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Justification for the study

Governments invest in health and social long-term care (LTC) to provide universal access to care for older persons, ensure financial protection, and provide a social safety net for those unable to pay for needed care. LTC includes medical or nursing care, personal care services, assistance services and social care services. This study focuses on LTC to meet the health and social needs of older persons.

Profound shifts in population ageing and fertility decline require changes in how countries organize and pay for the care of older people. In many countries, families and communities deliver most LTC. However, as populations age, countries face reductions in the supply of informal caregivers and seek alternatives in managing chronic and social needs. Where the provision of social care (personal and assistive services) is not formalized, there is greater pressure on the health system to meet these needs. Governments have therefore invested in LTC to ensure access to needed services, protection against high out-of-pocket spending, as well as to reduce the pressure on health systems and hospital services.

1.1 The scope of LTC

LTC involves a range of services including medical and nursing care, personal care services, assistance services and social services that help people live either independently or in residential settings when they can no longer carry out routine activities on their own. LTC services are considered part of the health or the social care system (Barber, Ong and Han 2020). Typically, LTC includes four main components: medical or nursing care, personal care services, assistance services and social care services (OECD, Eurostat and WHO 2011):

Medical and/or nursing care includes the management of symptoms involving medical and nursing care services, and emotional support to older people and their family members. Such care may include preventive services, chronic disease management; rehabilitation; care to maintain functionality; and care when functionality can no longer be fully maintained or rehabilitated. It may also include palliative and end-of-life care.

Personal care services are provided in response to limitations in self-care primarily due to frailty, disability and/or illness. These services provide help with activities of daily living (ADL) such as eating, bathing, washing, dressing, toileting, and getting in and out of bed. Most residential care as well as some day-care and home-based services will include personal care services.

Assistance services enable a person to live independently in their homes. They aid with tasks of household management (i.e. instrumental (I)ADL), such as shopping, laundry, vacuuming, cooking and performing housework, managing finances, using the telephone, etc.

Social care services involve community activities and occupational support given on a continuing or recurrent basis to individuals, such as activities whose primary purpose is social and leisure. These services are typically provided by household members, friends, community members, or social welfare and community service organizations.

1.2 The drivers of LTC demand

Profound demographic shifts will require changes in how countries organize and pay for the care of older people. In high-income countries, almost one in ten persons will be 85 years or older by 2100 (UN DESA 2020a). Even relatively young nations will experience a substantial growth in older populations in the coming decades. By 2050, 71% of people 65 years and older will be in middle-income countries (UN DESA 2020a). Fertility declines among women are occurring in every region of the world (UN DESA 2020b). This implies fewer children to care for older members of their household.

Across OECD countries, about three in five caregivers over 50 years of age are women (OECD 2019). The availability of a spouse to provide informal care is associated with lower public expenditure for LTC, and this effect is larger than the effect of the presence of children (Yoo et al. 2004). However, the impact on informal caregivers' health and employment through foregone wages and other opportunity costs can be significant.

One category of LTC is assistance with routine IADL, such as cooking, cleaning, washing, and taking medications. Individuals informally supply much of this kind of LTC to older members of the household and people within their community, and this support enables individuals to live in their own communities and function well. In many countries, the burden of LTC is often on the household members and the community. Older persons may reside with their families and children who provide care, and the government role is limited. However, with economic and demographic changes, declines occur in the supply of informal caregivers, and the extended family, household, and community do not provide the same level of personal and nursing care.

Having a large share of the population at older ages does not necessarily result in higher levels of disability. Populations may be healthy as they age, or they may face higher levels of chronic diseases or disability over time requiring more complex services. Rechel, Jagger and McKee (2020) consider three possible scenarios: an expansion of morbidity in which people spend more years living in poor health as life expectancy increases; compression of morbidity in which longer life expectancy is accompanied by fewer years of disability; and dynamic equilibrium with an increased prevalence of chronic diseases offset by a reduction in their severity. Each of these scenarios has implications for economies, public finance and health and LTC spending.

Moreover, different scenarios can apply to separate population groups even within a given country. For example, in Australia and across OECD European countries (OECD 2017), evidence nationally suggests that a person's lifetime spent in ill health remains relatively constant. However, for those in the lowest socioeconomic areas, there is an expansion of morbidity with a greater proportion of life spent in ill health (AIHW 2020). Indeed, the share of the population requiring LTC is likely to be higher in low-income countries, which is related not to ageing but to the prevalence of chronic conditions in early life that contribute to disability in later life (WHO 2007).

1.3 Why governments should invest in LTC

Public LTC spending is projected to increase gradually over time. According to projections for countries in the European Union, public LTC spending is estimated to increase from 1.6% to 2.2% of GDP between 2016 and 2040 (European Commission, Economic Policy Committee 2018). In Australia, national government expenditure on aged care services accounts for 0.9% of GDP in 2014-15 and is projected to rise to at least 1.7% of GDP by 2054-55 (Commonwealth of Australia 2015). These increases are attributable to population ageing, a decline in informal family caregivers, increased availability and costs of formal LTC, and growing household wealth.

A primary reason that governments have invested in LTC is to reduce health expenditures through substitution. Where no family members are available to provide care, or medical attention is needed, people may be admitted to hospitals or other health institutions. In many settings, governments developed formal LTC programs to substitute hospital care with other less costly services that could better meet the needs of older persons (Costa-Font, Jimenez-Martin and Vilaplana 2018). Similarly, to reduce length of stay among older persons in acute care hospitals, governments have established alternative institutional or community care solutions. In some settings, however, not enough funding for the level of need is provided, and prices may vary at subnational level. Government intervention can foster fair prices to improve equity in access.

Even with the expanded role of government in LTC, family members continue to provide personal and assistance care. With increasing demand to deliver appropriate services to older persons and reduce the pressure on hospital systems, there is a shift toward formal caregiving financed in part or fully by the government. As a result, an increasing proportion of LTC is covered by public financing schemes in high-income countries, in contrast with low- and middle-income countries where needs are also increasing.

LTC markets, like health care markets, face the problems of adverse selection and moral hazard, which leaves a role for the government. Adverse selection occurs because people who have some certainty of using private LTC insurance (LTCI) are the main buyers; moral hazard occurs when there is an additional utilization of LTC services due to the presence of insurance (Konetzka et al. 2019). In addition, many people do not believe that they will need LTC in the future, underestimate the cost, or believe that costs are covered by health insurance programs (Brown and Finkelstein 2011; Norton 2016; Zhou-Richter, Browne and Grundl, 2010). Indeed, while some people never need LTC, others may require intensive support or institutional care, which may exceed their available income or wealth. Using data from the USA, it was estimated that men and women 50 years of age have a 50% and 65% chance, respectively, of needing residential care (Hurd, Michaud and Rohwedder 2013). Given the potentially catastrophic and uncertain costs, pooling risks make the costs more predictable.

Where strong public LTC programs exists, there is weak demand for duplicative private coverage. Other reasons for low demand of private LTCI include perceptions of risk by younger persons of working age and limited ability to estimate LTC dependency (Costa-Font and Courbage 2015; Fernandez et al. 2009). Premiums are usually paid entirely by individuals, not partially or wholly by employers as is the case of health insurance, and those who enroll must continue to pay premiums until they need LTC. Because of these factors, private LTCI markets remain relatively small (Fang 2016) and do not represent a major source of funding for LTC. In the USA, the decline in the private LTC insurance market is also the result of pricing and market instability. Insurers have dramatically increased premiums for policies, both new and in-force, and this has led to much lower demand. Also, the total number of insurers actively selling in the market has dramatically contracted (U.S. Department of Treasury 2020). However, in some countries (i.e. France, USA), individuals do purchase private voluntary insurance to complement or substitute public programs.

1.4 Why price setting is important

Prices are a key component of provider payment systems that create economic signals and incentives and influence the behavior of people that provide the services, those that pay for them, and those people that use them. From a societal perspective, the price is the amount that must be paid to elicit the supply and quality of services that society wishes to have and is willing to pay for. Countries have aligned pricing policies with the broader goals of ensuring financial protection, equitable distribution of resources according to health needs, promotion of quality and public health objectives as well as controlling the growth in health care and LTC expenditures and increase efficiency. Price regulations may help to achieve these

objectives, as it promotes price transparency, setting price ceilings on commercial health plans, and instructing providers on conditions of billing within the legislative framework for the LTC sector. Through price regulation, the government may also set the maximum financial contribution paid by individuals to purchase services.

Price setting and regulation is a key component of strategic purchasing. It is linked with revenue raising, given that ultimately the prices must be in line with the available resources. There are also associations with pooling, e.g. price setting and regulations can be used to harmonize payment methods and rates across different schemes or pools. Price adjustments and add-on payments can be used when prices are set unilaterally or negotiated collectively to ensure that specific services or care for populations in need, particularly where there are additional costs of providing care or it is considered unprofitable. In this manner, pricing can be an important tool in allocating resources to meet public health goals

In the context of LTC, pricing is challenging because of the wide range of providers and institutions established to respond to diverse health and social care needs. Subnational governments in several countries finance and deliver personal and social care, and thus play important roles in price setting for LTC for older persons. Measuring quality in LTC is a long-standing challenge given the diversity of providers and institutions involved in care provision and the heterogeneity in relevant outcomes, which poses difficulties for integrating quality measures into pricing and payment systems.