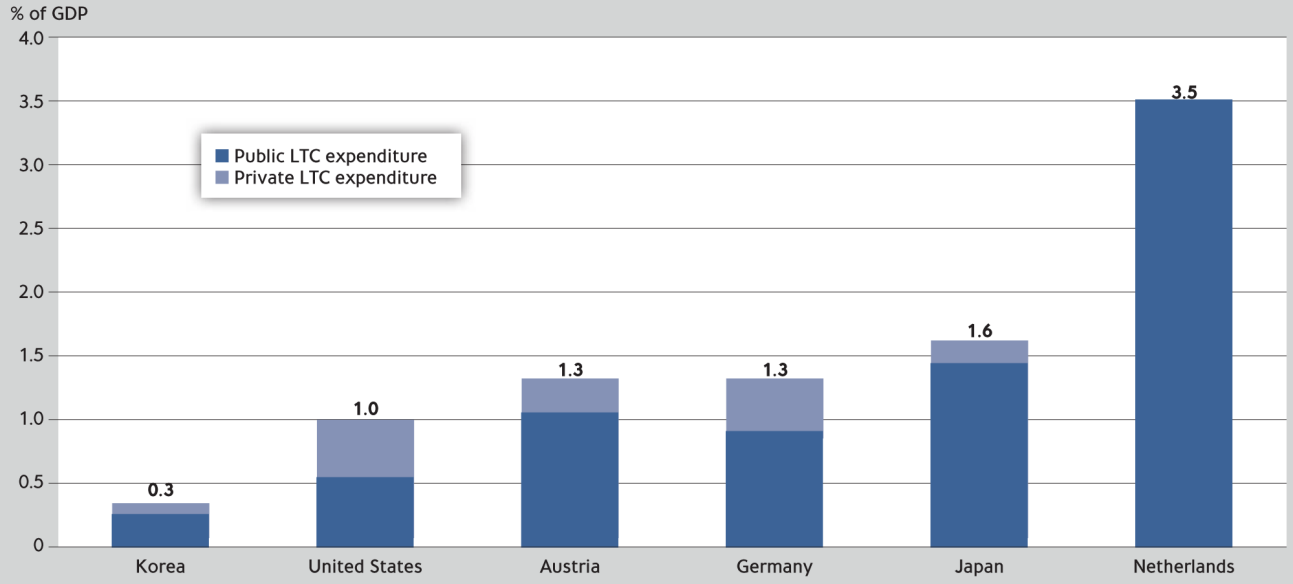
Medicaid offers relatively comprehensive LTC coverage for low-income individuals. Private LTC covers the number of days for nursing home coverage (supplemental coverage for what Medicare covers). As a result, a large portion of LTC in the U.S. currently is provided through informal resources, often in the form of care by family and friends. It has been estimated that 10 million to 11 million Americans living at home received care from family and friends in 2007.

Austria

A universal LTC system that replaced Austria's

FIGURE 2

LTC Expenditure as Share of 2008 GDP



Note: Data for Austria and the United States refer only to health-related LTC expenditure. In other cases, expenditure relates to both health-related (nursing) and social LTC expenditure. Data for Austria and the United States refer only to nursing LTC in institutions. Data for the United States underestimate expenditure on fully private LTC arrangements. Data for the Netherlands don't reflect user copayments, estimated at 8 percent of total LTC expenditure in 2007.

Because of the structure of the Israeli LTC market, comparable LTC expenditure figures aren't available. In this market, about 7 percent of the population is covered by the Israeli National Insurance Institute, and its LTC benefit payments were about 0.5 percent of GDP in 2008. About 52 percent are covered by semi-public arrangements through collective LTC policies held by the four Israeli sick funds and insured by private insurers. About 6 percent are insured by individual LTC policies issued by insurance companies. Data concerning the LTC outlays by the insurance companies aren't available.

Source: OECD Health Data, 2010

unique regional programs was implemented in 1993. While the federal government is responsible for managing and providing LTC benefits, regional governments are involved in establishing benefit levels. Because Austria allows beneficiaries to choose between different care settings, 24 percent of its population older than 65 received LTC at home in 2008.

Austria's LTC system is a mixture of social insurance, social protection, and social assistance. Available only for those who qualify, the element of social protection provides a combination of cash benefits and in-kind services. But all users of LTC services, regardless of age, are eligible for a cash benefit that can be used to purchase formal care services or to reimburse informal caregiving. If a beneficiary's cash benefit, personal income, and assets aren't sufficient to cover the cost of care, social assistance picks up the difference.

Germany

Germany's public LTC system used to be similar to the U.S. system, but reforms were prompted in 1994 by growing financial pressure on states and municipalities, and continuing disparity between the financing of acute care. Before reform, Germany's acute care was covered by universal health insurance, and LTC coverage was available only through a means-tested program. Opponents of the system cited a lack of social equity and parallel coverage.

Germany replaced its means-tested program with a universal, comprehensive social insurance LTC program. While still evolving, the program already has achieved many of its stated goals, which include:

- shifting the financial burden of LTC off states and municipalities;
- expanding home- and community-based services;
- lessening dependence on means-tested assistance; and
- increasing support for informal caregivers.

Both acute care and LTC are administered by sickness funds – quasi-public, quasi-private insurers that are heavily regulated by the government – but acute care and LTC are fiscally

separate. The sickness funds are responsible for collecting premiums, determining eligibility, negotiating fee schedules, reimbursing providers, and enforcing quality of care. While it's possible to purchase expanded LTC coverage through private insurers, less than 10 percent of the German population has private LTC insurance.

Netherlands

The Dutch were the first to establish a universal social LTC insurance program. Implemented in 1968 with the enactment of the Exceptional Medical Expenses Act (AWBZ), the Dutch program is administered by private insurance companies instead of the government. While services and benefits have evolved over time, the original framework largely remains unchanged.

Available to all Dutch citizens, the program is widely popular for eldercare and other LTC needs. Because it's coordinated with the national health insurance system, it covers catastrophic medical costs as well as LTC expenses, including both home health and institutional care.

Given the program's popularity, there's significantly less informal care in the Netherlands than in other countries, and that has increased the Dutch program's financial burden. While private insurance companies manage the program, they don't bear financial risks. The Dutch government is struggling with significant cost increases, driven primarily by the broad range of care that is covered by the program and the large group of people eligible to receive care within the system.

Israel

All Israeli residents since 1995 have been enrolled in a national health program that offers cradle-to-grave coverage, including acute care and hospitalization, but not LTC. The program is financed by a salary-based tax and managed by the four Israeli sick funds.

Approximately 65 percent of the Israeli population has some additional LTC coverage. Among those, 52 percent are covered by collective, three-year renewable LTC policies that are held and managed by the sick funds. These policies are paid for by age cross-subsidized premiums to keep them affordable for older people and to provide three to five years (and in some cases more) of LTC payments. Transfer of membership among sick funds is allowed and, because insurance companies sell the LTC policies to the sick funds, individuals who cancel their sick-fund coverage can retain their private LTC policies without underwriting. About 7 percent of Israelis are covered by the Israeli National Insurance Institute (INII) and its means-based program. The balance of Israelis with LTC coverage hold various private insurance policies. These usually require underwriting, with various durations and provisions, and are far more costly than those offered through the sick funds. In certain segments of the population, including among Arabs, certain religious groups, and kibbutzim (residents of commune-style villages), LTC is more likely to be provided by families and the community.

The Israeli commissioner of insurance has proposed major changes in the LTC market that would affect those not insured by the INII. His proposal urges private and collective policies that would accumulate reserves, which would provide some LTC coverage even when premiums are stopped. The plan would require fixed premiums that don't increase at older ages to prevent overload on retirees, and coverage and benefit payments for life rather than for three to five years. At the same time, the Ministry of Health has lobbied to add LTC to the National Health Insurance Act and finance the program through a salary-based tax of 0.5 percent.

Japan

Providing care and public assistance to elderly is considered a crucial benefit in Japan. All citizens who attain retirement age are required to join the Citizens' Health Insurance plan, a nationally administered program that provides home health and institutional care to the frail elderly. Beginning in 1973, elderly who require care became entitled to free hospitalization without restrictions. Widely used, the program ended up filling almost half of all hospital beds with elderly patients and driving up health care costs. Over time, the national government increased the number of nursing home beds, adult daycare centers, and home health providers to address this costly

phenomenon of "social hospitalization."

Japan has had a universal LTC program based on mandatory social insurance since 2000. While the price and benefit parameters are determined by the national government, eligibility and benefits determination are made at the local government level.

The market penetration of private LTC insurance in Japan is minimal. Most, if not all, private LTC insurance policies sold in Japan are supplemental coverage.

South Korea

South Korea is one of the first countries to implement a social LTC insurance program. First enacted in 2008, the program mostly is a mixture of the German and Japanese approaches. One notable exception is that the South Korean program has uniform contributions and benefits that are rooted in its centralized, single-payer health insurance system. The insuring agency, the National Health Insurance Corporation (NHIC), administers LTC insurance alongside health insurance. As is the case in Japan, private LTC insurance hasn't been a popular option for the South Koreans because they have a rich social insurance program and there is not the need to purchase private coverage.

Benefit Structure

United States

Benefits in the U.S. for LTC vary by program. Medicare primarily covers short stays in nursing homes and some home health care. To be eligible for Medicare, individuals generally must have worked 10 years and be 65 or older. Medicare-covered services are designed to provide care when recovering from an acute illness rather than for long-term conditions. Institution-based LTC is only covered for 100 days (with a significant copayment for days 21 through 100), and home health services are provided on a limited basis only if skilled care also is required. In addition to post-acute care, Medicare covers end-of-life care through a hospice benefit.

Medicaid has historically had a bias toward institutional care but covers both home health and nursing homes. Eligibility generally is automatic for those receiving Supplemental Security Income, but the degree of coverage and type of care offered varies from state to state.

Most private LTC insurance policies cover both institutional and non-institutional care for policyholders who meet an activities-of-daily-living (ADL) or cognitive impairment requirement. Those policies that supplement the social programs in the U.S., such as Medicare-covered services, provide additional care as well as additional financial assistance for the cost of care.

Austria

Austria's LTC benefit is a combination of cash benefits (that can be used for home, institutional, hospice, or respite care) and in-kind services. Eligibility for the cash benefit is determined through an ADL assessment by physicians and other experts. For those who qualify, the need for LTC must be at least 60 hours a month for a period exceeding six months. There is no age requirement.

The benefit amount is based on the level of service and assistance needed. There are currently seven levels determined by need. Age, income, assets, or the reason for care have no effect on the benefit amount, which is considered a legal entitlement and not taxable. The recipient decides how to spend the benefit. In 2009, approximately 60 percent of the population age 80 and older and 10 percent of those between age 60 and age 80 received cash benefits. Monthly benefits in 2011 ranged from about 154 euros to 1,655 euros.

Germany

The German LTC insurance program is available to disabled people of all ages. The program covers both home health and institutional care. The eligibility criteria are established nationally and depend solely on functional status (i.e., ADLs and mental conditions). ADL assessments are performed by doctors and nurses who are employed by the sickness funds. There are three levels of functional limitations, which vary by level of disability. Each level defines the benefits and maximum expenditure per person for LTC. The eligibility criteria for each level are the same for home health and institutional care, and apply to those insured through the sickness funds or private insurance.

The German LTC insurance program recognizes and encourages informal care. Beneficiaries who are receiving care outside of an institution or are living at home may choose to receive a cash benefit instead of services paid for by the sickness funds. Although the cash benefit is less than half of the value of the service benefits, it a popular option for beneficiaries who live at home because its use is unrestricted.

Netherlands

The Dutch LTC system is currently being revised. Previously all LTC for both the elderly and the mentally challenged used to be arranged in the AWBZ. All Dutch citizens were eligible for the AWBZ program with no underwriting. Every request for care, however, was assessed by an independent organization – the Centre for Needs Assessment (CIZ) – that determined whether an individual would be eligible for one or more services covered by the program. These included at-home assistance, personal care, nursing, institutional treatment and stay, and extended stay for psychiatric reasons.

Given the relatively high LTC costs in the Netherlands in comparison to most other countries, the system is changing. The AWBZ ended at the beginning of 2015, and it is being replaced by the Wlz, Wmo, and Zvw. The Wlz is the continuation of the AWBZ for the most critical LTC. It arranges the LTC for the vulnerable elderly and those citizens that need 24-hour care or permanent supervision. The Wlz also arranges care after the first three years for vulnerable people with a mental disability in psychiatric hospitals. The latter care during the first three years is to be covered by the Zvw, which is the regular care and cure insurance system in the Netherlands. The Zvw now also will include coverage for nursing care and general care for the elderly and mentally challenged. Based on the Wmo general assistance, daytime activities and protected housing schemes for the elderly and mentally challenged are arranged locally. These programs will now be part of the national health insurance system, which is executed and covered by private insurers and no longer covered by government funding. In addition to these changes, it is also expected that the coverage will be reduced overall, which means the care that is considered less essential will be transferred to the informal network of family and friends. All of these changes aim to make the system more cost effective by introducing more informal care and more private sector competition.

Israel

Eligibility for LTC support is based on the inability to perform a certain number of ADLs. Those with deficiencies in four ADLs are eligible for full support and those with deficiencies in three (and in certain cases two) ADLs qualify for partial support. Selected physicians and nurses make the determination and follow up to reconfirm the need of the person for continuance of LTC support. Benefits are paid from the collective sick-fund policies and private policies for a limited period of benefits, usually three or five years, although some cases can be doubled.

Benefits cover the cost of a nursing facility or a full-time caretaker. They also can be used to help family members who provide care. The hospitalization and medical needs of LTC patients are covered under the national health program. As noted above, expansion of LTC coverage, structure, and benefits, especially for the elderly, is under consideration by several Israeli government agencies.

Japan

The Japanese LTC insurance program covers both home health and institutional care. But unlike the German and Dutch programs, there's no cash benefit. All citizens age 65 and older and those age 40 to 64 with disabilities are eligible to apply for the program. Eligibility is determined by a comprehensive assessment of medical and physical status, and is re-evaluated every six months. The assessments, which vary by region, are conducted by experts appointed by local governments. If approved, an applicant is allocated benefits based on the level of services required. The Japanese LTC program pays for 90 percent of the cost of care, regardless of the type of service, but doesn't cover medical care.

South Korea

South Korea provides LTC benefits to all citizens age 65 and older, as well as those with geriatric diseases regardless of age. South Korean LTC insurance covers age-related LTC (home health and institutional) but does not provide coverage for disability-related long-term care. The insurance primarily provides service benefits, with cash benefits provided only in exceptional cases (e.g., when no providers are available in a region). LTC eligibility and level of need are determined through statistical analysis of a questionnaire based on ADLs, and assessments are reviewed by a locally appointed committee. Similar to Germany, there are currently three levels of functional limitations, each with a different level of benefits.

Program Financing

United States

LTC is funded through various means in the U.S. Medicare is a federal program funded mainly through a payroll tax. Medicaid is a joint federal and state program funded through general tax revenue. Private LTC insurance is paid for by individual policyholders. Beneficiaries' out-of-pocket costs vary by program. Figure 3 shows the sources of public and private financing of LTC, but the proportion of informal care, while significant, is not included in the chart.

The financing of LTC in the United States is a major challenge, particularly given the aging population and the retirement of the baby boom generation.

Austria

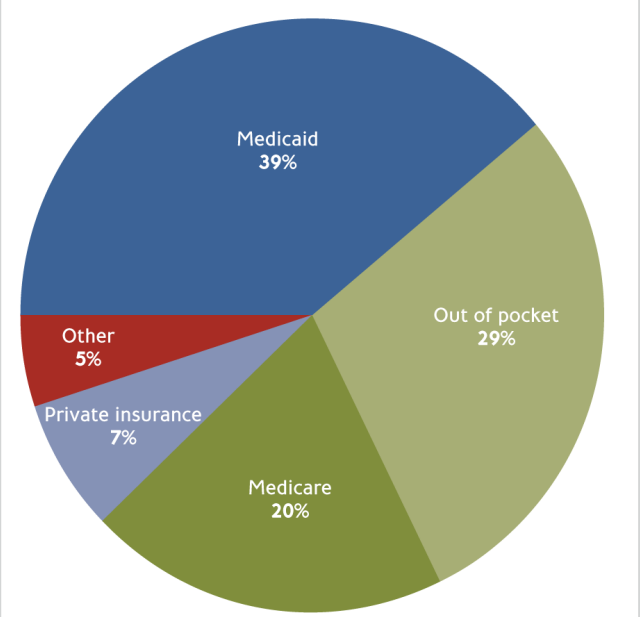
Austrians finance their LTC needs using government cash benefits, personal income, and assets. A wide variation of private copayments exists for home care and residential care.

More than 75 percent of total LTC expenditures in Austria are funded with tax revenues, and the rest funded through private means. Because Austria doesn't have a separate tax for funding LTC benefits, the funds draw on federal and municipal government general revenue. Tax-financed expenses include cash benefits and in-kind services. Almost two-thirds of tax funding is used for cash benefits, with the remainder spent on in-kind services provided through social assistance.

FIGURE 3

2008 Sources of Payment for LTC by Payer

Total payments: $264 billion



Note: Numbers do not add up to 100 percent due to rounding. Private insurance payments include Medigap insurance as well as LTC insurance. Other sources include the Veterans Administration, individual state programs, and private philanthropy.

Source: The SCAN Foundation, 2011

Germany

Germany's LTC insurance program is a pay-as-you-go system funded by mandatory contributions and retiree premiums. The contributions are income-dependent and shared equally between employees and their employers. Since July 2008, the standard contribution for workers with children is 1.95 percent of the first 44,550 euros of income and 2.20 percent of that same amount for workers with no children.

The German government pays the entire contribution for those who aren't working through the unemployment insurance fund. Retirees typically contribute half of the cost of their premiums, and their pension funds pay the remainder.

Netherlands

The AWBZ program is a pay-as-you-go system that is funded through social security

premiums, taxes, and copayments. The social security premium is collected from all Dutch citizens with a taxable income who are at least 15 years old. In 2010, the annual premium was 12.15 percent of income up to 32,000 euros.

In addition to the premiums, the program's beneficiaries are responsible for copayments that are adjusted for income, care setting, and family status. Individuals pay approximately 75 percent of the program's annual cost while general fund revenues cover the remainder.

Israel

LTC coverage in Israel is financed differently depending on the source. The sick funds' policies are limited-term (usually three years) renewable policies, managed by the sick funds but written by insurance companies. Each term is intended to be self-supporting. As a result, premiums increase with every policy renewal. Members of each sick fund are encouraged to join the fund's LTC policy, either as an individual or as a family (including all children younger than 18).

The government's LTC program is an element of the social security system that covers all Israeli residents, and the system also includes pension, unemployment, army annual service period, and other benefits. The program is salary-based, with a sliding scale depending on income, and is paid up to age 70. The level of payments to the INII for LTC is between 0.14 percent of salary and 0.23 percent, of which about half is paid by the employer.

Individual insurance policies are risk adjusted, with premiums based on age, gender, and health risk, and usually require underwriting. Collective LTC policies occasionally are offered to certain groups.

Japan

Japan's pay-as-you-go system is funded through mandatory social insurance, taxes, and copayments. Mandatory contributions levied on all citizens 40 years and older cover about half the costs, while the other half is paid from national and local government tax revenues. Mandatory contributions vary geographically and are means-tested. LTC insurance beneficiaries also bear out-of-pocket costs through a 10 percent coinsurance on all services, subject to out-of-pocket maximums that can vary with income level.

Korea

Korea's LTC program is funded through a combination of contributions from the insured, limited government subsidies, and copayments from beneficiaries. The financing model is built on an existing vehicle established for funding other Korean welfare programs, including ones for health insurance, pensions, unemployment insurance, and workplace injuries. Using the same financing model allows the Korean government to leverage its existing system and provides operational efficiencies. The LTC contribution is paid by the working-age population and is based on a fixed percentage of its contribution for health insurance.

The 2011 health insurance contribution is set at 5.33 percent of wages, 6.56 percent of which goes toward LTC. The two contributions are collected together. Overall financing of the program consists of a government subsidy of 20 percent, copayments of 15 percent (for home health) or 20 percent (for institutional care), and personal contributions that range from 60 percent to 65 percent.

Comprehensive Strategies Are Necessary

Aging populations with growing incidences of disabilities, looser family ties, and more two-worker households are all factors driving the increased demand for LTC. Countries around the world will need to develop more comprehensive strategies to address this multidimensional challenge. This will require reframing existing challenges in a manner that facilitates progressive change to the roles of public and private resources and fosters more innovative approaches.

As countries consider LTC reforms based on their own experiences, it might be helpful to consider a variety of financing arrangements, both public and private. At the same time, all countries should consider continuing to provide incentives and improve support to LTC providers and informal caregivers to ensure quality and access in the face of growing demand.

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