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Long-term care financing: lessons for low- and middle-income settings

Brief 6. Ensuring financial protection in long-term care

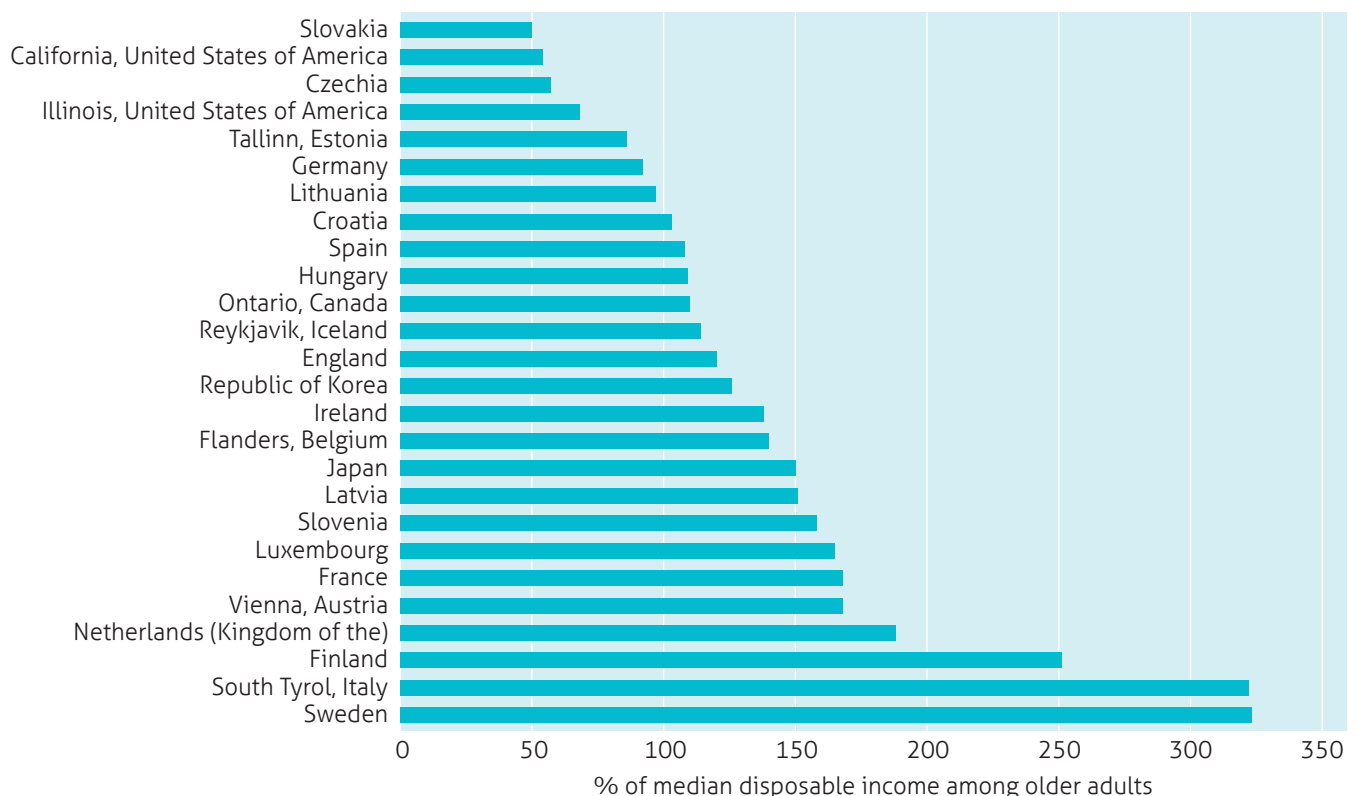
Key messages

- Financial protection in long-term care (LTC) is important because the vast majority of people are unable to save enough money to meet the high costs of accessing needed LTC services as they age.
- Women and low-income people are disproportionately affected by the costs of LTC. Women are more likely to reach older ages, experience care needs for a longer duration and lack resources for care. Those who are poor and those in ill health may have higher care needs that correspond to higher payments.
- Countries that take a universal approach to providing LTC and offer generous benefits may better protect low-income people from high spending in comparison with selective LTC systems that target benefits to low-income people.
- In some universal LTC systems, individual contributions and cost-sharing are linked to the ability to pay; however, there are many challenges in measuring income and assets to implement cost-sharing effectively while ensuring access and financial protection.
- Targeting benefits to individuals with severe disabilities can better protect them from high payments associated with needs for intensive caregiving; health and LTC benefits packages can also incorporate prevention of the conditions driving long-term care use, including dementia and stroke.
- Policies that cap maximum individual payments for LTC and eliminate caps on needed benefits can protect people from very high LTC spending.
- In recognition of the distinct needs of older people, in some settings they receive special entitlements to reduce out-of-pocket payments for needed health and social care.
- Fees for board and accommodation can account for a large share of costs for persons in residential LTC institutions; given that cost-sharing may be expected, low-income older persons may require additional financial support.

Financial protection in long-term care is important because most people are unable to save enough money to access the services needed as they age; older low-income women are disproportionately affected

Financial protection in health and long-term care (LTC) is achieved when direct payments made to obtain services do not expose people to financial hardship and do not threaten their living standards (1). Financial protection for LTC is important because many people underestimate their future needs and the costs of LTC, or mistakenly assume that LTC services are covered under the health system (2). It is often not possible for individuals and households to plan for and save enough money to access the LTC services that they may need as they age. Without systems of financial protection, the costs of accessing LTC are exceptionally high for older adults, even for those with moderate needs (Fig. 1). The Organisation for Economic Co-operation and Development (OECD) reports that in high-income countries, approximately 50% of older people with care needs would experience income poverty in the absence of public LTC systems (3). The same reports finds that some 90% of people with the needs for intensive caregiving would face excessively high payments in the absence of financial protection. This occurs even in settings where incomes and pensions are relatively high.

Fig. 1. Estimates of the cost of home care for people with moderate needs aged 65 years and older as a share of median disposable income in 26 settings, 2023^a



^a The analysis includes countries and subnational areas in the European Union and the Organisation for Economic Co-operation and Development.

Source: Organisation for Economic Co-operation and Development (3).

Formal LTC systems vary in the strength of their financial protection mechanisms. The OECD reports that in seven countries or subnational areas (Finland, France, Germany, Luxembourg, Netherlands (Kingdom of the), Slovakia and Reykjavik in Iceland) public LTC systems guarantee that no

older person experiences income poverty as a result of accessing care (3). However, public LTC systems do not always provide sufficient financial protection to prevent older people from paying high out-of-pocket costs or falling into poverty. In an additional eight countries or subnational areas (Croatia, Czechia, Hungary, Lithuania, Latvia, Tallinn in Estonia, and Illinois and California in the United States of America (USA), public systems do not cover any costs for care for older people earning a medium income who have low care needs. Such systems leave many at risk of income poverty.

In countries without formal LTC systems, high costs are shifted to individuals, families and communities. The impact is more severely felt among women and low-income people. Women are disproportionately affected as they are more likely to reach older ages, experience care needs, lack resources for care and primarily serve as informal caregivers (4). Those who are poor and those in ill health are also disproportionately affected, given that the need for care can correspond with higher payments (5). This may result in an increased reliance on informal caregivers or forgone care.

Countries that take a universal approach to providing long-term care and offer generous benefits may better protect low-income older people from high spending in comparison with selective long-term care systems that target benefits only to low-income people

The choice of population coverage – whether universal or selective – impacts financial protection for older people. The universal approach to LTC is based on the principle of ensuring that the entire population has equal access to services for health and social needs. Selective, means-tested LTC approaches primarily focus on providing services for low-income people. Selective LTC place a major financial burden on those who do not meet the thresholds for low income or low assets but who require LTC. Among countries with formal LTC systems, those with selective approaches face a greater challenge in ensuring effective financial protection. This is because selective approaches may not cover the costs of care for older people earning a medium income who have low or moderate needs for care. As such, many older people are at risk of income poverty and unmet needs (6). In some settings with selective LTC, individuals need to spend down their resources before becoming eligible, which negatively impacts not only these individuals but also family and intergenerational wealth.

Paradoxically, countries that have taken a generous universal approach to LTC coverage and benefits have better protected low-income people from high LTC spending in comparison with countries that have focused mainly on providing LTC services for low-income people. Research suggests that older adults report lower out-of-pocket expenditures for LTC in settings where social protection systems are more inclusive and LTC more affordable for the whole population (7). Systems that are more affordable (even if they are not progressive in their financing approaches) ensure that LTC expenditures remain modest across the income distribution. In systems that are progressive or target benefits to low-income people, lower income households can still incur costs that are large relative to their resources, particularly households that do not meet eligibility thresholds or that face copayments.

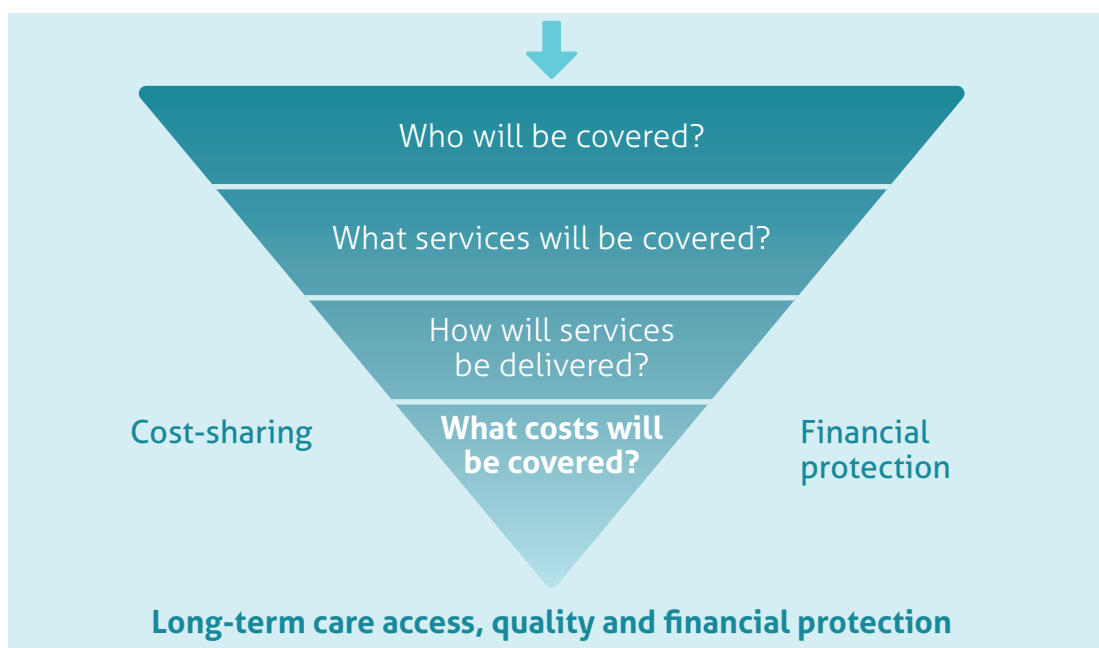
These findings suggest that taking a universal approach to LTC combined with offering relatively generous benefits packages is an effective strategy

to ensure financial protection among low-income people and reduce out-of-pocket expenditures compared with selective approaches that mainly target benefits to low-income people. Universal approaches may also reduce the stigma associated with means-tested programmes that focus on low-income people (8). Such findings are similar to the design and implementation of public health benefits packages in which targeting can be administratively complex or costly, households near the low-income threshold may be missed or beneficiaries face stigma that prevents the use of needed services (9). In recognition that fees linked to utilization are inequitable and disproportionately burden those in ill health, some experts also advocate for the development of more innovative policy alternatives that decouple payments from use (5).

Individual contributions and cost-sharing in long-term care have been linked to the ability to pay to better protect low-income beneficiaries from high payments; however, there are major challenges in measuring income and assets to implement cost-sharing effectively

In some OECD Member States, public LTC systems guarantee that no older person experiences income poverty as a result of accessing care whether through the formal LTC system or in cooperation with social welfare programmes (3). Other established LTC systems – even when universal in their approach – do not fully cover the costs of care. This results in wide variation in the generosity of benefits. As such, the main policy questions presented here concern the generosity of public benefits for the covered population, how countries have determined cost-sharing and the mechanisms in place to protect older persons from the high costs of LTC (Fig. 2).

Fig. 2. What will be covered by public funds?
Cost-sharing and financial protection in long-term care



Source: Figure adapted from Wismar et al. (10).

Many countries implement cost-sharing based on a person's ability to pay. In this way, individual support is targeted to those that are low-income and may have higher needs. Japan is an example of a universal LTC approach that comprehensively targets support to low-income individuals through multiple mechanisms, which has resulted in low out-of-pocket payments (11). Copayments are adjusted to income in Japan. Most users pay 10% of the total fee for LTC services. As levels of income increase, the copayment rises. In 2020, about 10% of users paid 20% to 30% of the total fee for LTC services. Notably, LTC insurance premiums in Japan are also adjusted by income and pension level.

For low-income persons in Japan who cannot afford copayments, the LTC service fee is paid directly to providers by the public assistance welfare system. In 2020, some 1.06 million people aged 65 years or older received public assistance, accounting for 52% of all welfare recipients. While this number is large, it reflects to a great extent the size of the population in this age group rather than the effectiveness of LTC targeting. Notably, older women are overrepresented in the low-income group. As such, cost-sharing related to ability to pay could increase the affordability of formal care among low-income people and older women, who disproportionately experience poverty (4).

Australia applies a means-tested contribution to the cost of LTC care, with the amount deducted from the level of subsidy paid by the government. For the hotel-related costs of residential care (e.g. meals), residents pay a set rate for their basic daily services (85% of the single age pension) as well as fees for any additional services that facilities may offer at market prices such as Wi-Fi and social events. For home care, an income-tested care fee is applied and can result in a reduction to the home care subsidy paid by government, with annual and lifetime caps on the out-of-pocket costs paid by individuals (12). The Netherlands (Kingdom of) also utilizes means testing to set lower rates for LTC copayments for low-income people to provide financial protection and prevent forgone care.

Practically, there are major challenges to measuring income and assets to implement cost-sharing effectively. Income tests typically define a percentage of the care recipient's income that must be devoted to paying for services. Thresholds are identified, and beneficiaries that fall below these thresholds receive public support. Thresholds are difficult to implement in practice as they can be arbitrary and result in people on the borderline losing support for needed care. Assets tests assume that people with high net wealth are able to cover the costs of care from their assets. In these settings, older people may have to deplete their assets to qualify for public support or forgo care to retain their assets (13).

Targeting support to individuals with severe disabilities can better protect them from high payments associated with needs for intensive caregiving; benefits packages can also incorporate prevention and care for conditions driving long-term care use, including dementia and stroke

Out-of-pocket spending is higher for those with who need more intensive LTC. As such, there is reason to identify those who have greater impairments because their caregiving needs incur higher financial costs. Cognitive impairment and stroke are two examples of situations in which people may need more intensive LTC.

Cognitive impairment, most notably in the form of dementia, is a strong predictor of need for LTC (14). Although many people with dementia can live independently, particularly in the early stages, they will likely need support as their condition progresses. For those experiencing more severe symptoms of dementia, there is an increased demand for LTC, including home and residential care (15). In some settings, specific needs assessments in LTC programmes are carried out to determine benefit eligibility based on factors such as cognitive status, mental well-being and the need for complex care (Box 1).

Box 1. Identifying needs for complex care using graded dependency assessments, Australia and Germany

In Australia, if an older person is deemed to require residential care, an independent assessment using the Australian National Aged Care Classification (AN-ACC) system is carried out to determine the complexity of an individual's care needs. AN-ACC classifications are based on a resident's physical ability, cognitive ability, and behavioral and mental health. The level of government funding is determined on the individual's care complexity as well as facility's location and specialization.

In Germany, individuals are administered a uniform needs-based assessment test, which assigns them to one out of five care stages ranging from little impairment of independence to hardship. The stages define the amount of benefits received. The assessment covers six elements: mobility, behaviour and psychological issues, cognitive and communication skills, self-care, coping and dealing independently with illness and treatment-related demands and stresses, planning day-to-day living and maintaining social contact. Germany provides an extra benefit for those with cognitive problems.

Source: Barber et. al (12).

Stroke is another major driver of LTC use. Global estimates predict that among people older than 25 years, the lifetime risk of a stroke is 25% (16). More than 80% of the global burden of mortality and disability from stroke is in low- and middle-income countries (LMICs), and the burden of stroke is increasing faster in LMICs than in high-income countries (17). Ischaemic stroke is the most frequent type and can result in long-term disability.

Importantly, prevention and treatment for conditions driving LTC utilization can be introduced into LTC or health benefits packages. For example, although age is a strong risk factor, dementia is not an inevitable consequence of ageing. An estimated 40% of dementia cases are attributable to 12 risk factors (Box 2) (18). Risk prevention efforts could help prevent the onset of disabling conditions and/or slow symptom progression, which could help reduce the need for intensive LTC services (19).

Box 2. 40% of dementia cases are attributable to 12 risk factors (18)

Vascular and metabolic: obesity, hypertension, diabetes

Behavioral: smoking, excessive alcohol use, physical inactivity, education

Psychosocial: depression, low social contact

Other: hearing loss, traumatic brain injury, air pollution

Similarly, stroke prevention should be a critical part of health and LTC benefits packages given that over 84% of the stroke burden could be prevented (20). Such prevention activities include controlling risk factors for noncommunicable diseases, such as reducing the consumption of alcohol, tobacco, salt and sugar, and controlling high blood pressure (21). Investments in prevention and treatment can help delay the demand for LTC.

Policies that cap out-of-pocket expenditures for individuals and eliminate caps or limits on needed long-term care benefits can protect beneficiaries from very high spending on long-term care

In some LTC systems, cost control and budget predictability are emphasized, resulting in benefits caps or maximum benefit levels in which the government limits the amount of care publicly paid for regardless of need. However, this places LTC beneficiaries at financial risk, and the burden of high payments for needed care is shifted to individuals and families. In effect, those who are most vulnerable and those in need of intensive services face the highest risk. This contrasts starkly with health coverage for which governments typically prohibit benefit caps and apply limits to individual out-of-pocket payments for needed care.

Take the Netherlands (Kingdom of), for example. Generous support for LTC and relatively low LTC copayments are provided for beneficiaries receiving care in nursing homes. However, while monthly copayments are relatively low, the total amount paid can be very high, given that people could spend months or years in nursing home care. As a consequence, beneficiaries can face high financial risks over their lifetime (22).

To protect older people from high LTC spending, it is necessary to cap individual out-of-pocket payments – rather than public expenditures – and eliminate caps or limits on needed benefits for LTC. In some settings, the beneficiary pays for LTC services up to a cap, after which public funds cover the cost of care. For example, in Japan, there is a monthly cap on copayments after which the costs of entitled benefits are covered by public funds. Australia applies annual and lifetime caps on out-of-pocket costs paid by individuals for home care. In Sweden, in addition to very low cost-sharing with beneficiaries, a ceiling is set annually by the government, representing the maximum amount that a recipient can be charged. This may be further reduced if the recipient's monthly income is below the minimum cost of living. Within these rules, each municipality determines their own schedule of cost-sharing for recipients (12).

In recognition of the need to protect individuals from high and poverty-inducing LTC expenditures in England, a lifetime cap on contributions was established in 2023 (23). This cap limits the amount that any person in England will need to spend on LTC (US\$ 108 000), after which costs are covered by public funds.

Countries have implemented special entitlements for older people to reduce out-of-pocket payments for needed health and social care

In some settings, there are special entitlements for older persons in recognition of the need for financial protection in accessing needed care. In Australia, most older adults are eligible for a Pensioner Concession Card. Those holding this card or other concession cards are entitled to

substantially reduced copayments for prescription medications included in the Pharmaceutical Benefits Scheme (PBS) and a lower threshold to reach the PBS and Australian Medicare safety nets (Table 1). For concession card holders, an incentive is paid to general practitioners to provide consultations with zero copayments, with a higher incentive payment in rural areas. General practitioners are permitted to use bulk billing, which results in no out-of-pocket costs for patients. Health providers charge the regulated prices in the Medicare Benefits Schedule directly to the government for these services.

Table 1. Entitlements and copayments for holders of the Pensioner Concession Card compared with the general population, Australia, 2024^a

Category of care	Pensioner Concession Card ^a	General population ^a
Prescriptions		
PBS regulated medicines	5.10	20.93
PBS safety net threshold	183.64	1091.73
PBS co-payment once qualified under safety net	0	5.10
Incentive payment per GP consultation for providers to charge zero copayments to patient		0
	13.68 (metro areas)	
	26.25 (remote areas)	
Medicare safety net threshold for out-of-hospital services	537.82	1685.60
Copayments for those who reach Medicare safety net threshold	Up to 80% of copayments covered by the safety net for the remainder of the calendar year	

PBS: Pharmaceutical Benefits Scheme; GP: general practitioner

^a Prices in US dollars: Aus\$ 1.00 = US\$ 0.66.

Source: Government of Australia (24, 25).

In Australia, to qualify for either the PBS or Medicare safety net, beneficiaries must incur a specified amount of out-of-pocket costs. Once they qualify, the person and their household are entitled to additional benefits that will reduce their copayments for the remainder of the calendar year. Concession card holders face a much lower threshold to qualify for benefits, representing less than 20% of the threshold for the general population. In 2020, the Australian government spent around US\$ 4 billion on concession card entitlements, with the majority spent on prescriptions. This accounted for around 80% of total government expenditure on prescription medications. Those aged 65 and older account for 29% of consultations with general practitioners but are only 15% of the population (12).

In France, a declaration of *longue maladie* (i.e. a medical condition that requires LTC) provides beneficiaries with 100% financial coverage from the national insurance fund, including no copayment on all or certain services associated with the medical condition (12). Recently, Austria has abolished copayments linked to assets for institutional care, making this care option more affordable to lower-income individuals. Prior to its abolishment, the thresholds for exemption from payment were set at low levels and thus low-income individuals faced high payments disproportionate to their income (5).

Fees for board and accommodation can account for a large share of costs for those living in residential long-term care institutions; given that cost-sharing may be expected, low-income older people need additional support

The costs of residential LTC can be high and may dwarf the costs incurred for personal care and nursing, particularly if board and accommodation are included. Board and accommodation costs (i.e. primarily covering food and shelter) may represent up to half of the total costs of care in residential facilities and can result in very high spending because some people spend one year or more in these facilities (3). For low-income individuals, many countries offer additional means to cover the costs of accommodation and board.

In OECD countries, financial support may be offered to low-income persons under an LTC programme, and this may be subject to means- or assets-testing, or both, such as the case for the Medicaid programme in the USA. In other settings, board and accommodation are considered a housing expense, and the costs for persons in residential LTC institutions are treated separately from the determination of LTC needs. In these settings, such support may be covered under separate social assistance programmes, such as it is in Japan (11).

Implications for low- and middle-income countries

Protecting individuals from high out-of-pocket costs for LTC requires investments in systems and policies to ensure financial protection. In many LMICs where no LTC system exists, the cost burden is shifted to the family and community. Research suggests that low-income individuals are better protected by LTC systems that are universal and generous in their approach as compared with means-tested systems targeting benefits to low-income people that require individuals to be in poverty or spend down their resources to qualify for support. In LTC systems where cost-sharing is implemented, copayments can be linked to the ability to pay to better protect low-income individuals. However, in practice the mechanisms to identify low-income people to determine eligibility can be complex to administer and identifying those in greatest need of financial protection can be difficult. Individuals with complex needs – such as those with dementia or who have had a stroke – can be targeted for coverage, given that they face high payments associated with their needs for intensive caregiving. This is particularly important in LMICs where the burden of both conditions is projected to increase, and prevention for these conditions could be incorporated into health and LTC benefits packages. Policies that cap

maximum LTC payments for individuals and eliminate caps on needed benefits can reduce the risk of high spending among beneficiaries and ensure they have access to needed care, particularly for the most vulnerable groups that have intensive care needs for a longer time. Some countries have implemented special entitlements for older people to increase their access and reduce out-of-pocket payments for needed health and social care. These may include providing support for board and accommodation costs for persons in residential LTC institutions. In LMICs, investments need to be made to strengthen institutions and policies to protect families from high LTC spending or forgone care.

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