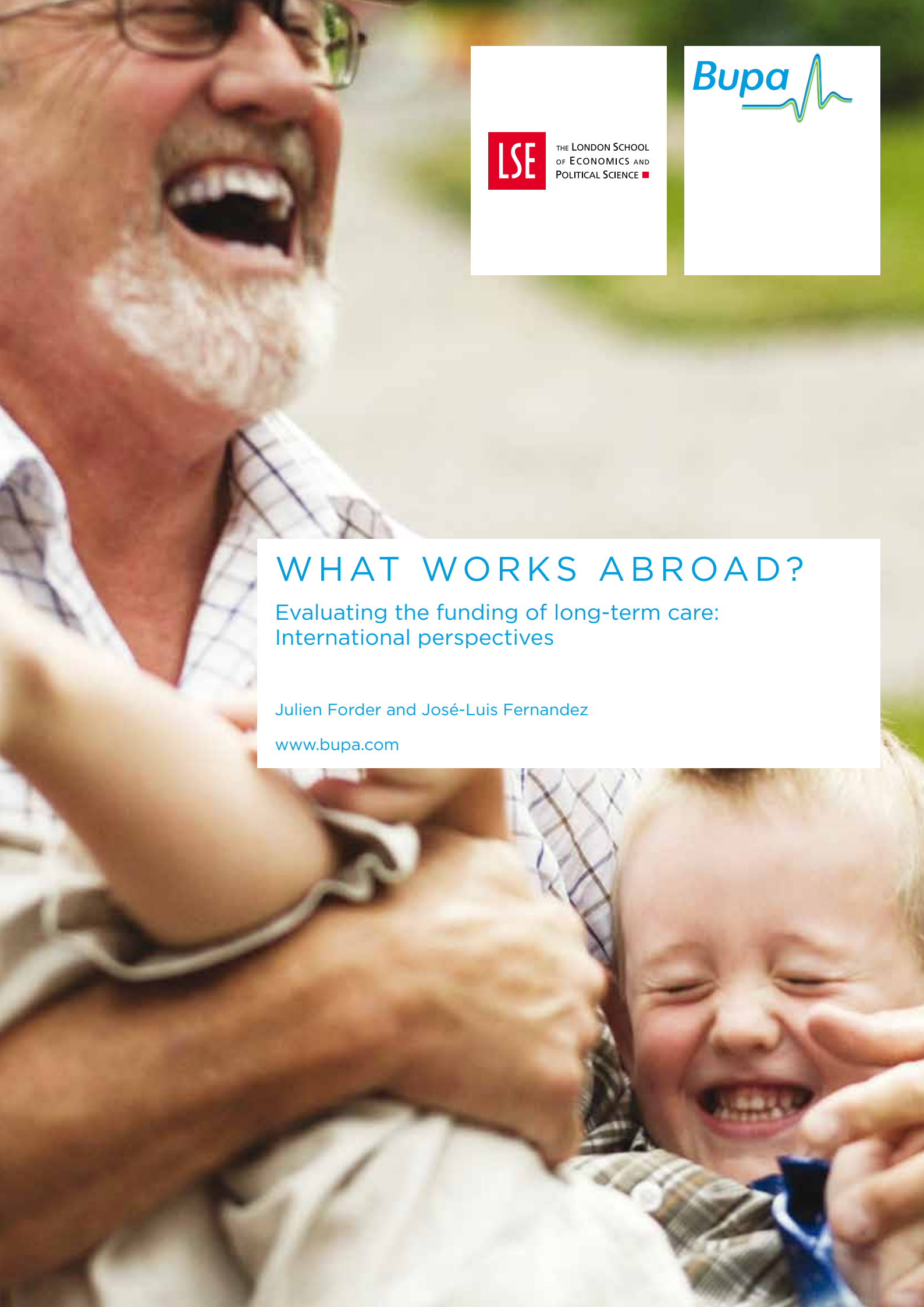

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WHAT WORKS ABROAD?

Evaluating the funding of long-term care: International perspectives

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CONTENTS

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1. EXECUTIVE SUMMARY

The arrangements for funding long-term care for older people in England have remained unchanged in principle since the 1948 National Assistance Act. In recent years, a Royal Commission, a number of influential policy reviews and Green and White Papers have recognised the failings of the current system but have been unable to produce a workable consensus about the shape of any reform in England. The Dilnot Commission is currently investigating the issue and will put forward policy recommendations to Government in the summer.

The aim of this paper, commissioned by Bupa, is to inform the debate about the most appropriate way to reform the funding system in England, learning from the international experience, and in particular from the recent and on-going reforms in Germany, Japan, France and Australia. The experience of these countries is most relevant because their starting point for reform was similar to the current situation in England.

In its first section, the paper argues that achieving efficiency, equity and sustainability should constitute the main objectives of any reforms. It then provides an overview of the funding systems in the four countries examined. Germany, Japan and France have all implemented state-run social insurance arrangements for long-term care, although there are some differences in the exact design of these arrangements and in their core philosophy. Under these long-term care insurance (LTCI) arrangements all people covered by the system (often the whole adult population) are required to pay regular contributions either as taxes or mandatory insurance premiums. In return, should the insured person develop a care need they become entitled to support from the system – either as services or cash allowances – regardless of their income. These are universal systems in that everyone is covered.

Currently in the midst of reform, the Australian system is characterised (as is presently the case in England), by a means-tested, tax-funded long-term care programme which targets help on poorer people. These are non-universal systems because wealthier people are not covered by the public system and generally have to make their own private arrangements for any care costs.

A number of implications for reform in England are drawn from the experience of these four countries:

- **There is an important debate about who should bear the responsibility over accommodation costs in residential care**. In Japan, accommodation costs were initially covered on a universal basis, but later this was felt to be too expensive. Financial help was instead prioritised on a means-tested basis. Similar arrangements exist in Germany and France with wealthier people largely expected to pay accommodation costs themselves.

- **Even if wealthier people are primarily responsible for accommodation costs, there are public policies that can help**. State-run or state-backed annuity-type arrangements can give people an income stream from their assets specifically to meet accommodation costs. In Australia, accommodation bonds are used: residents invest a lump-sum with the care home provider who then gets revenue from the interest and also by retaining an amount of the principal when the bond is repaid.

- **Social insurance systems give service users a right or an 'entitlement' to a pre-defined level of support (in services or cash) depending on the person's need**. These systems often also have defined contributions (premiums or taxes). Building in flexibility to adjust the benefits provided or the level of contributions required is important to guarantee these systems' sustainability.

- **Sustainability** – both financially and politically – also appears best served where contributions to the insurance system are made, at least partially, by those most likely to benefit from this insurance (e.g. older people). In Japan, contributions to the system are made by both over 40s and over 65s.

- **Small co-payments at the point of need can help limit excess demand for services**. In Japan, service users pay 10% of the care cost, with the remainder paid by the social insurance fund. Co-payments can deter people with a relatively low willingness-to-pay (i.e. low preference) for formal support.

- Because an entitlement to support in insurance systems needs to be defined explicitly and objectively, **informal care** is usually ignored during the needs assessment process. This can mean that someone with significant informal care is entitled to the same level of support as someone with no such help. In Germany, people can opt for a cash payment that can be used to pay family carers, but the value of the cash payment is set at half the value of the service option. This allows the (indirect) targeting of resources to reflect informal care levels.

- **Social insurance systems vary according to the amount of care costs they are designed to cover**. In France and in Germany only part of the cost of care is expected to be met. In France many people use private LTCI to cover the remaining costs. The state can help promote this practice e.g. by giving employers an incentive to bundle this insurance with employee remuneration packages as often happens in France. Linking LTCI to pensions is another option.

- **Universal systems insure people against care costs depending on the way they target state support**. Different levels of support can be provided for different types of people, or for different levels of costs. Focusing on the risk of incurring higher than expected care costs once a need for care is established (tail-end risk) is cheaper than covering total costs, which also includes the risk of a care need developing in the first place. Covering tail-end risk helps people protect their assets but can still lead to under-consumption of care (so called unmet need).

Overall, the experience of countries with social insurance systems suggests that some form of universal funding arrangements in England could lead to important benefits. But achieving greater coverage of the population is not without a price. Such a reform would require, following the Japanese experience, higher contributions in the form of general or earmarked taxes. Alternatively, to cover more people within the same envelope of total public funding, the amount of public support would need to be re-distributed away from high need and/or most poor groups, as in the German example. Whereas either option poses important challenges, it is worth reflecting that many other countries appear to sustain higher levels of per capita spend on care than in England.

2. INTRODUCTION: AIMS OF THE PAPER

The arrangements for funding long-term care for older people in England have remained unchanged in principle since they were laid down in the 1948 National Assistance Act. In recent years, a Royal Commission, a number of influential policy reviews, and Green and White Papers have recognised the current failings of the system but have been unable to produce a workable consensus about the shape of any reform. The Dilnot Commission is currently investigating the issue and will put forward policy recommendations to Government in the summer.

Part of the problem is that any reform needs to be made in the context of the complexities and inherited principles of the current system. Nonetheless, starting from a similar context, a number of countries have been able to implement fundamental reforms. Germany implemented a (mandatory) social insurance system for long-term care in 1995; the Japanese equivalent was introduced in 2000; and France reformed along similar lines in 2002. Major reforms have been undertaken in Austria, Spain and Israel. In social insurance systems the people covered by the system (often the whole adult population) are required to pay regular contributions either as taxes or mandatory insurance premiums. In return, should a person develop a care need they become entitled to support from the system – either as services or cash allowances – regardless of their income. These are universal systems.

The Community Living Assistance Services and Supports (CLASS) Act was implemented in 2010 in the US, and aims to create a voluntary public insurance system for long-term care. Other countries are deep in the process of determining how they should reform; Australia is an example. At present Australia has a comprehensive tax-funded program for long-term care but support, as in England, is given on a means-tested basis i.e. prioritising help for poorer people.

The aim of this paper is to inform the debate about possible routes for reforming funding arrangements in England, learning from this international experience and specifically from that of the social insurance arrangements in Japan, Germany and France. The aim of the paper can be summarised therefore as evaluating the benefits and challenges involved in moving towards some form of universal system of funding. A social insurance system is an example of a universal system but not the only example. The Scandinavian countries operate universal tax-funded arrangements where public authorities provide care and support to all with little or no charge, funded out of general taxation (generally without a pre-defined entitlement to care). But the experience of the social insurance countries is more relevant because their starting point for reform was very similar to where England is now.

We also look at the Australian system as an example of a different means-testing system to reflect on whether English reform might best take the form of adaptations to current arrangements for means-testing in England.

The paper is structured as follows:

- **Section 3** outlines the aims and objectives that might guide the choice of funding arrangements for long-term care.
- **Section 4** summarises some key choices facing decision-makers in the way that long-term care funding systems are configured. This will frame an overview of the main features of the comparator countries, summarising coverage, funding and operation.
- **Section 5** discusses the benefits and costs of implementing some form of universal care funding system, drawing particularly on the experience of mandatory social insurance arrangements in Japan, Germany and France. This discussion will be framed by the criteria outlined above (efficiency, equity and sustainability).
- **Section 6** discusses the implications for reform in England, concluding with some views about whether to introduce more universal insurance arrangements.

3. AIMS AND OBJECTIVES OF A LONG-TERM CARE FUNDING SYSTEM

3.1 Equity

Ensuring that care funding systems are equitable is an important policy goal. At a fundamental level there is an aspiration that care and support systems should achieve equal access to support for people with equal need, where 'need' takes into account the physical and mental dependency of the individual and their carer.

A common implication of an equity goal in long-term care systems is that a person should not be denied access to critical support because they are unable to pay for care themselves. Addressing issues of affordability of care for lower income groups is therefore a key policy priority, as is tackling potential inequalities in access by population sub-groups (e.g. by gender). Affordability can be hard to judge, however. Equity might be undermined, for instance, if a system is so pro-poor that moderate income people have no public support and are unable to afford the full costs of (private) care themselves.

Even more challenging questions are the extent to which people should be required to contribute more to the financing of services from the wealth they have accumulated throughout their lives, or whether individuals should receive less support if they have access to informal care support. Whereas people with access to informal care are less dependent on formal services, providing informal care is often very challenging and can lead to negative health and employment consequences for carers. Deciding the extent to which funding rules take into account informal support requires therefore judgements to be made as to the optimum balance of responsibilities between the family, the community and the state more broadly.

Inter-generational equity considerations should also be made. In collective funding systems, working age adults often contribute the majority of the resources for financing care, with the implicit expectation that they will be helped if they develop care needs in old age. But economic prosperity can be quite different between generations, as can the 'dependency ratio' of working age people to older people in the population. Working age adults at present are paying for the care of relatively wealthy (baby boomer) pensioners, for example. This problem is lessened when people in the older population are contributing to a reasonable degree to the costs of their own generation's care.

3.2 Efficient use of resources

A care system should get the best value from resources. This principle requires that resources are used where they give the greatest benefit (allocative efficiency), and that services and support are produced at the lowest cost for the required quantity and quality (technical efficiency). This efficiency principle has a range of implications for the design of funding systems. Principally, market failure problems are likely in unregulated care markets and will lead to under-consumption of care and under-use of insurance.[1] Examples of relevant market failures are 'risk neglect' where people under-estimate their care needs and 'adverse selection' where with better information about their own risks than insurers, high-risk people can raise the average price of premiums, driving out low-risk people.

Public intervention can help to address market failure. Social insurance systems, for example, in requiring that people are covered against cost risk, yield insurance benefits and mitigate the problem of private under-insurance. But there are also reasons why efficiency can be compromised in a publicly-funded system (Forder 2002). Public authorities may not be sufficiently responsive or motivated to produce support at least cost. Information problems also apply: public agencies may not be able to accurately measure what constitutes 'greatest benefit', allocating resources inappropriately. They may also lack information about people's needs and preferences leading to over-consumption (moral hazard).

In practice, any collective system for funding care will need to have regard to the incentives it creates when determining charging rules; in terms of what income and assets are means-tested; the form of monetary and non-monetary arrangements that are used to overcome risk neglect and so on.

In some means-tested systems the value of the user's house is taken into account when calculating residential care charges, but excluded from the calculation of care charges for community-based support. This differential treatment of housing assets can generate perverse incentives in favour of institutional care from the point of view of the state, and an incentive against residential care from the point of view of service users.

[1] In theory, perfectly functioning markets can achieve allocative and technical efficiency by both motivating people (giving them the right incentives) and co-ordinating their behaviour (through a price system) (Milgrom and Roberts 1992). But markets are never able to function perfectly in practice, including in care systems (Forder, Knapp et al. 1996). Information and structural problems cause under-consumption of care by individuals.

Funding systems should support diversity in the supply of services to ensure that a range of services are available to cater for the different circumstances, wishes and preferences of services users. Effective interaction between public services, such as between health and social care services should also be encouraged.

3.3 Sustainability of the social care support system

Self-evidently, social care funding systems need to remain financially solvent and also to continue to command public and political support. The sustainability of a system in this sense will be affected by at least three factors:

- People's perceptions of its **fairness and value**, set against the cost (affecting political sustainability).
- The **affordability of the system** to the public purse. Affordability is a relative concept but the system needs to ensure that the costs of the system stay generally in line with societal willingness to pay for its benefits.
- The system's **capacity to adapt to changes** in circumstances to remain solvent. For example, both the willingness and capacity for the country to cover the costs of the system may change with economic prosperity; a sustainable system will be one that adapts quickly to the fiscal position of the economy and to perceptions about the value of care and support for older people.

4. FUNDING ARRANGEMENTS

4.1 Configuration

Social care funding arrangements can be differentiated along a series of key design dimensions (Brodsky, Habib et al. 2003; Wanless 2006):

- The degree to which the provision of care is primarily a state responsibility or a private (family) responsibility. State responsibility implies some form of collective funding of care services and also mechanisms for publicly-funded support or services to be allocated to individuals. It will also involve some re-distribution in that the amount of publicly-funded care and support that people receive will not be directly linked to the financial contributions they have made. Wealthier people and those people who do not end up needing much care will subsidise poorer people and those who are less fortunate and do go on to develop substantial care needs.

In that informal care will always be an important part of care provision, some private responsibility is always implied.

- Whether the (public) system is set up around an **entitlement principle or is budget-constrained**. With the former, anyone who fulfils the prevailing criteria has a (legal) right to receive public support even if this puts the whole system into deficit. By contrast, in a budget-constrained system public authorities are allowed to change the criteria at any time in order to balance the books.

- The **degree of risk pooling/insurance** in the system. Of central importance is the basis for coverage. Does the system cover the risk of anyone needing care (full social insurance) or just the risk of people needing care who could not otherwise afford to meet care costs themselves (a safety net)? Also, are people required to contribute and be insured on a mandatory basis or can they enrol into the system on a voluntary basis?

- Is the system **targeted at specific populations** e.g. long-term care costs incurred by older people or perhaps the whole population?

- The **nature of the contributions** that need to be made e.g. is it general taxation or through hypothecated premiums. Also, the degree to these funds are supplemented by charges or co-payments made at the point of need.

- Whether **financial eligibility conditions** apply and need to be satisfied in order for people to get publicly-funded support.

- The **scale of benefits** (relative to the costs of care) and the form those benefits take.

- The use of **demand-management arrangements** e.g. mandatory co-payments that need to be made before people get benefits.

- Arrangements for the **provision of support**, such as: the explicit use of pre-defined criteria and scoring of need rather than individual care management; how far eligibility is determined locally; the degree to which informal care availability affects the benefits provided by the system (i.e. whether it is carer sighted or carer blind); whether cash payments can be used rather than just services; and if people are allowed to top-up the benefits they receive with their own resources or not.

4.2 Current international systems for long-term care funding

Table 1 summaries the main features of the four comparator countries plus England according to the dimensions outlined above. Full details for each country are given in Appendix I.

4.3 Japan

Japan's compulsory public LTCI system (Kaigo Hoken) was implemented in April 2000. It is a mandatory system covering the whole population from 40 years and older. The scheme mixes contributions from general taxation (both nationally and locally) and also from specific age-related premiums: roughly one half of revenues are from taxation, a third are from premiums from people aged between 40-64 (at a rate of 1% of income) and a sixth from people over 65 (according to a fixed tariff of premium rates).

Recipients are required to make a 10% co-payment (reduced on a mean-tested basis for lower income people). The LTCI scheme is primarily designed to cover the care needs of those aged 65 and over; for adults aged 40-64 the system only covers long-term care needs arising from age-related disease (such as dementia, osteoporosis and Parkinson's disease). The insurance benefits are designed to cover the total costs of care and are high by international standards. They vary according to the person's assessed need being classified into seven levels (five care support and two preventative). Assessment is carer blind. In 2009 benefit rates for people in institutional care ranged from around £1,500 to £3,250 a month (at current exchange rates). The value of home and community care services ranged in 2009 from around £380 to £840 per month for the preventative levels 1-2 and £1,270 to £3,000 per month for care

TABLE 1

Comparing funding systems – key dimensions

	Japan	Germany	France	Australia	England
Responsibility	State	State plus private top-up	State plus private top-up	State and private	State and private
Entitlement or budget-constrained	Mainly Entitlement	Entitlement plus budget constrained social assistance	Entitlement plus budget constrained social assistance	Budget constrained	Budget constrained
Risk pooling	Mandatory social insurance	Mandatory social insurance	Mandatory social insurance	Safety-net (high level coverage)	Safety-net (moderate coverage)
Population coverage	Adults over 40, main benefits to over 65s	All ages	Adults 60+	Older people	Older people
Financing/ contributions	Income-based premium at 40-64 & at 65+, local and general taxation	Income-based premium, paid by all working age and retired population	General revenue	General revenue	General revenue
Eligibility	Universal, eligibility after 10% means-tested co-payment; carer blind	Universal, eligibility plus means-tested social assistance; carer blind with selection	Universal, eligibility, means-tested top-ups; carer blind	Means-tested, carer sighted	Means-tested, carer sighted
Benefits	Service only; high level of support	Services and/or cash; moderate support	Voucher; 10% to 100% sliding scale of support	Services; high level of support	Services and/or cash; moderate support
Organisation and management	Municipalities (LTC Depts)	LTC funds (alongside sickness funds)	Voucher; 10% to 100% sliding scale of support	High public subsidies: Federal and State	Local authorities

levels 1–5. Unlike in many other countries, there is no cash option and benefits must be taken as formal services in kind. The design philosophy of the system is that it helps to substitute for informal care rather than complement informal caring as in Germany.

At the onset of the scheme, accommodation costs in care homes were covered but, in 2005, reforms aimed at controlling the overall costs of the scheme changed the basis of support for these costs from a (full) entitlement basis to a means-tested basis. Presently, on average, about half of accommodation costs are paid by the scheme, varying with income. The 2005 reforms also re-defined (and reduced) levels of support for lower-needs groups. Before 2005, low-need people received care services whereas now they receive (cheaper) preventative services.

In 2010, just over five million people were eligible for benefits, equating to 17.2% of those insured. However, 20% of those eligible did not choose to receive benefits, which is partly attributed to the co-payment and also the service-only nature of benefits. After implementation in 2000 the numbers of beneficiaries increased rapidly but the growth rate fell back after the first three years or so to a rate close to the growth rate of the over 75 population. Mirroring these trends, expenditure increased at a high rate initially. In 2000 the 4.3 trillion Yen budget was under-spent with expenditure at 3.6 trillion Yen. But the 5.5 trillion Yen cost originally forecast for 2005 was far exceeded, reaching 6.8 trillion Yen. Since the 2005 reforms however, expenditure growth has fallen back so that expenditure per head of population over 75 has remained broadly constant over time.

4.4 Germany

Germany's universal, pay-as-you-go social insurance for long-term care has been in place since 1995, with a headline premium rate of 1.95% of income for working age adults (shared equally between employers and employees). Lower rates are paid by pensioners, students and unemployed people. Its introduction recognised long-term care needs as a 'social risk' that ought to be covered collectively and in such a way as to minimise individuals' reliance on social assistance (social security benefits) in order to meet social care costs. Overall, and in contrast with the Japanese case, the German social insurance system is built around, and depends on, the care contributions of informal caregivers, with strong cultural (and legal) expectations that the bulk of the support should be provided by family members. This reliance on caregivers is reflected in the 0.25% extra insurance contributions required of childless individuals (who are less likely to receive informal support), and on the reduction in the value of the benefits when taken in cash rather than services, an option chosen by approximately four out of five cases and typically used to compensate family members for the care they provide.

Although universal, the levels of support in the German system are relatively modest, its explicit aim being to contribute towards rather than to cover fully care costs. The expectation is that the shortfall in resources will be made up by the dependent individual or through the contributions of informal caregivers. As a result, and despite a significant fall in the number of people relying on it, many people still need (means-tested) social assistance from their Länder (federal state).

Eligibility for support is determined on the basis of an algorithm which defines three levels of support, depending on the frequency with which assistance is needed with personal care activities, housekeeping and chores, and the amount of daily care provided by an informal carer. Levels of support are much lower than in Japan and range between approximately £370 and £1,280 per month for services-in-kind in the community, and between £870 and £1,280 per month in residential care (individuals are responsible for accommodation costs incurred in residential care). As indicated above, levels of support in cash are worth approximately half of the value of the services in kind. Since 2008, extra support has been made available for people with cognitive impairment to cover some of their 'supervision' needs.

Overall, the introduction of the national insurance system has led to an increase in care recipients, and to reductions in the reliance on means-tested social assistance. It has also spurred the growth of the supply side of the system (and particularly in the community), with more and more-varied types of services emerging as a result. Services remain, however, significantly more 'medicalised' than in the English system.

As in many other countries, the growth in expenditure following implementation largely exceeded original expectations. This led to a 13-year freeze in cash terms of benefit levels and to significant erosion in actual levels of support. New contribution rates and levels of payments were set in 2008 and whereas the system currently is not in deficit, concerns persist about whether these rates are sustainable.

4.5 France

As in Germany, the introduction in 2002 in France of the Allocation Personnaliséed' Autonomie (APA) was precipitated by the view that the risk of developing long-term care needs should be addressed collectively. The APA is funded through general taxation but implemented at a regional level. Access to the system is universal as with the German and Japanese systems, but the amount of support people receive is dependent on their financial means as well as their level of assessed need. In this way people are entitled to state support, which ranges from 90% to 10% of the assessed care costs depending on the income and assets of the service user. Overall, the taper linking charges to resources is steep, which means that many service users are responsible for a large proportion of their care charges (on average in 2008, the APA covered around two-thirds of the personal care component of the care package).

In the APA system, needs eligibility is restricted to people over 60 years of age. It is defined on the basis of a specific assessment scale (the AGGIR) that has five levels of need taking into account individuals' capacity to perform activities of daily living and their mental health state. The maximum level of support ranges from approximately £410 to £970 per month for the GIR 4 and GIR 1, respectively the lowest and highest need groups entitled to support. Once the maximum level of payment is set, a care plan is designed by a team of medical and social care professionals together with the service user. Although service users enjoy considerable freedom in their choice of support services, APA resources cannot be received as a direct payment or used to pay a spouse. In residential care, individuals are responsible for their accommodation costs, supported by means-tested social assistance if they lack sufficient funds.

In addition to the support provided through the APA, the French system offers incentives for individuals to pay for care privately, with people able to partially count these expenditures to offset their income tax liabilities. These are particularly effective for higher income people, who by definition receive the lowest levels of state support through the APA. With the aim of encouraging the employment of personal and domestic staff in the home, families can deduct from their income taxes half the cost of employing declared workers, up to £10,200 per year (this excludes support purchased through the APA). In residential care, the costs of long-term nursing or residential care are eligible for a tax allowance of 25%, up to £2,100. Furthermore, insurance payouts are not taxable and are excluded from the income assessment of the APA means test.

Collective, employer-based private insurance schemes also benefit from tax allowances, a factor which has contributed to the comparatively large uptake of voluntary private insurance policies in France, where in excess of three million policies were held in 2010. Other factors driving the growth of the private insurance market include the focus on insurance products designed with cash payouts rather than services in kind, the dovetailing of eligibility criteria between the public and private insurance systems around the same AGGIR need groups, and the already widespread use of voluntary private insurance to cover health care co-payments in France.

Overall, and in spite of recent reforms curtailing eligibility, the introduction of the APA has led to a significant growth in the number of people receiving state support with their long-term needs (in 2008 there were in excess of one million recipients of APA). It has also fostered increased competition among the growing number of home care providers. Like in Germany and Japan, both the number of recipients and the overall cost of the policy after implementation exceeded significantly original expectations. Nevertheless, current policy debate in France concerns ways of extending the limited levels of cover currently provided by APA, with proposals for new forms of universal compulsory insurance systems and the recovery of care charges from a persons' estate after death.

4.6 Australia

The Australian care system is a means-tested scheme with wealthier people getting less public support than poorer people. Unlike entitlement systems and in common with the arrangements in England, the amount of public support that people receive is dependent on their assessed level of need and financial means, but also on the total available budget, local policies regarding prioritisation and regional preferences. There are different means-test rules for different care programmes but overall anyone with sufficiently high wealth (income and/or assets) is required to pay the full costs of their care, or indeed make private arrangements. Where charges are made, they are only indirectly related to actual care costs.

Care programmes are specifically targeted according to age. In 2009-10, total direct government expenditure on aged care services was around A$11 billion (£6.96 billion), including Australian Government and state and territory government expenditure. Around two-thirds of that expenditure was on residential care, with the balance for all types of care in the community, assessment and information services and services provided in mixed delivery settings. Around 163,000 people were permanently based in residential care at the end of June 2010, either in high level residential care (70% of residents) or low level residential care. A range of high level community care packages are available including the Community Aged Care Packages (CACP) programme; Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH-D). As of the end of June 2010, just under 50,000 older people received help from these three programmes. The low intensity Home and Community Care (HACC) programme helped more than 600,000 older people with low-level needs throughout 2009/10.

An important feature of the Australian system is that the scale of support from the public system at any given time is limited to a maximum number of recipients/care placements defined as a proportion of the at-risk population. This 'approvals limit' arrangement aims to help contain total expenditure. A tariff of subsidy rates for personal care costs in residential care is paid according to assessed need (up to a maximum of £720 per week). The amount of the subsidy is offset by an income-related charge payable by the resident. Accommodation costs are paid by the individual. The system sets a maximum rate that providers can charge for accommodation, based on the means of the resident, but providers can claim a specific accommodation supplement for low-income residents. Accommodation costs are either covered by an accommodation charge in high level care or met indirectly using an accommodation bond for low level residential care (essentially an interest free loan made by the resident to the provider to give a return on capital).

Community care subsidies are also made to providers at a rate reflecting the average cost of care for a person with a given level of need. As of June 2010, public subsidies were in the order of £500 per week per recipient for EACH and around £150 per week per recipient for CACP. Providers – 80% of whom are non-profits – can levy a charge on recipients up to a maximum rate set according to the person's income (but not capped by the cost of care). In this case, and also in regard to accommodation charges, these charging arrangements would appear to give providers an incentive to select wealthier residents (Henry Review 2010).

5. DISCUSSION

The experience of Germany, Japan and France can illuminate a key policy question for the English context: should the English system be reformed so as to become a universal system? In this discussion, the arguments about the value of moving to a 'universal' system mostly concern whether the publicly-funded system should extend coverage so that all people, regardless of their financial means, are eligible for at least some state support.

The guiding principle of the English care system is to provide a safety net so that people who cannot afford or are otherwise unable to make provision for their own care needs receive publicly-funded support. In practice, the 'safety net' in the English system helps (at least in part) the majority of people over 65 with significant care needs. Nonetheless a significant and growing minority of older people with care needs receive no public help. As a budget-constrained system, the extent of the safety net – in terms of who is eligible and how much support is offered – is adjusted according to the available resources.

Moving to some form of universal arrangement involves the system providing everyone with at least some support, and in doing so, potentially creating an entitlement to support. In particular, it implies that anyone who meets a basic needs test would become entitled to some (financial equivalent) support from the public system. There are important distinctions about what benefit is included in this non-means-tested entitlement.

We need to be clear that the rationale for extending coverage is to improve the overall benefits provided by the system, such as an increased number of in-need people that use care. It is inevitable that any such reform that helps more people but does not penalise people already covered by a safety net must imply higher collective/public expenditure. As such, any argument that the expected increases in demand for care due to the ageing of the population will make the current system financially unsustainable cannot be used as a rationale for reforms that lead to greater universalism. This is not to say that a more universalistic system could not be better value for money – but it should not be expected to be a cheaper system on the public purse unless that system re-allocates some of the support that poorer people receive in the current system up the wealth distribution. The distinctive philosophies of the Japanese, German and French systems are particularly germane in this regard.

Any judgement about whether a universal system should be implemented in England will address: (a) whether this yields significant benefits in terms of more, better, and potentially more equitable distribution of support for people to meet their care needs; (b) whether there is a willingness in society to pay for the additional benefits; and (c) whether the benefits of a (more) universal system are greater, given conditions a and b are met, than those that might accrue from spending more on the current safety net system (following the Australian experience, for instance).

A number of Scandinavian countries have universal care systems with very high levels of coverage, funded from general tax revenues in the main. The experience of these countries is potentially relevant but in contrast to Germany, Japan and France it stems from a historical tradition of high tax-and-spend public services (Fukushima, Adami et al. 2010).

5.1 Benefits of universalism

Making care an entitlement means that a higher proportion of the over 65 population will be supported by the care system. Whilst like-with-like comparisons are difficult for definitional reasons, it is interesting to compare uptake levels internationally. In Japan in 2010, there were nearly four million beneficiaries in total, a rate of around 160 recipients over 65 per 1,000 population 65+. In Germany, at that time, the public system supported 1.8 million or 120 recipients over 65 per 1,000 population 65+, with up to 10% more supported by the mandatory private insurance system. In England, in 2009/10, there were just under 0.8 million people over 65 receiving social services support, or an equivalent of 100 recipients over 65 per 1,000 population 65+.

In Australia in the middle of 2010, up to some 265 older people per 1,000 population 65+ were receiving public support. This figure may suffer some double counting, and more importantly includes the large number of recipients of the low-intensity Home and Community Care (HACC) program and the Veterans home care programme. A better basis for comparison is to exclude this support, which then gives a figure of around 95 recipients per 1,000 population 65+.

5.1.1 Efficiency

Greater eligibility/coverage of the population by a state system is beneficial if it brings in people that would not otherwise buy care outside the public system due to market failure. In this case, an increase in coverage by the state system will also mean an increase in the total number of people securing care support. In theory in a safety net system those people who are not covered are the higher-income groups who are better able to afford care or care insurance privately than those who are eligible. But, as outlined in section 3.2, market failures due to information and structural problems, especially relevant in the long-term care example, can mean that these private markets are 'missing' or at least smaller than would be optimal. An important potential benefit of a universal system, therefore, is that it provides greater insurance against care cost risk, and in turn less 'unmet' need.

How far did this improvement result in practice in countries like Japan and Germany? After the implementation of the reforms, a higher number of recipients in the system would of course be expected. But did the reform simply crowd-out private consumption of care that would have occurred anyway? In both countries, recipient numbers grew rapidly after implementation. In the Japanese system, in the six years after implementation in 2000 the number of beneficiaries increased by 109%, a much faster rate than the underlying older population growth (Tsutsui and Muramatsu 2007). In Germany between 1996 and 1999 recipient numbers grew by over 18%, an average per annum growth rate of nearly 6%. Thereafter in the years to 2006, growth rates fell back to below 2%. By reducing the 'price' (the out-of-pocket cost) for care that recipients must pay compared to the amount that would have been charged in the previous means-tested system, this increase in demand is not surprising, especially where it also includes a proportion of people that would not have approached the old state system as it stood before implementation.

What is less clear, however, is just how far the value of this reduction in unmet need in the population justifies the additional cost. A number of studies have assessed the impact of the LTCI on people's exposure to financial risk. One study in the Japanese case (Iwamoto, Kohara et al. 2010) found that the negative impact of care costs on household consumption was lower following the introduction of LTCI, and that the system has helped Japanese households to reduce the welfare losses associated with a disabled family member.

A similar study in the German case (Zuchandke, Reddemann et al. 2010) investigated the assessment by individuals of the financial implications of long-term care risks, and whether this had been altered by the introduction of compulsory LTCI. The results found that the perception of financial security in relation to long-term care needs had increased in all segments of the population since the introduction of LTCI.

An increase in recipients overall is likely to mean a reduction in unmet need, but the amount of support per recipient is also important. As indicated above, the German and French systems on their own only insure people for part of their care costs, and are less generous than the Japanese system. Faced with the prospect of paying high costs to make up the remainder, some people inevitably defer or make do with less, resulting in unmet need. Moreover, there still remains a significant risk that people will have to draw down on assets if they do wish to pay. An analysis of the German case (Keese, Meng et al. 2010), using conservative assumptions about future increases in care costs, found that one-third of individuals covered by LTCI faced long-term care costs after the age of 65 that would exceed their total wealth (before income). Around 37% of homeowners covered by the social insurance system would face costs that exceeded their non-housing wealth, suggesting a possible need to sell their homes to cover their care costs.

An important rationale used in Japan for implementing the system was to reduce the burden on informal carers, especially women. There is an argument that female participation rates in the labour force would improve under a more comprehensive system, potentially fuelling economic growth.

5.1.2 Equity

The adoption of a more universal system also has potential benefits on equity grounds, including on the basis of a principle of equity of opportunity. In Germany and France especially, a solidarity principle was a main rationale for reform. In particular, the view has been that the risk and consequences of long-term care needs should be 'socialised' as an extra pillar of the social welfare estate.

In safety net systems, those people who are not eligible for support usually face the full costs of care, which can still be unaffordable for middle income groups of people with care needs. A universal system would provide subsidies for this group improving their opportunity to secure reasonable levels of care. In most cases this is a

beneficial feature but it is a nuanced argument, particularly when reform occurs in the historical context of a means-tested system. If the new system gives the wealthy 'too much' subsidy then a counter-argument can be made that tax payers are funding those people that already have more than enough opportunity to secure their care support.

It can also be argued on fairness grounds that means-testing penalises those people that do make their own financial provision to meet care needs should they arise. A universal system can therefore be more politically sustainable on these grounds.

5.2 Costs and disadvantages

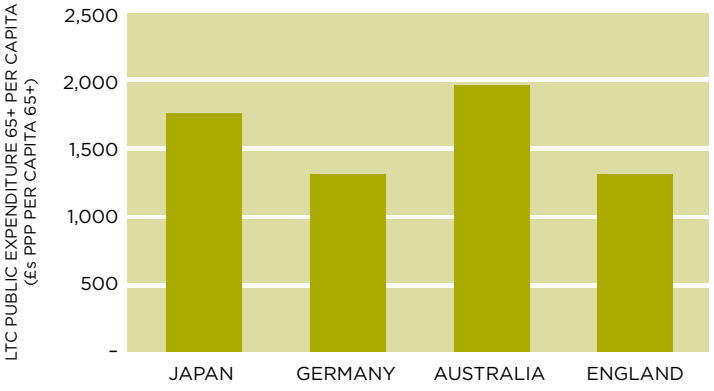
The main downside of a universal system is the potentially higher cost to the public purse this entails, whether that is in the form of higher contributions through general taxation or through some hypothecated, but mandatory, contribution system for long-term care. Clearly, additional public funding of long-term care has opportunity costs in either reducing public funds available for other public services or, in taxing people to a higher level, reducing their disposable income or wealth. In most countries political resistance to additional mandatory contributions will exist unless a strong willingness to pay for the benefits can be established.

A key rationale for implementing a public universal system is there would otherwise be under-insurance and under-consumption due to market failure in private markets for care – see section 3.2 above. But public systems are also likely to create inefficiencies. One problem is over-consumption; the lower price that people face for formal support from the public system might result in a 'crowding-out' of their use of informal care. In Germany and France, the limited generosity of the social insurance system is likely to limit this problem, although perhaps a number of people claim benefits they would not otherwise want if they paid the full price.[2] A related problem is that a public system cannot fully discriminate between care needs, which will mean under-provision of support to some groups and over-provision to other groups. In Germany, resources were under-allocated to cover the costs of supervision for people with cognitive impairment leading to revisions in 2008. In Japan, the significant increase in demand in the low-level needs population might suggest over-consumption.

The expectation is that universal systems are more costly on the public purse than safety net systems, but is this actually the case? And if not, what benefits are being sacrificed? Again, with the caveats about making like-with-like comparisons, it is useful to get some sense of the scale of public/collective support made available in each country. Figure 1 gives a comparison of public expenditure on care for people over 65 (in 2005) following the approach by Campbell et al. (2010). In this comparison, as far as possible, account is made of public funding of care purchase whether it is direct expenditures through the care system or social assistance benefits that help meet residual care costs. See Appendix II for details.

FIGURE 1

Public/collective expenditure on long-term care for people 65+ per capita, 2005 (in £s purchasing power parity)



As we might expect given the difference in coverage and pay-outs, overall expenditure is higher in Japan than in Germany. Another important implication is that safety net systems such as in England do not necessarily involve lower public expenditure than these universal systems – compare expenditure in Germany and England. In Australia, which is a high public subsidy system – it is clearly an over-statement to see the Australian system as a 'safety-net' arrangement, despite its extensive use of means-testing – expenditure per capita is higher still.

With similar levels of expenditure per capita, the key differences between the German and English cases are (a) in the targeting of public resources and (b) in the level of support provided by informal carers. In the English system, public funding is more focused on the poor and on those with the highest level of need than in the German system. In other words, the costs of implementing universal coverage within the same overall funding envelope would be to reduce the level of public support to some groups.

With the explicit eligibility rules that are required in entitlement systems, assessment of need that accounts for informal care support is generally not possible i.e. assessment is 'carer-blind'. In means-tested systems, as in England, an assessor is able to make a more subjective assessment and consequently allocate less support to people who

[2] This is inefficient because indirectly, through contributions, the person is paying an amount for care they would rather not buy at this price if they had a choice in a private market.

already have informal care. A subjective arrangement may be less accountable, but it will also be less costly and more flexible with respect to people's particular circumstances.

The option to take a cash payment in Germany with only half the value of the services-in-kind is noteworthy in this regard. The expectation is that this cash payment would be mainly used to support informal care arrangements. As such, in making this choice, the service user is revealing that they do have informal carers and that they need less formal support.

5.2.1 Sustainability

The increase in recipient numbers following a decision to implement a universal system will be uncertain and subject to change over time. Even if predictability improves after the system becomes established, its year-on-year balance sheet will be subject to some uncertainty. A range of other factors could also change. Societal willingness-to-support a universal system is likely to be contingent on the performance of the wider economy. Unit costs will also change over time with uncertainty. In both the Japanese and German cases, expenditure increased at a faster rate than was expected (and presumably desired at the time) such that a number of responsive policy adjustments had to be made to limit cost growth. It might be expected that cost control in universal systems that make care an entitlement is more difficult than in systems which are explicitly budget-constrained. But is this actually the case?

Higher than expected costs have been a feature of Japan's LTCI system since soon after its launch. But as indicated above, the series of reforms in 2005 did appear to reduce pressure on expenditure. Since then, expenditures have continued to increase, but at a rate in line with the increase in the over 75 population i.e. expenditure per head of population aged 75 and over has remained largely constant since 2006 at around 500,000 Yen per person (including the co-payment) (Ikegami 2010).

In Germany, after the initial growth in uptake, expenditure growth between 1999 and 2009 has been modest at around 2.3% per year (in cash terms). This is partly explained by controls over entitlement where people need to have been in the insurance scheme for at least five years before they are eligible to make a claim. Also, the minimum need threshold is for 10.5 hours of care a week (at least half of which must be basic personal care). Nearly 30% of applications for assistance were rejected in 2007, and eligibility was held to about 10% of the population aged 65 and over; in Japan, only around 3% of applications were rejected, with around 17% of the 65+ population eligible for benefits (although actual take-up was 13.5%) (Campbell, Ikegami et al. 2010). The other significant brake on cost growth in Germany was that benefit amounts were not adjusted for inflation, and had eroded significantly in real terms. In 2008, a new agreement was reached to increase benefits, with a corresponding increase in the contribution rate from 1.7% to 1.95% of income.

In future, costs are likely to continue to grow in absolute (real) terms due to the ageing of the population, but the experience in Japan and Germany does not suggest that costs will increase uncontrollably. An increase in the size of the older population would require a lower absolute increase in funding under a safety net system with smaller coverage and lower expenditure than a universalistic system. But the proportional increase in costs need not be different just because coverage is different. The question might be therefore one of flexibility, in terms of the way in which universal entitlement systems can respond to changes in the availability of resources in the system.

In addition, contributions to these insurance systems have been at least partly targeted on older people. In Japan, around a half of total receipts are from age-related premiums and co-payments. A third overall comes from premiums paid by people between 40 and 64 and another sixth from premiums for the over 65s. In Germany, the bulk of contributions come from working age adults but, since 2004, pensioners have had to pay a normal contribution (assessed mainly against pension income). From a sustainability perspective, where contributions are age-related to some extent, this will help to mitigate problems associated with an increasing dependency ratio (of pension age people over working age people), namely the reduction in the ratio of contributors to potential beneficiaries.

6. IMPLICATIONS FOR THE ENGLISH DEBATE

The social insurance arrangements in Japan, Germany and France have proved popular, have improved uptake and helped, to some extent, to reduce people's risk of substantially eroding their wealth to pay for care. Furthermore, even in the Japanese system with its comparatively generous benefits, measures to control expenditure growth have proved broadly successful at least for the life of the scheme so far.

The Australian system shares many of the characteristics of the English funding system, although there are differences, such as: approval quotas, use of accommodation bonds and the differentiation of care and accommodation costs. The English means-tested system has a number of recognised shortcomings – the under-insurance/ unmet need of middle income people above the means-test threshold for getting public support; the perceived unfairness for those who do save for old age; and the inconsistent charging and incentives between care settings. These problems also apply to varying degrees in the Australian case, although the greater generosity of the Australian system makes the first problem far less significant than in England. The perverse incentive problem is arguably greater, however, in the Australian case. Recognising these problems, the Australian Government intends to reform, and is consulting at present on the options (Productivity Commission 2011).

There are a number of specific lessons or relevant considerations:

- **An important issues is whether accommodation costs in residential care should be covered in a universal system**. In Japan, accommodation costs were initially covered on a universal basis, but later this was felt to be too expensive. Financial help was instead prioritised on a means-tested basis. Similar arrangements exist in Germany and France with wealthier people largely expected to pay accommodation costs themselves.

- **Even if wealthier people are primarily responsible for accommodation costs, there are public policies that can help**. State-run or state-backed annuity-type arrangements can give people an income stream from their assets specifically to meet accommodation costs. In Australia, accommodation bonds are used: residents invest a lump-sum with the care home provider who then gets revenue from the interest and also by retaining an amount of the principal when the bond is repaid.

- **Social insurance systems give service users a right or an 'entitlement' to a pre-defined level of support (in services or cash) depending on the person's need**. These systems often also have defined contributions (premiums or taxes). Building in flexibility to adjust the benefits provided or the level of contributions required is important to guarantee these systems' sustainability.

- **Sustainability** – both financially and politically – also appears best served where contributions to the insurance system are made, at least partially, by those most likely to benefit from this insurance (e.g. older people). In Japan, contributions to the system are made by both over 40s and over 65s.

- **Small co-payments at the point of need can help limit excess demand for services**. In Japan, service users pay 10% of the care cost, with the remainder paid by the social insurance fund. Co-payments can deter people with a relatively low willingness-to-pay (i.e. low preference) for formal support.

- Because an entitlement to support in a social insurance system needs to be defined explicitly and objectively, **informal care** is usually ignored during the needs assessment process. This can mean that someone with significant informal care is entitled to the same level of support as someone with no such help. In Germany, people can opt for a cash payment that can be used to pay family carers, but the value of the cash payment is set at half the value of the service option. This allows the (indirect) targeting of resources to reflect informal care levels. Since over three-quarters of beneficiaries in Germany choose this option its popularity cannot be questioned; total expenditure is lower as a consequence. Cultural differences about the role of the family, however, should be taken into consideration when exploring similar mechanisms in England. In Japan limiting reliance on informal carers is an explicit policy goal but it does come with a cost.

- **Social insurance systems vary according to the amount of care costs they are designed to cover**. In France and in Germany only part of the cost of care is expected to be met. In France more than three million people use private LTCI to cover the remaining costs. The state can help promote this practice e.g. by giving employers are incentive to bundle this insurance with employee remuneration packages as often happens in France. Linking LTCI to pensions is another option.

- **Universal systems help protect people against unexpected care costs**. But the support offered by the system can be targeted in different ways. People can be covered against the risk of incurring any care costs or just against the risk of incurring higher than expected care costs (so called tail-end risk). Without state intervention both these risks tend to be under-insured in the population. Focusing on the latter tail-end risk is cheaper and helps people protect their assets but can still lead to an under-consumption of care (i.e. unmet need)

There are two main rationales for implementing a universal care funding system. First, there are market failure arguments, specifically that information problems will lead to under-insurance (which means that people are insufficiently protected against the risk of asset spend-down), and also that point-of-need use of care services and support will be too low (because people are insufficiently prepared for the cost[3]). Second, there is the equity or social solidarity argument. The latter was particularly important in Germany, France and Japan, although the current debate suggests that the market failure argument, and particularly a concern about the lack of asset protection, is stronger in England. If this characterisation is accurate, it suggests that whilst implementing a universal system would be beneficial, a fully comprehensive mandatory entitlement system might be regarded as over-insurance for some beneficiaries.

Overall, the experience of countries with social insurance systems suggests that there would be benefits if reforms in England led to a more universal care funding system rather than means-testing. But there would clearly be a price to pay. Either, following the Japanese experience, everyone would be required to pay more into the system (as additional taxes or earmarked contributions). Or the price would be in the form of having to re-distribute the benefits provided in the current means-tested system in England away from high need and/or most poor groups, as in the German example. Both options do not appear to have great political appeal although the former is perhaps more palatable. It is also worth reflecting that many other countries appear to sustain higher levels of per capita spend on care, including Australia, than is the case in England.

[3] Even if they are risk neutral.

7. APPENDIX I: CARE FUNDING SYSTEMS

7.1 Japan

Japan's compulsory public LTCI system (Kaigo Hoken) was implemented in April 2000. It replaced a system in which institutional care was mostly provided by the health sector and all costs (including board and lodging) were covered by health insurance; domiciliary care was mostly provided by local government social services and was means-tested.

7.1.1 Coverage

The LTCI scheme provides universal coverage (subject to needs eligibility rules), regardless of the recipient's financial means or the availability of informal care from relatives (it is 'carer blind'). Eligibility criteria are set nationally but administered locally (Glendinning and Moran 2009).

The scheme provides broad coverage (Ministry of Health, Labour and Welfare 2010a; Campbell et al 2010; Ikegami 2010):

- In October 2010, a total of 29.07 million people were insured under the scheme, of whom 48% were aged 75 and over.
- Just over 5 million were eligible for benefits, equating to 17.2% of those insured.
- More than 80% of the eligible are aged 75 and over, across all levels of need.
- Around 20% of all those eligible do not choose to receive benefits.
- Thus 13.5% of Japanese aged 65+ actually receive publicly funded long-term care under the insurance scheme.
- Those aged 40 – 65 accounted for just 3% of the benefits recipients.

Figure 2 shows the number of people eligible since the beginning of the scheme. In 2000, it was estimated that 12% of individuals aged 65 and over would be eligible for services but this had reached 17% by 2010. The greatest increase has been in the lower need groups and in the numbers of domiciliary care users (compared with residential care users).

FIGURE 2

Numbers certified as eligible for LTCI benefits (as of June in each year)

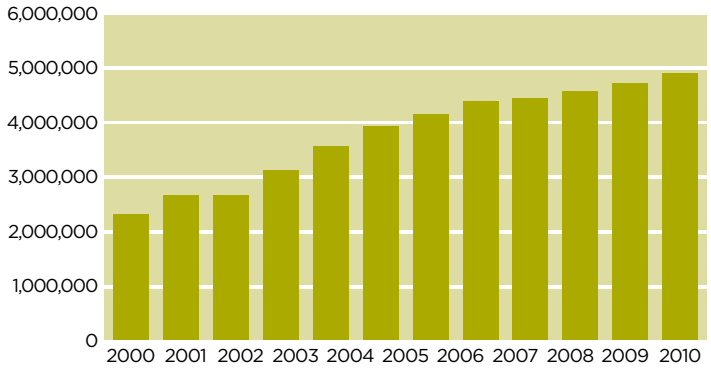


TABLE 2

LTCI in Japan: insured persons and beneficiaries (all ages)

	Number of individuals (millions)			
	Institutional care	Home care	Care in the community	Total
Number of insured persons*	-	-	-	29.072
Number of eligible persons*	-	-	-	5.003
Number of beneficiaries**	0.843	3.009	0.263	4.115

** 31 October 2010*

*** August 2010*

(Source: Ministry of Health, Labour and Welfare 2010a)

Table 2 shows the number of people eligible for benefits under LTCI and those actually in receipt of the main categories of benefits in 2010.

7.1.2 Funding

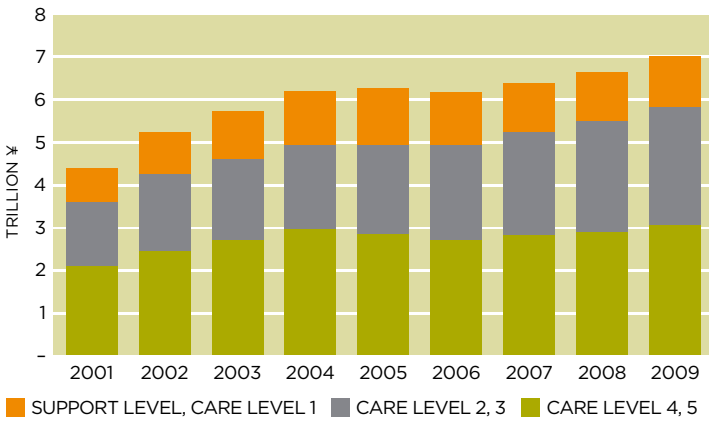
There are three sources of public funding:

- **Premiums from those aged 65 and over**. One-sixth (on average) of total income is financed from the premiums that all those aged 65 and over pay. These premiums are set and collected by the (approximately 3,000) municipalities and are means-tested. In practice there is significant variation in rate between municipalities.
- **Premiums paid by those aged 40 – 64**. About one-third of the public budget is financed by the premiums paid by people aged 40 to 64, collected together with their health insurance premiums. The contribution rate is around 1% of income on average, up to a ceiling. Half of the premium is paid by the employer.
- **From taxation**. About half the public funding is from central and local taxation.
- **User co-payments**. A means-tested co-payment of 10% of the cost of services is paid by the recipient (with a reduced rate for poorer people).

In the first year of implementation (2000), the 4.3 trillion Yen budget was under-spent, and expenditure on long-term care was 3.6 trillion Yen. From that point, expenditure rose sharply in line with recipient numbers reaching 6.8 trillion Yen in 2005. Thereafter the growth rate reduced as a result of a series of reforms implemented in 2005 that (a) changed the benefits made available to low-level needs people from care services to (lower-cost) preventative services and (b) removed automatic coverage of accommodation costs in residential care from the benefits package (see below for more details).

FIGURE 3

LTCI expenditure, including co-payments (trillion Yen)



(Source: Ikegami 2010)

All prices of services and conditions of payment to providers (the fee schedule) are set nationally by the government, with a conversion factor for regional cost differences. This means that providers must compete through quality and convenience. The fees are revised every three years and can be adjusted according to financial outcomes and policy goals. Fees for profitable services can be lowered to achieve cost containment.

7.1.3 Benefits

Needs-based eligibility criteria, which are set nationally, classify people into seven categories (Support Levels 1 and 2 for light support and Care Levels 1 to 5) on the basis of a 74-item (Ikegami 2010) assessment process that measures activities of daily living (ADL) and instrumental activities of daily living (IADL) deficits (the latter referring to non-personal care tasks such as shopping and cleaning). An algorithm is initially used to indicate the appropriate needs level which is then reviewed by an expert committee (including physicians, care managers and academics). Following classification a care manager works with the service user to draw up a care plan and organise provision. Benefits are delivered as services and include home help, adult day care, respite care, home modification, assistive devices, visiting nurses, rehabilitation and institutional care. There is no cash alternative to services.

Under the LTCI scheme, the assessed package of services covers the individual's full care needs, less the 10% co-payment.

- **Institutional care**. The cost of care met by the scheme depends on a person's level of need. In 2009 this ranged from around £1,500 to £3,250 a month (at current exchange rates) (Campbell, Ikegami et al. 2010). Following the 2005 reforms only a third of accommodation costs were automatically covered with further support subject to a means-test. On average, residents now pay about 50% of the actual accommodation costs (Ikegami 2010). As well as aiming to reduce LTCI expenditure, the new policy was also intended to make alternative community settings appealing to older peopled by reducing the gap in service benefits that are higher in institutions than in community settings (Tsutsui and Muramatsu 2007).

The Government announced that LTCI hospitals would be abolished by March 2012. This type of institutional care has the highest fees because of the greater number of medical staff. This type of care will be restructured with facilities having a lower level of medical care. The gradual decrease in LTCI hospital beds has been a main factor containing total LTCI expenditure in recent years (Ikegami 2010).

- **Home and community care**. A maximum value of care is set by the municipality for each of the seven needs levels. This ranged in 2009 from around £380 to £840 per month for Support Levels 1-2 and £1,270 to £3,000 per month for Care Levels 1–5 (Campbell, Ikegami et al. 2010). Privately financed top-ups are allowed.

The 2005 reforms brought in a number of changes designed to reduce expenditure (Glendinning and Moran 2009). First, users in the two lowest needs categories (Support Levels 1 and 2) were restricted to preventive health promotion interventions mostly delivered in day centres, such as muscle strength training, oral health improvement, and nutrition information. At the same time, many people in Care Level 1 were reclassified "downwards" into Support Level 2, so long as they would benefit from preventive services. Second, help with practical care (for people in Support Levels 1 and 2) was initially ended on the grounds it was making older people more dependent. However, this was so unpopular that the policy was changed through the introduction of a new focus on reablement.

TABLE 3

Eligibility and recipient numbers – by care and support level (000s of people), 2010

	Support		Care					
	L1	L2	L1	L2	L3	L4	L5	Total
Total number eligible for benefits	656	656	894	877	699	634	587	5,003
Total number of service recipients	380	465	725	795	673	586	490	4,115
- Home care recipients	378	461	634	633	423	286	193	3,009
- Community services recipients	2	3	48	64	70	47	28	263
- Institutional care	0	0	43	98	180	254	269	843
Percentage of those eligible who opt to receive services	58%	71%	81%	91%	96%	93%	84%	82%

(Source: From data in Ministry of Health, Labour and Welfare 2010a)

Table 3 gives a break-down of how recipients are split between care levels (in 2010).

7.1.4 Specific issues

As discussed in more detail in the next section, recipient numbers increased significantly, as expected, after the implementation of the LTCI system and there are studies that suggest people's financial position improved (Iwamoto, Kohara et al. 2010).

LTCI has also helped to reshape the long-term care market. Previously, only quasi-public welfare organisations were allowed to provide care but, since 2000, new for-profit and non-profit providers have entered the market. The proportion of for-profit community care providers increased from 27.2% (in 2001) to 44.6% (in 2005) (Ikegami 2010).

The workforce has expanded and there have been moves to make it more professional. The number of FTE workers in community care doubled from 377,000 (in 2001) to 749,000 (in 2005).

As indicated above there is now a greater emphasis on preventative services and, with policies to close long-stay hospitals, more emphasis on a social rather than medical model of care. The explicit distinction between care and accommodation charges has also created better incentives for substitution between residential care and community care, and for greater innovation in housing alternatives (Tsutsui and Muramatsu 2007).

Two particular features of the Japanese system – the mandatory 10% co-payment and the lack of cash option – may help explain why uptake is below eligibility levels. Benefit levels as outlined above are the maximum amount payable and in the community there is an indication that people routinely receive less than the maximum either through choice or to reduce the Yen amount of co-payment they must make. While these features improve overall financial sustainability they might also imply unmet need.

Even aside from the question of whether LTCI systems such as the German and Japanese examples inherently imply faster proportional cost growth than other arrangements (see section 5.2.1 above), demographic pressures will mean than total costs need to increase to maintain current benefits. Various options specific to the Japanese system have been suggested to reduce cost growth (see Ikegami 2010).

On the funding side:

- **Increase the co-payment**, perhaps from 10% to 20%. However, users would be likely to complain if co-payments increase without tangible benefits.
- **Increase the premiums**. But as one sixth of total expenditures is financed from pension deductions from those aged 65+, doubling the current premium contribution amount would be difficult.
- **Increase the proportion financed by general revenues**. Expanding LTC services would create new jobs, but increasing taxes further at the present would be politically difficult.

On the benefits side:

- Further reduce the LTCI coverage of **accommodation costs** in institutional care.
- Further reduce benefits for those in **light care levels**.
- Eliminate the **light care eligibility levels**; however, this is opposed by municipalities because the financial responsibility would revert back to them.
- **Reform the current algorithm** so that there is an explicit change in the eligibility criteria which narrows eligibility. In such a situation, those already receiving services could be allowed to continue, but new applicants would not be eligible.

A more fundamental reform would be to expand the coverage to those below 65 (i.e. to bring in those under 40 and those aged 40-64 with non-age-related disabilities). This would involve the 20 to 39-year-olds starting to pay premiums, and benefits being expanded to cover all adults under 65. The attraction of this approach is that the lower age groups are bigger contributors and lower users, but employers have resisted such a move because it pushes up employment costs, and younger employees are also not keen to pay contributions. If such a path were followed, the eligibility criteria and benefits would have to be made more relevant to young adults with physical disabilities and those with learning difficulties.

7.2 Germany

Germany's universal, pay-as-you-go social LTCI scheme was introduced in 1995. Until then, financial support for those in need of care had been provided through means-tested welfare support. The reform made LTCI compulsory, either through social LTCI or private LTCI. The rationale was to treat the risk of long-term care as an existential risk (Zuchandke, Reddemann et al. 2010), and protection against that risk became the so-called 'fifth pillar' of Germany's social security system (joining unemployment insurance, health insurance, pensions and accident insurance).

The social LTCI covers around 90% of the population, and has defined contributions and benefits. The benefits are not intended to cover the full costs of long-term care, and a contribution is expected from individuals' own funds; for example, the costs of food and board in institutional care must be financed by the patient. Means-tested social welfare still exists for those without adequate private resources to cover non-insured costs.

Social LTCI encourages care in the home and community-based services over institutional care. It has improved the situation for many frail elderly (and their carers), and boosted the market for long-term care services (Arntz and Thomsen 2010).

However, the social LTCI fund faces shrinking revenues and increasing expenditures. Contribution (and benefit) rates were increased in 2008, but concerns persist about the long-term sustainability of the scheme, and many commentators believe that further reforms will be necessary.

7.2.1 Coverage

The social LTCI system is administered by the health insurance funds, each of which has an affiliated care insurance fund (there are around 250 care funds in total). As with health insurance, these care funds are independent, self-governing corporations under public law. Whoever is covered by statutory health insurance also belongs to their health fund's LTCI scheme.

Those whose jobs are not covered by the social scheme must take out private LTCI. This includes civil servants and the self-employed; those with incomes above the social security threshold can choose whether to join the social LTCI scheme or have private insurance. Nevertheless, around three million people (such as the homeless) are not insured for the risk of needing long-term care (Heinicke and Thomsen 2010). Table 4 shows the most recent data for the number of insured persons and beneficiaries of LTCI. More than 80% of social LTCI beneficiaries are over 65.

TABLE 4

Long-term care insurance: insured persons and beneficiaries

Number of insured persons (million)		Number of beneficiaries (million)		
		Institutional care	Home care	Total
Social Long-Term Care Insurance (STLCI)[4]	69.77	0.702	1.541	2.243
Private Long-Term Care Insurance (PTLCI)[5]	9.29	0.039		0.092
Total	79.06	0.741	1.633	2.374

(Source: Bundesministerium fur Gesundheit 2010a)

[4] At 1 January 2010.

[5] At 31 December 2008.

7.2.2 Funding

The current contribution rates for social LTCI are shown in Table 5, and apply nationally (except for Saxony which in 1995, unlike the rest of the country, decided against removing a public holiday to help employers finance social LTCI). Contributions are levied on gross income between lower and upper thresholds. (€400 and €3,750 in 2010, respectively). The financial sustainability of the social LTCI scheme has been the subject of much debate. Between 1999 and 2007, the social LTCI fund operated with an annual deficit, (except for 2006 when a change in the date for contributions led to a surplus). In 2008, when the new contribution rates were announced, the German Ministry of Health said that the increase would be sufficient to fund the social LTCI services until at least the end of 2014 without having to draw on the minimum reserve that is maintained. In 2008 and 2009 the scheme did indeed return annual surpluses (Table 6); liquid funds at the end of 2009 were approximately €4.8bn.

TABLE 5

SLTCI contribution rates (% of wages or assessable income)

Employee	Employee (with children)	Employee (aged under 23, no children, and year of birth after 1939)	Total
0.975%	0.975%	-	1.95%
0.975%	-	1.225%	2.2%

(Source: Deutsche Sozialversicherung 2010)

TABLE 6

The financial situation of the SLTCI fund (Billions euros)

Year	Receipts	Expenditures	Net outcome
1995	8.41	4.97	3.44
1996	12.04	10.86	1.18
1997	15.94	15.14	0.80
1998	16.00	15.88	0.13
1999	16.32	16.35	- 0.03
2000	16.54	16.67	- 0.13
2001	16.81	16.87	- 0.06
2002	16.98	17.36	- 0.38
2003	16.86	17.56	- 0.69
2004	16.87	17.69	- 0.82
2005	17.49	17.86	- 0.36
2006	18.49	18.03	0.45
2007	18.02	18.34	- 0.32
2008	19.77	19.14	0.62
2009	21.31	20.33	0.99

(Source: Bundesministerium fur Gesundheit 2010b)

From the perspective of the public purse, the introduction of social LTCI led (as intended) to a sharp decrease in claims for social assistance support, and the cost of social assistance benefits fell by around two-thirds. However, it remains significant and, in 2009, there were social assistance payments totalling €3.33 billion, more than three-quarters of which went to people in institutional care.

Private LTCI premiums are based on an assessment of the person's risk of needing care in the future, rather than their income. There are restrictions on the premiums that can be charged, for instance they cannot be higher than the maximum social LTCI contribution. The employer pays the lesser of 0.85% of wages or half the actual premium.

Unlike social LTCI, private insurance is fully capital funded; only around 20% of the current private LTCI revenues are spent on benefits and most of the contributions are used to build up capital stock and reserves for members (Arntz and Thomsen 2010). Private LTCI has run at an annual surplus since 1995, the most recent figures showing a €0.38bn surplus for 2008 (Bundesministerium fur Gesundheit 2010).

7.2.3 Benefits

To be eligible for benefits from social LTCI, an individual must have required frequent or substantial help with normal day-to-day activities for at least six months. The LTCI fund's Medical Review Board verifies and assesses a person's need for care, with the assessment carried out by a physician or nurse using a single national needs assessment tool. The four basic domains of activities evaluated are personal care, nutrition, mobility and housekeeping. During this process, a person requiring long-term care is assigned to one of three care levels (Table 7), and this determines the benefits received.

TABLE 7

Definitions of care levels for Social LTCI

	Care Level I (Considerable need of care)	Care Level II (Severe need of care)	Care Level II (Extreme need of care)
Assistance needed with personal care, nutrition or mobility	At least once a day for at least two tasks in one or more areas	At least 3 times a day at different times of the day	Around the clock
Assistance needed with housekeeping and chores	Several times per week	Several times per week	Several times per week
Average amount of daily care provided by informal carer	Not less than 90 minutes, of which more than 45 minutes must be accounted for by basic care.	Not less than 3 hours, of which at least 2 hours must be accounted for by basic care.	Not less than 5 hours, of which at least 4 hours must be accounted for by basic care.

Entitlement to benefits and services

A person is entitled to LTCI benefits only after paying contributions for at least two years (this qualifying period was reduced from five years as part of the 2008 adjustments). The benefit that an individual receives depends on what care level they fall into, whether they are at home or in an institution, and whether they choose to take cash or care-in-kind. Key points are:

- **The cash payment for home care is around half the value of services-in-kind**, but it can be spent on anything and can also be paid to family members. However, cash allowances can only be made when care is provided by a third person, i.e. not the recipient him/herself (Heinicke and Thomsen 2010). Despite the much lower value, cash has always been more popular than services-in-kind among home care beneficiaries; in 2009, 79% of recipients opted for cash, with their payments accounting for 62% of social LTCI-funded home care (Bundesministerium fur Gesundheit 2010). A recipient of cash must take part in regular advice meetings with a professional care service (at least once every six months) in order to ensure that their care needs are being met and to monitor quality of care.

- It is possible to take a **combination of cash and care-in-kind**.

Between 1995 and 2008, benefits were not adjusted for inflation, and had eroded significantly in real terms. A three-step increase in payments was announced, with increases in 2008, 2010 and 2012. A summary of the main current and 2012 benefit levels is shown in Table 8. After 2012, there is a commitment that payments will be adjusted every three years from 2015 onwards.

TABLE 8

Social LTCI benefits in services and cash (monthly, Euros)

Care Level	2010	2012
	Home care – benefits in kind	
I	440	450
II	1,040	1,100
III	1,510	1,550
(particularly severe)	1,918	1,918
	Home care – benefits in cash	
I	225	235
II	430	440
III	685	700
	Institutional care	
I	1,023	1,023
II	1,279	1,279
III	1,510	1,550
(particularly severe)	1,825	1,918

(Source: Bundesministerium fur Gesundheit 2010a)

The 2008 reforms also introduced a specific benefit for people identified with mental impairments, such as dementia. The payment (either €100 or €200 a month depending on severity) is assigned for supervision, but can be spent as the recipient chooses (Arntz and Thomsen 2010).

In addition, relatives or friends who provide care for more than 14 hours a week, and who are not employed, qualify for a monthly care allowance and payment by the social LTCI of pension contributions (as well as their social LTCI contributions, as mentioned above).

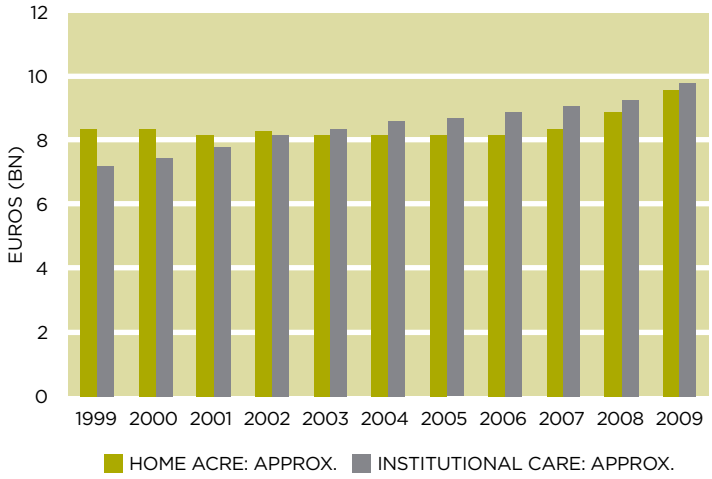
Social LTCI recipients

As shown in Table 4, at the beginning of 2010 there were 1.541 million recipients of social LTCI-funded home care, and around 702,000 insured persons in institutional care. Table 9 shows the number of recipients by care levels.

Since 1995, the proportion of social LTCI expenditure accounted for by institutional care has slowly increased, despite the emphasis on home care whenever it is a viable alternative (Figure 4). And despite these efforts to avoid institutional care, as Table 9 indicates, more than 40% of institutional residents funded by social LTCI are assessed as belonging to the lowest needs category (Care level I).

FIGURE 4

Expenditure split between home care and institutional care



(Source: Bundesministerium fur Gesundheit 2010)

TABLE 9

Care levels of SLTCI beneficiaries (at 1 January 2010)

Home care			
Care level I	Care level II	Care level III	Total
936,223 (60.8%)	466,728 (30.3%)	138,147 (9.0%)	1,541,098

Institutional care			
Care level I	Care level II	Care level III	Total
286,761 (40.8%)	277,495 (39.5%)	137,912 (19.6%)	702,168

(Source: Bundesministerium fur Gesundheit 2010)

7.2.4 Specific issues

The experience in Germany of introducing social insurance is highly relevant to current discussions in England about funding system reform. Some of the features of the German model need to be considered in terms of whether they would be suitable in England, and some of the difficulties offer lessons on what to avoid.

- Social LTCI was **grafted onto a pre-existing framework of health insurance funds**, a structure that does not exist in England.

- To improve the financial viability of the social LTCI fund, the German government decided that it was **necessary for childless people to pay higher contributions**, but this distinction might be politically challenging in England.

- Affordability has also been achieved by offering a **cash alternative that is worth much less than services-in-kind**. Without a significant proportion of recipients taking the lower cash option, the cost of the scheme would be significantly higher, with a consequent need for higher contributions. In England, the cash alternative offered to those taking a direct payment for long-term care is not supposed to be worth less than services-in-kind, and the introduction of a dual benefit rate might not be acceptable.

- **Those on higher earnings can choose to opt out** of Germany's social LTCI but must then take out private insurance. At the moment an active private LTCI market does not exist in England, so such an arrangement would require significant development work. Alternatively, the German experience suggests that a social insurance system may be more viable financially if the whole population is insured in a single integrated system. The existence of more than one system raises unresolved questions of fairness, particularly if the risk structure between both branches of the insurance differs as much as it does in Germany (Rothgang, Niebuhr et al. 2004).

- The German system does **not pay out until someone has needed care for six months**. In England this is also the case for Attendance Allowance/Disability Living Allowance (AA/DLA), but not for the existing means-tested social care system.

- The level of social LTCI benefits is **not particularly generous compared either to the real costs of care or to fully-funded care packages in England**. As already noted, the payouts are not designed to cover the whole cost of care and require significant top-ups from many people. The Care level I home care cash option, for example, is worth less than the current lower rate of AA, while the eligibility threshold is arguably higher. Introduction of a similar social insurance system in England would need to involve a degree of expectation management so that it was not misunderstood as an offering of free personal care. For home care, anyone who currently receives both AA/DLA and means-tested social care could well receive less under the German system. The main gainers would be those in England at Care levels II and III who currently do not pass the means test for state-supported care.

7.3 France

The Allocation Personnaliséed' Autonomie (APA) was introduced in 2002 as a contribution to the costs of long-term care for those aged 60+. The APA system provides coverage for a much larger number of people than the previous system and has no provision for recovery of funds from inheritance (Da Roit, Le Bihan et al. 2007). Like the German system, the APA can be seen as a response to defining dependency and disability as a social risk.

Separately to the APA benefits regime, tax breaks for private contributions to care are an additional significant source of public subsidy.

7.3.1 Coverage

According to official data (DREES 2008), at 31 December 2007, there were 1.078 million recipients of APA, an increase of 5.1% on a year previously. Of these, 61% were living at home and 39% were living in residential care. Overall, 75% of first-time APA applications from people living at home, and 90% in residential care were granted.

After very rapid growth in the first year after implementation (with 6.5 million recipients by March 2003), the growth in recipient numbers has been at a rate of around 100,000 more recipients per year. Most of these additional recipients were in domiciliary care.

As with other insurance systems, recipients are classified by need. In 2007, just under half (44%) of recipients were at the lowest level of need (of the four need categories). The policy of helping people to remain in their own homes appears to have some scope for further progress as 25% of those in care homes are classified as having relatively low needs.

Separate from APA, and since its introduction, there has in fact still been some financial assistance for those categorised as having needs below those covered by APA under the home help allowance given by the French pension system. This assistance, CNAV (Caisse nationale d'assurance vieillesse), predates the introduction of APA and is provided in cases of geographical isolation, lack of family, great age or particularly difficult social situation. Around 228,000 individuals received such benefit in 2007. Overall, CNAV recipients have decreased by around a quarter since 2002 due to those with higher needs qualifying instead for APA (Pavolini and Ranci 2008).

7.3.2 Funding and Benefits

Unlike the German or Japanese systems, the APA is funded through general taxation. But, like the German system, APA is designed only to meet part of the cost of care with the remainder coming from the individual.

The amount of support people get depends firstly on an assessment of need which determines the maximum rate of support (in money terms) that the person could receive. The second step involves a means-test, based on the person's wealth, which determines what proportion of this maximum rate is to be met by the insurance fund and how much is left for the recipient to pay from their own pocket. The (maximum) payment rates and means-testing rules are set nationally and implemented regionally. The system operates in a slightly different way for domiciliary and residential care.

The maximum rates depend on the recipients assessed need. The assessment uses the national AGGIR (Autonomie Gérontologique – GroupeIso Ressources) scale of dependency scale, which defines the following categories (translated from French Ministry of Health definitions, see also Kessler 2008):

- **GIR 1:** Bed-ridden or confined to an armchair, having lost their autonomy mentally, physically, for movement and socially, necessitating continuous assistance.
- **GIR 2:** Bed-ridden or confined to an armchair, whose mental faculties are not completely impaired but who needs someone to carry out most activities of daily living; or someone whose mental faculties are impaired.
- **GIR 3:** Mental and locomotive autonomy preserved, but in need of help several times a day with activities of daily living.
- **GIR4:** Unable to wash and toilet/dress unaided, unable to get up in the morning without help, but once they are up can move around the inside of the home.
- **GIR 5:** In need of punctual help for toileting/ dressing, meal preparation and housework.
- **GIR 6:** Autonomous in their everyday lives.

In order to qualify for APA, an individual aged 60+ must be classified as belonging to one of the first four (1-4) categories. Anyone classified as falling into these categories has a right to some level of benefits under APA. Assessment is carried out by one of a team of medical and social care staff responsible for assessments.

As regards domiciliary care, the AGGIR classification is used to select a corresponding rate from the national tariff to define the maximum value of the care package. The means-test rule then reduces the actual amount of assistance from APA according to the person's income as the co-payment increases from 0% to 90% of the value of the care package. The means-test takes into account the income declared in the user's last income-tax return. In addition, some assets are assessed. The main residence is not taken into account so long as it is still occupied by the older person, their partner, children or grandchildren.

In the case of a care home placement, the care home fee has three components:

- **Accommodation costs** (tarif d'hébergement), paid for by the individual or, if they lack the resources, through means-tested social assistance.
- **Nursing care** (tarifsoins), paid for by the state health insurance system.
- **Dependency care** (tarif dépendance) i.e. personal care, paid for by the user using any APA benefit.

The calculation of the APA benefit which pays the dependency (personal) care element depends on: the assessed need of the user; the maximum dependency care rate paid for a person at their assessed level of need; and the financial resources of the user. In all cases, the minimum charge is a fixed contribution equal to the payment tariff for the lowest-need levels (GIR 5 and 6 above). Thereafter APA funds are provided to meet the personal care costs on a sliding scale. In this case, the co-payment for the personal care element can be up to 80% of the personal care cost. The family home is not included in the calculation of assessable income so long as a spouse/partner, child or grandchild remain living there.

In addition to these rules, there is a personal expenses allowance for those in care homes (as in England) which sets a minimum level for the user's residual income after paying accommodation costs and the dependency care fee. In September 2008 this allowance was 76 euros (£60) a month.

The APA is explicitly designed as a partial contribution towards residential costs, and family members often contribute – whether explicitly required to do so or otherwise – to the total cost of residential care. If the user does not have the financial resources to pay the co-payment, where they are required to meet all accommodation costs as well as the charge for the personal care element, they can apply for social assistance, subject to the eligibility rules.

Tax incentives

Tax incentives represent a significant additional public subsidy for long-term care. They encourage the employment of personal and domestic staff in the home. Families can deduct half the cost of employing care workers from their income taxes. This has particularly enabled middle and higher income families, whose co-payments are significant, to employ a personal care assistant or domestic worker (it covers childcare and house-cleaning as well as help for dependent older people) (Da Roit, Le Bihan et al. 2007).

The tax break only covers assistance purchased privately, and does not cover help paid for by the APA subsidy. Half of the total private expenditure can be offset against income tax up to a limit of 12,000 euros a year, or up to 15,000 euros depending on the number of children and over 65s in the household (January 2005 thresholds).

Separately, the government has also introduced a "service employment voucher" to simplify the administrative side of employing someone in the home (Da Roit, Le Bihan et al. 2007).

7.3.3 Benefit levels

Domiciliary care benefits and co-payments

The maximum thresholds for payments for the different AGGIR groups in 2008 are shown below in Table 10 (DREES 2008). Any expenditure above these levels must be paid for in full by the individual.

TABLE 10

Maximum monthly value of the APA care package, 2008 (euros)

Dependency category	2008
GIR1	1,208.94 (£966)
GIR 2	1,036.19 (£829)
GIR 3	777.32 (£622)
GIR 4	518.55 (£414)

A user cannot use APA funds to pay a spouse/partner. The funds can be used to employ a relative or other private individual as a carer, but this must be for the performance of specific tasks under the care plan (Da Roit, Le Bihan et al. 2007). Generally the funds can be used for a wide variety of care purposes, from hiring carers to adapting homes (Gleckman 2007). But any expenditure must be part of the agreed care package, and must be accounted for (Pavolini and Ranci 2008).

Data is available which gives a breakdown of the average amounts paid out under APA and the average corresponding co-payments (DREES 2008). This is provided – with sterling equivalents - both for domiciliary care and residential care in the tables below.

TABLE 11

Actual average monthly APA benefits and co-payments for those in receipt of domiciliary care, euros, 31 December 2007

	Total monthly benefit value	Benefit value as % of relevant APA maximum	State contribution - average	Co-payment - average	Proportion of recipients making a co-payment	Average co-payment
GIR 1	982 (£786)	83%	821 (£657)	161 (£129)	70%	229 (£183)
GIR 2	771 (£617)	76%	633 (£506)	138 (£110)	74%	187 (£150)
GIR 3	574 (£459)	75%	479 (£383)	96 (£77)	73%	131 (£105)
GIR 4	352 (£282)	69%	296 (£237)	56 (£45	75%	74 (£59)
TOTAL	493 (£394)	72%	411 (£329)	82 (£66)	74%	111 (£89)

TABLE 12

Actual average monthly APA benefits and co-payments for those in receipt of residential care, euros, 31 December 2007

	Total monthly benefit value	Benefit value as % of the applicable care tariff	State contribution - average	Co-payment - average
GIR 1 and 2	511	72%	366	145
GIR 3 and 4	315	57%	181	134
TOTAL	429	67%	288	141

7.3.4 Specific issues

Overall, the minimum need qualifying for public assistance (GIR 4) is fairly high in terms of level of dependency. It amounts to an inability to carry out at least 3 ADLs without assistance. This is a higher entry threshold, for instance, than for Attendance Allowance and Disability Living Allowance in the UK, and also than for a social care package in some English authorities.

In addition, the APA benefits for domiciliary care are not generous given the degree of dependency at each level (GIR 1 to 4) and do not cover all care costs. The average actual public subsidy to those in category GIR 1 (complete dependency) works out at around £160 a week, which would not cover the necessary amount of care. For GIR 4, it amounts to just £58 a week, less than higher rate AA/DLA.

The means test domiciliary care results in a reduction in the APA benefit at relatively low income levels. For instance, anyone with assessed income approximately above the current level of UK (guarantee credit) pension credit would have to pay some amount in co-payment. Anyone with an annual assessed income above approximately £26,000 would be paying a co-payment of 90% of the value of the care package.

For residential care APA is only intended to contribute towards the dependency care fee (tarif dépendance) and individuals are expected to pay their own accommodation costs unless eligible for social assistance. In practice, the APA benefit does not cover the whole of the dependency care fee. For example, on average for GIR 1 and 2 recipients, the average state contribution would only cover about half of the actual applicable tarif dépendance in the care home. Given that the accommodation costs are not covered at all under APA this means a substantial contribution from the user or family unless the individual qualifies for further state social assistance.

The French system links the public contribution to the provision of a specific care package, unlike in Austria and Germany. This acts against the development of a grey market and has promoted the development of a formal care services market.

The tax breaks offered for private expenditure present a very significant further public subsidy for middle and higher income individuals.

The relatively buoyant market for private LTCI in France represents a big contrast with the situation in England. The market for private LTCI in France is the second largest in the world, with around three million policyholders of l'assurance dépendance (Kessler 2008). France's experience of healthcare funding may explain why the market for LTCI is far larger than in other European countries, including the UK where it has all but disappeared. Also, collective, employer-based private insurance schemes benefit from tax allowances. Other factors driving the growth of the private insurance market include the focus on insurance products designed with cash payouts rather than services in kind, and the dovetailing of eligibility criteria between the public and private insurance systems around the same AGGIR need groups.

7.4 Australia

Formal aged care services in Australia are predominantly financed by taxpayers, with some user co-contributions. Means-testing is widely applied in the care system to determine the level of charges due from the service user.

The subsidised care system provides services-in-kind, with no cash option. Community and residential care services for older people are provided by religious, charitable, community-based and commercial organisations, as well as state, territory and local governments. Over the last 20 years, there has been an increasing emphasis on community care and a re-balancing from low-level to high-level residential care.

In 2010, the Australian Government's Productivity Commission conducted a wide-ranging inquiry into aged care, with a remit that included the development of funding options that "are financially sustainable for Government and individuals with appropriate levels of private contributions". Draft recommendations, published in January 2011, include proposals for significant reforms to the funding system for residential and community-based aged care.

7.4.1 Coverage

The Australian Government and the state and territory governments operate a range of programmes for older people with care needs[6]:

- **Residential care:** Around 163,000 people were permanently based in residential care at the end of June 2010, either in high-level residential care (70% of residents) or low level residential care. Low-level residential care provides accommodation and related everyday living support (meals, laundry, cleaning), as well as some personal care services. High-level care covers additional services such as nursing care, palliative care, other complex care, equipment to assist with mobility, medical management and therapy services.
- **Community Care packages:** Designed for older people who are eligible for residential care but who prefer to remain in the community (and are safely capable of doing so), a number of programmes are available including Community Aged Care Packages (CACP); Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH-D). As of June 2010, just under 50,000 older people received this support.
- **Home and Community Care (HACC):** Low intensity support to help people maintain their independence at home and in the community. Services include meal preparation and delivery, community transport, domestic assistance such as house cleaning and home maintenance, home modification, and personal care. Most HACC clients (90%) receive less than two hours of support each week. Throughout the year 09/10 more than 600,000 older people in Australia benefited from HACC support.

In addition, there are Australian Government subsidised programmes specifically for veterans, for residential respite care and for older people leaving hospital (transition care).

Community care packages for older people are principally delivered by charitable and other not-for-profit (NFP) community-based providers (over 80% of providers); the remaining places are provided by commercial organisations, state and local governments. The median length of receipt of a community care package was just under 12 months for males and 14 months for females (up to December 2009).

At the end of June 2010, there were 2,773 aged care facilities in Australia delivering formal residential care for older people. Around 59% of the beds were operated by not-for-profits; 35% by commercial organisations; and 6% by state and local governments. The median length of time in permanent residential care was 1.2 years for males and 2.2 years for females (up to December 2009).

Clients can refer themselves to a HACC Assessment Service or be referred by a GP, health service or community organisation. Individuals then receive a needs assessment carried out by the HACC provider. Support is prioritised to those with the greatest assessed need, within the budget funding available to the provider.

Aged Care Assessment Teams (ACATs) assess and approve older people for the Australian Government subsidised aged care services – primarily the Community Care packages (CACP, EACH, EACH-D) and residential care. ACATs generally comprise, or have access to, a range of health professionals, including geriatricians, physicians, registered nurses, social workers, physiotherapists, occupational therapists and psychologists. The team determines the care needs and services an individual may require, working closely with the client, their carer and family. ACATs are also the assessment gateway for Transition and Respite Care.

[6] See the report by the Productivity Commission (2011) for more details

7.4.2 Benefits and Funding

In 2009-10, total direct government expenditure on aged care services was around A$11 billion (£6.96 billion), including Australian Government and state and territory government expenditure. Around two-thirds of that expenditure was on residential care, with the balance for all types of care in the community (including HACC), assessment and information services and services provided in mixed delivery settings (Table 13).

Table 14 gives the average level of public expenditure per recipient in 2009/10 for various services. On average public subsidies for high level residential care are AU$ 990 per week (£630 p.w.). With an average public contribution of 74%, the total cost of high level residential care per week averages AU$ 1340 (£850 p.w).

TABLE 13

Government expenditure on aged care services, 2009-10 (AU$ million)

Services	AU$ million
Residential care services	7,290
Community care services (including HACC, CACP, EACH, EACH-D, Respite care, veterans' programmes and other programmes)	3,169
Services provided in mixed delivery settings (including Transition care and other programmes)	458.4
Assessment and information services (only includes Australian Government expenditure)	96.7
TOTAL	11,004

TABLE 14

Expenditure per recipient, 2009/10

	Recipients (30 June 2010)	Public cost per recipient (AU$)	Average private contribution (%)	Average publicly-funded share (%)	Total average cost per recipient (AU$)
Residential care					
Residential high care	112,900	51,550	26	74	69,700
Residential low care	50,100	20,150	53	47	42,900
Community					
EACH packages	5,200	39,600	4	96	41,300
EACH-D packages	2,300	43,300	4	96	45,100
CACPs	40,100	12,700	10	90	14,100
HACC	407,400*	4,800	5	95	5,100

*(Source: estimated using data from Productivity Commission 2011; Steering Committee for the Review of Government Service Provision (SCRGSP) 2011, Chapter 13) *Estimated from total recipients in 2009/10*

For residential care, the Aged Care Funding Instrument (ACFI) is used to calculate the level of public subsidy that goes towards the care component of total costs – as opposed to accommodation costs and everyday living costs. It was introduced in 2008 as an improvement on the previous classification scale, and aims more closely to match funding to the care needs of residents. Aged care residents are assessed into one of 65 ACFI classifications covering three major care domains: ADLs, behaviour and complex health care. A daily care subsidy is paid for each level of the three care domains (Table 15). The total subsidy is generally the sum of these subsidies, up to the maximum ACFI rate (currently AU$162.89 per day).

Residents with sufficient income can be asked to contribute to the cost of their care through an income tested fee (see below). In this case, the amount of public subsidy payable to the provider is reduced by the amount of the income tested fee.

TABLE 15

Daily ACFI rates (2010-2011)

Level of care	Activities of daily living AU$	Behavioural AU$	Complex health care AU$
Nil	0	0	0
Low	30.32	6.93	13.64
Medium	66.03	14.36	38.86
High	91.47	30.25	56.11

Accommodation costs in residential care are not covered by public funding. The maximum amount of the accommodation cost is regulated, however: providers can only charge a maximum amount that varies with a person's assets. It does not generally reflect the actual cost of the accommodation. Contributions are either as an accommodation charge for high level care or accommodation bonds for low level care (see below).

Providers can receive an accommodation supplement from the public system that compensates for accommodation fees charged to low-income people. The amount of the accommodation supplement depends on the proportion of residents accepted by a facility who are unable to meet accommodation costs. For facilities with more than 40% of these low-income residents, the accommodation supplement is at the full rate. For those facilities with 40% or fewer supported residents, a 25% discount is applied to the accommodation supplement. In other words, providers implicitly bear some of the costs of accommodation, which is acknowledged to create incentives for providers to seek better off residents (Productivity Commission 2011, p. 160). The public purse does not pay living expenses in care homes; instead the Government sets a limit on the basic daily fee than providers can charge (which all residents must pay).

As regards community services, under the HACC programme clients are asked to pay a modest fee (set by each state/territory) after which care is publicly funded. Community care (EACH, EACH-D and CACPs) has a nationally determined fee structure for client contributions with a public subsidy for care costs according to the level of recipient's need. For HACC services providers assess clients for need and allocate services on a prioritised basis within their current budgets. By contrast, access to community care packages and residential care is restricted by the aged care planning and allocation system and by ACAT-determined eligibility. In particular, financial exposure of the public purse is managed by limiting the number of approvals (at a level determined from the size of the potential need proportion) and operating waiting lists.

Following their ACAT-determined entitlement, recipients are allocated to a provider, who receives the funding for the care. Providers receive an amount per client based on the average care cost in the relevant broad category of community care — CACP, EACH and EACH-D — rather than the individual's specific needs (Henry Review 2010).

7.4.3 Charges

Many older Australians receiving care (whether in the community or in residential care) are required to make some financial contribution to the cost, including from their old age pension. The level of user charges is dependent on income and assets and this is assessed through a means test.

HACC fees are usually set (by the individual state or territory) as an hourly rate for assistance. Fees are means-tested, although generally are at a modest for all. Means-test thresholds vary significantly across the country.

The level of user charges from community care packages is subject to Government rules:

- **All care recipients** can be asked to pay a fee equivalent to 17.5% of the single age pension towards the cost of an Australian Government provided community care package.
- **Recipients of a full Government age pension** (the pension is means-tested) cannot pay more than 17.5% of their income (around 90% of community care package recipients received some form of government pension or benefit in 2008).
- **Recipients with income above the full rate pension** can be charged up to 50% of that additional income and the total amount that can be charged is not capped by the actual cost of the care package. Commentators note that as a result providers have a financial incentive to 'cherry pick' wealthier recipients of care (Henry Review 2010, p. 640). If wealthier recipients pay for more than the cost of their care, they effectively cross-subsidise lower paying recipients and providers end up playing a redistributive role.

For residential care, fees relate to the different cost components:

- **Basic daily fee:** all residents in aged care facilities, including respite residents, can be asked to pay a basic daily fee as a contribution towards accommodation costs and living expenses like meals, cleaning, laundry, heating and cooling. The maximum basic daily fee for permanent residents entering an aged care home on or after 20 September 2009 is 84% of the annual single basic age pension.
- **Income tested fee:** residents in permanent aged care with total assessable income above the maximum income of a full pensioner are asked to pay an income tested fee (in addition to the basic daily fee) as a contribution to the costs of care. The amount they pay depends on their income and the level of care they require. As well as assessing income, the income test assumes a certain rate of return on assets depending on the type of asset. This income tested fee is however capped, limiting the liability of wealthy residents (with no such capping in community care).
- **Accommodation charge (high level care only):** residents with assets in excess of AU$38,500 who enter high level care may be asked to pay an accommodation charge. The charge increases to a maximum of AU$28.72 per day for residents with assets of just over AU$98,000. In 2009-10, the average accommodation charge for new residents was AU$22.51 per day. Subject to agreement with an aged care provider, a resident can defer payment or make a payment from their estate.
- **Accommodation bonds (low level care and extra service places only):** residents with sufficient assets who enter low level residential or who enter an extra service high care place may be asked to pay a bond. This is in effect an interest free loan to the provider.
- **Extra service charges:** are charges for the provision of a higher standard of accommodation services and food for residents occupying 'extra service' places.

7.4.4 Specific issues

Unlike entitlement systems, and in common with the arrangements in England, the amount of public support that people receive is dependent on their assessed level of need but also accounts for the overall available budget, local policies regarding prioritisation and regional preferences. The system works on the basis of defined charges; that is, people pay charges according to explicit rules accounting for their financial means and their care type. Often charges are only indirectly related to actual care costs. This arrangement is in particular contrast to the German and French systems where benefits are defined and people top-up to their desired level of care.

Many of the main shortcomings of the Australian system are similar to those in England, stemming from the intricate mix of means-testing arrangements and the inconsistency between them. The sheer complexity of the means-testing rules makes the system difficult to understand. As in England, the basis for means-testing as between community and residential care services is different and this can create financial incentives for people to select one care type or another that have nothing to do with care need or even the costs of services. The rules also differ between community care programmes; HACC charge schemes are different from those for the extended aged care at home programmes.

Although the amount that providers (community or residential) can charge is heavily regulated and capped, some of the rules appear to give provider an incentive to seek higher income recipients. Both in regard to extended community services and accommodation costs providers are allowed to charge wealthier clients a higher rate or ask them for a higher value accommodation bond without an apparent offsetting reduction in public subsidy rates.

Whilst there are limits on the maximum charges that care recipients pay (albeit different between the main care programmes), in general wealthier people can face the full cost of their care (or even more than this level for community care packages) which is paid out of pocket. There is little opportunity for these people to insure against this risk. As in England, fairness arguments can be made in regard to means-testing and the implied penalising of people that make financial provision for their old age.

Within the context of ageing populations financial sustainability will always be an issue. In the Australian case the proportion of care costs met by client contributions is low for community care (see Table 14). The Productivity Commission (2011) acknowledges scope for client contributions to increase. These charges are lower, for example, than equivalent charges for community care services in England. Coverage is also very high, with low eligibility thresholds; for example, the AU$ 2bn-per-year HACC programme provides mainly low-level practical and some personal care (most people get less than two hours per week of support). Client contribution rates are also low in this case.

The Australian system appears to be significantly more generous compared to England with public funding levels per capita 65+ at 60% higher even when including Attendance Allowance and Disability Living Allowance in England and HACC service in Australia, in 2009/10.

8. APPENDIX II

The comparison of expenditures reported in the text uses estimates of a range of funding sources. In particular it includes for Germany: estimates of the expenditure on social assistance used by low-income recipients to top-up care; the value of mandated payments to private insurance and expenditure on welfare for war victims (as reported in Rothgang 2010). Furthermore, expenditure in the German and Japanese insurance systems has been pro-rated to compare only spending for recipients 65 years and older.

Expenditure on the Australian care system includes both Australian Government subsidises and those provided by the States and Territories. Figures are available for elderly recipient population which includes indigenous people aged 50–69. The totals include subsidies for residential care and for the range of community programmes. Also included is care expenditure by the Australian Department of Veteran's Affairs.

Expenditure on the English system includes net social care expenditure for older people made by councils. This expenditure does not include personal care services funded by the NHS (which cover around 30,000 older people). Also excluded is public expenditure on disability-related benefits in England (i.e. Attendance Allowance and Disability Living Allowance), in part to make like-with-like comparisons with the other countries and also because there is no requirement that these benefits be spent on care (or data about how they are actually used).

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