# 2
# Organization and financing of LTC

LTC is delivered in a variety of contexts, from residential and other institutions to the home and community. In many OECD countries, residential facilities have traditionally been the focus of formal LTC systems. However, residential facilities operate at relatively high cost, face problems with maintaining quality, and there is an increased demand for home-based care. As such, families, governments, and purchasers have sought alternatives to residential facilities that meet the specific health or social needs of older persons at reasonable cost and quality.

This section focuses on the organization and financing of LTC based on the findings from case studies carried out in Australia, France, Germany, Japan, the Republic of Korea, the Netherlands, Spain, Sweden and the United States of America (USA) in 2020. LTC systems can be classified into several approaches and by the level of public and private funding, benefits packages and institutional mechanisms for implementation including pricing and payment systems (Applebaum, Bardo and Robbins 2013; Colombo et al. 2011; Wong 2013). These approaches determine to a large extent the way in which countries fund and determine eligibility for LTC.

## 2.1 Settings for LTC provision

LTC can be delivered through institutions and facilities, or at home and in the community. Some countries have created facilities according to the level of nursing care required, including residential nursing facilities, residential facilities, and short-term nursing and rehabilitation facilities.

**Residential nursing facilities** address the needs for people who may require intensive nursing care and assisted living[1]. There are also specialized care units in nursing homes to meet specific patient needs, such as care for people with cognitive decline. Within skilled nursing facilities, care is generally provided for an extended period to individuals requiring ongoing nursing care by licensed nurses that provide nursing and part of personal care.

**Residential facilities** have also been established for individuals who are no longer able to live or function on their own optimally or safely, but who do not require a high level of medical care and supervision. These facilities also seek to sustain and foster residents' independence for as long as possible. Depending on the facility, they may also provide other types of social support, such as assistance with day-to-day living tasks and assistance toward independent living.

**Short-term nursing and rehabilitation facilities,** unlike acute hospitals, play a role in inpatient rehabilitation outside hospital settings for older persons and others. Most dedicated rehabilitation facilities provide step-down services, in which older persons can regain strength following a hospital stay and

1 In the USA, assisted living is better categorized as a residential facility rather than a nursing facility.

before they return home. Some facilities also offer step-up services, which aim to provide services that prevent hospital admissions. Typically staffed by skilled professionals, including medical professionals, nurses, and mental health and social workers, rehabilitation facilities offer physical and occupational therapy, with the aim to prevent admission or re-admission to acute care hospitals. As an example, in Spain, skilled nursing facilities offer intermediate socio-health care to patients that are transitioning from an episode of acute hospitalization to their homes or residence.

Home- and community-based rehabilitation services are also offered in some settings. The care model can include health issues; however, rehabilitation facilities primarily focus on promoting independent functioning rather than addressing health problems.

**Hospitals** provide inpatient long-term nursing and rehabilitative services in some settings to persons requiring convalescence as well as to facilities specializing in the LTC of persons diagnosed with learning difficulties, physical disabilities, chronic illnesses, cognitive impairment, or mental health problems. Subacute care facilities may also be established as step-down facilities after hospital discharge.

In France, LTC departments in hospitals function like a residential nursing facility in a hospital setting, where they attend to the needs of people who require high level of medical attention and support (all age groups). However, the policy in the past two decades has been to shift older people to dedicated residential care facilities outside hospitals. In Australia, public hospitals are the largest providers of end-of-life care. In Japan, 24% of non-psychiatric hospital beds are LTC beds[2]. In Spain, LTC beds represent 9% of total beds in government facilities, which typically offer palliative care either for chronic patients or patients with cancer. In contrast, in the Netherlands, hospitals do not play a major role in LTC provision.

**Home care.** Shifting LTC provision from institutions towards home-based care has been the focus of LTC policies in developed nations (OECD and European Commission 2013). This trend has been driven by both patient demand and the high cost of LTC institutional care that can fall on both older persons and government. Such care substitutes for LTC provided in institutions and can also enable quicker discharge for hospital inpatients. In addition to medical care, lower-level clinical care, principally provided by nurses (and some allied health), comprises the majority of LTC at home and addresses chronic care needs.

For people with higher care needs in rural and remote areas, particularly those who require a higher level of medical supervision, appropriate and cost-effective home care may be possible with suitable technology and referral systems. Indeed,

2 LTC beds are beds in hospitals – excluding psychiatric beds, infectious disease beds and tuberculosis beds – and medical clinics mainly used for patients requiring LTC.

in the Netherlands, home care is no less expensive in comparison with nursing home care for frail older persons (Bakx et al. 2020). However, it may enable individuals to receive care at home that meets their needs and preferences at a similar cost to institutional care.

## 2.2 Organization and financing of LTC

Most countries in the study, except for the USA, provide universal access to LTC benefits with the overall objectives of equitable access based on health needs. Personal evaluations of health and functional ability determine eligibility and the level of benefits. The use of both formal and informal care providers is common. Service packages tend to be comprehensive, including a range of home-based and institutional care, personal, assistive and social care. As such, public expenditures on LTC in these countries tends to be relatively high (except for Spain), and patient contributions are modest, primarily covering board and accommodation in institutional care. However, social care services may not be fully covered or adjusted by income where recipients pay a share of the cost through co-payments, savings, or private insurance.

Table 1. The organization of long-term care (LTC) by country and institution

| Institution/ program/ financing scheme | Types of services covered | Eligibility | Administration level | Number of users (million) | % of total population |
|---|---|---|---|---|---|
| Australia | | | | | |
| Commonwealth Home Support Program (CHSP) | Entry-level home support services mainly covering assistive service, some personal care, and limited clinical care. Services are available on an ongoing or short-term basis and may include day and residential respite services. | Guideline age is adults 65 years and over, 50 and over for Aboriginal and Torres Strait Islander people | National | 0.84 | 3.3 |
| Home care package program (HCP) | A structured, comprehensive package of assistive, personal care and clinical care tailored to meet the needs of older people living at home with more complex needs than the CHSP can support. | Guideline age is adults 65 and over, 50 and over for Aboriginal and Torres Strait Islander people | National | 0.14 | 0.56 |
| Residential care | Residential aged care facilities provide daily living, personal and clinical care and accommodation for those with higher care needs who are no longer able to live at home. | Guideline age is adults 65 and over, 50 and over for Aboriginal and Torres Strait Islander people | National | 0.22 | 0.88 |

| Institution/ program/ financing scheme | Types of services covered | Eligibility | Administration level | Number of users (million) | % of total population |
|---|---|---|---|---|---|
| Short-Term Restorative Care Program | Early intervention to reverse or slow functional decline in older people including assistive, personal, clinical and rehabilitative services. The focus of the program is to promote older peoples' independence and to prevent or delay their admission into residential care. | Guideline age is adults 65 and over, 50 years and over for Aboriginal and Torres Strait Islander people. | National | There were 809 people in this program in total in 2019-20 | <.01 |
| Transition care Program | Short-term, goal-oriented and therapy-focused services to older people in their own home or residential facility following a hospital stay. It is provided as a package of care that may include physiotherapy, occupational therapy, social work, nursing care and personal care. | Guideline age is adults 65 and over, 50 and over for Aboriginal and Torres Strait Islander people | National | There were 24775 people in this program in total in 2019-20 | <.01 |
| France | | | | | |
| Social Health Insurance (SHI) | Skilled nursing facility (SSR) (medical, assistance, personal); residential nursing homes (EHPAD) (medical, nursing); LTC services at home (medical, nursing) (SSIAD); palliative (acute care hospital; at home; mobile teams) | Universal | Central | Total population | 100 |
| Allocation personnalisée d'autonomie, APA ("Personal autonomy allowance") (Local authorities and Caisse nationale de solidarité pour l'autonomie) | Residential nursing homes (personal care), day care in residential homes (medical, nursing); LTC services at home | Adults 60 years and older with mid-to high dependency (the first four levels on the national dependency score (GIR)) | Local / regional | 1.3 | 1.9 |
| Social allocations for elderly | Allocations in residential nursing homes (accommodation), | Adults 60 years and older, everyone is eligible for tax benefits | Local | 0.12 | 0.2 |
| Tax benefits | LTC services at home; self-employed domestic help | Universal | Central | n.a. | n.a |

| Institution/ program/ financing scheme | Types of services covered | Eligibility | Administration level | Number of users (million) | % of total population |
|---|---|---|---|---|---|
| Germany | | | | | |
| Social Health Insurance (SHI) | Inpatient/hospital care, outpatient care, palliative care, home-based intensive care (medical) | Universal. Mandatory insurance | Federal, state (Länder), individual | 73 | 87.7 |
| Private Health Insurance (PHI) | Inpatient/hospital care, outpatient care, palliative care, home-based intensive care (medical) | Annual gross income > 64.350 per annum, civil servants, self-employed | Federal, state (Länder), individual | 8.73 | 10.5 |
| Mandatory Social Long-term care insurance (LTCI) (statutory) | Home-based care, residential care, day care | Anyone eligible. Needs assessment necessary to receive benefits | Federal, state (Länder), county | 4.0 | 4.8 |
| Mandatory Private Long-term care insurance (LTCI) | Home-based care, residential care, day care | Anyone eligible. Needs assessment necessary to receive benefits | Federal, state (Länder) and county | 0.23 | 0.3 |
| Japan | | | | | |
| Social Health Insurance (SHI) | Hospital care (medical, personal); home-based care (medical);palliative care (medical, personal) | Universal | Central | 125 (medical insurance applicants, 2018) | 98.6 |
| Long-term care insurance (LTCI) | Nursing facilities (medical, assistance, personal care); residential facilities (assistance, personal); home-based care (assistance, personal), palliative care (assistance) | Adults 65 years and older and those 40-65 years old with age-related conditions | Prefecture, municipal | 6.1 (2016) | 4.8 |
| Republic of Korea | | | | | |
| Social Health Insurance (SHI) | Hospital care (medical); long-term care hospitals (medical); palliative care (medical, assistance, personal) | Universal | Central | Total population | 100 |
| Long-term care Insurance (LTCI) | Nursing facilities (assistance, personal care); residential facilities (assistance and personal); home-based care (medical, assistance, personal) | Universal but more strict for persons <65 years | Central | Total population | 100 |

| Institution/ program/ financing scheme | Types of services covered | Eligibility | Administration level | Number of users (million) | % of total population |
|---|---|---|---|---|---|
| The Netherlands | | | | | |
| Social LTC insurance | Nursing facilities (medical, assistance, personal); palliative care (medical, assistance, personal) based on eligibility | Universal | Central/ Regional | 197 530 people (2019) | 1.4 |
| Social health insurance | Home-based care (medical, personal); palliative care (medical, assistance, personal) | Universal | Health insurers | 477 200 people 65 + (2019) | 13.5% of the population 65 years and over |
| Social support act | Home-based (assistance); social care in the community | Universal | Municipal | 789 750 people 60 + (2019) (540 870 people 75+) | 17.9% of the population 60+ (34.7% of those 75+) |
| Spain | | | | | |
| National LTC system | In kind (prevention, tele-assistance, home care, day/ night centres, residential care), cash (services purchase, informal care, personal assistance) | Anyone eligible | State (auto-nomous communities), municipal | 1.12 (December 2019) | 2.4 |
| National Health System | Health services (includes hospital care and palliative care) | Universal | State (auto-nomous communi-ties) | Total population | 100 |
| Sweden | | | | | |
| Municipal programs | Institutional care, home care, in kind, cash | Anyone eligible | Municipal | 236360 users of home health care (65+); 88 044 residential care home residents (65 +) (2018) | 2.3 (home health) and 0.9 (residential care) |
| United States | | | | | |
| Medicaid | Nursing care; residential care settings; home and community-based services | Low-income individuals | State | 4.7 million users of LTSS (5.5% of total Medicaid enrollees) (FY 2018) | 1.4 |
| Medicare | Skilled nursing facilities | People 65 years and older | Federal | 1.6 million (FY 2018) | 0.5 |
| Medicare | Home health care | People 65 years and older | Federal | 3.4 million (FY 2017) | 1.0 |

**Note:** In Japan, individuals such as public assistance recipients who do not subscribe to medical insurance are covered by the public assistance system.

**Sources**: Authors.

Germany, Japan, the Republic of Korea and the Netherlands have established LTCI systems to provide care and determine benefits (Table 1). Compulsory LTCI has been established in Germany, Japan and the Republic of Korea. The Netherlands uses a mix of compulsory LTC and health insurance. Social LTCI pays for care in nursing homes, social health insurance (SHI) pays for nursing and personal care provided at home, and the Social Support Act makes municipalities responsible for organizing and financing assistive and social support for the elderly living in the community.

LTC benefits are financed through taxes in Australia, Spain and Sweden. In France, LTC is funded from SHI and local taxes collected by sub-national government entities (*departments)*.

In contrast, in the USA, LTC operates as a social safety net targeted to people without the ability to pay for needed services; thus, coverage is more limited (Weiner et al. 2020). Public LTC is funded by general tax revenue (national and local) and eligibility and co-payments are based on needs assessments and means-testing. In such a system, the overall objective is poverty alleviation and protection of vulnerable groups. Eligibility for public funding is subject to means-testing and only granted after a person depletes his/her own financial resources and has a high level of disability.

In the USA, LTC is provided as a safety net, and eligibility for benefits is based on income and assets. Some analysts include Medicare as another major public payer of LTC for adults 65 years and older (Colello 2018). Medicare provides universal access to health care for acute medical care, outpatient visits and skilled nursing facilities. While the inclusion of Medicare as a public payer of LTC is debatable, this report, consistent with the approach used by the U.S. Congressional Budget Office, includes Medicare post-acute services (skilled nursing and home health services) as a component of LTC spending. In 1997, the Program of All-Inclusive Care for the Elderly (PACE) was established as a permanent Medicare and Medicaid benefit to help nursing home eligible seniors avoid institutional care by providing them with a mix of coordinated acute and LTC services in the community (MACPAC 2019). PACE is not, however, not universally available. Voluntary private health insurance complements the public programs.

The level of administration varies by country and program. Under Japan's LTCI scheme, municipalities act as the insurers and are responsible for setting municipal budgets as well as premium levels for beneficiaries. In Australia, Germany and the Republic of Korea, the funding of services providing care and support for older persons is primarily the responsibility of the national government; therefore, provision is essentially uniform across the country. In Spain, the regulation of LTC is primarily the responsibility of the national government, whereas the funding comes from a mixture of national and – for a large part - subnational sources.

In France, the government created a new (fifth) branch of social security for LTC funding in August 2020. LTC spending was previously part of the SHI budget and financed by National Objective for Health Insurance Spending. At present, it is covered by a new branch, called "autonomy", which is managed by the National Solidarity Fund for Autonomy. It receives a share of income tax funding from generalized social contribution to finance LTC services that was previously covered by health insurance. Sweden is an example of tax funded LTC services, which are organized and financed by local governments. Municipalities decide on their own tax rates and are responsible for providing "eldercare" services. These activities are also funded to some extent by government grants.

## 2.3 LTC spending

Total spending on LTC (including both the health and social care components[3],[4]) accounted for 1.5% of GDP on average across OECD countries in 2018 (Figure 1). At 3.9% of GDP, the Netherlands ranks as the highest spender followed by Sweden (3.4%). Both countries offer universal LTC. In those countries, expenditure on LTC was around double the OECD average. As noted in Table 2, out-of-pocket payments as a share of total expenditures on LTC are the lowest in the Netherlands, Sweden and Japan (8% or less).

At the other end of the scale, the Republic of Korea and Spain allocated 1% of their GDP to the delivery of LTC services. Notably, out-of-pocket expenditure as a share of LTC expenditure is highest in the Republic of Korea (31.5%) and relatively low in Spain (16.2%) (Table 2).

On a per capita basis, there is a large variation in spending, with the Netherlands spending US$ 2142 (in purchasing power parities, PPP) per person in 2018, six times the amount spent by Spain (Figure 1). This variation reflects differences in the population structure, the level of LTC investment, and the stage of development of formal LTC systems as opposed to informal arrangements provided by family members or friends.

3 Following the System of Health Accounts (SHA) framework (OECD, Eurostat and WHO 2011), LTC (health) consists of medical and nursing care and personal care services, whereas LTC (social) includes assistance services. Note that social care services are outside the SHA accounting boundaries.

4 From an expenditure tracking perspective (OECD, Eurostat and WHO 2011), LTC services are categorized according to several criteria. Dependent persons must require LTC services on a continued and recurrent basis for an extended period and suffer from chronic conditions with functional or cognitive limitations over an extended time. Moreover, the service is related to LTC dependency status. For example, medical treatment of a common cold will most likely not be related to LTC dependency and would not be classified as LTC. For the purposes of financial reporting, the OECD excludes informal care, because value is based on a transaction in which a service is financially remunerated. However, care allowances to beneficiaries or caregivers are included, as these payments are taken as a proxy for a paid transaction

Table 2. Long-term care (LTC) financing, 2018

| Country | Source of funding | Public spending on LTC (% of GDP) | Total spending on LTC (% GDP) | Out-of-pocket spending on LTC (% of total spending on LTC) |
|---|---|---|---|---|
| Australia | Tax, user payments | Not available | 1.4 | 22.3 |
| France | Tax | 1.9 | 2.4 | 24.8 |
| Germany | LTCI contributions, taxes, co-payments/out-of-pocket payments | 1.5 | 2.1 | 23.0 |
| Japan | 50% premiums (people >40 years); 50% public (half from central, 25% each from prefectural and municipal governments) | 1.8 | 2.0 | 8.0 |
| Republic of Korea | LTCI contribution (main), taxes, and copayment. | 0.7 | 1.0 | 31.5 |
| The Netherlands | Insurance premiums, general taxation, co-payments | 3.7 | 3.9 | 6.7 |
| Spain | Tax, regional grants | 0.8 | 0.9 | 16.2 |
| Sweden | 84% municipal taxes; 12% national grants | 3.2 | 3.4 | 6.9 |
| United States | Medicaid: general revenue, state general funds, health care provider taxes levied by the state. Medicare: general revenues, payroll taxes and beneficiary premiums. | Not available | 1.6 | Not available |

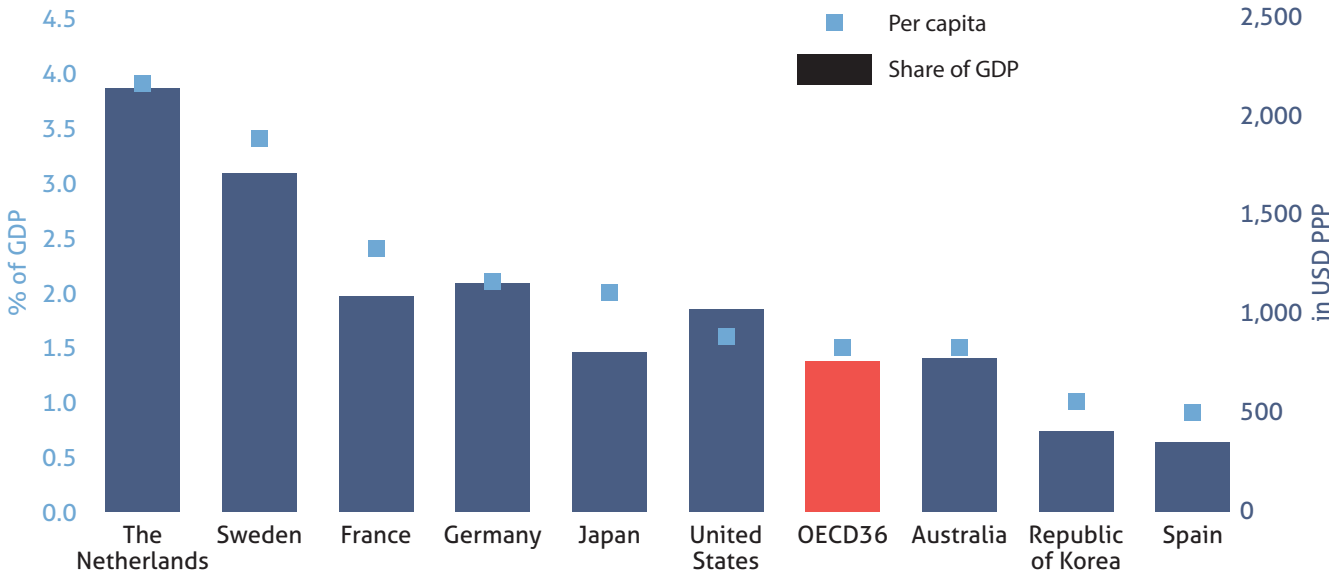
**Source:** OECD Health Statistics (2021).

**Notes:** For Australia, figures are estimated from the Aged care snapshot and the Eight report on the funding and financing of the aged care industry (Australian Government). The share of OOP is the proportion of total expenditure that is consumer contributions to the residential, home care and home support programs.

In Australia, accommodation in residential care is paid as a refundable deposit

For the United States, figures are from the National Health Spending Accounts (CMS)
LTCI: Long-term health insurance

Figure 1. Total LTC expenditure (health and social components) as a share of GDP and per capita, selected countries, 2018

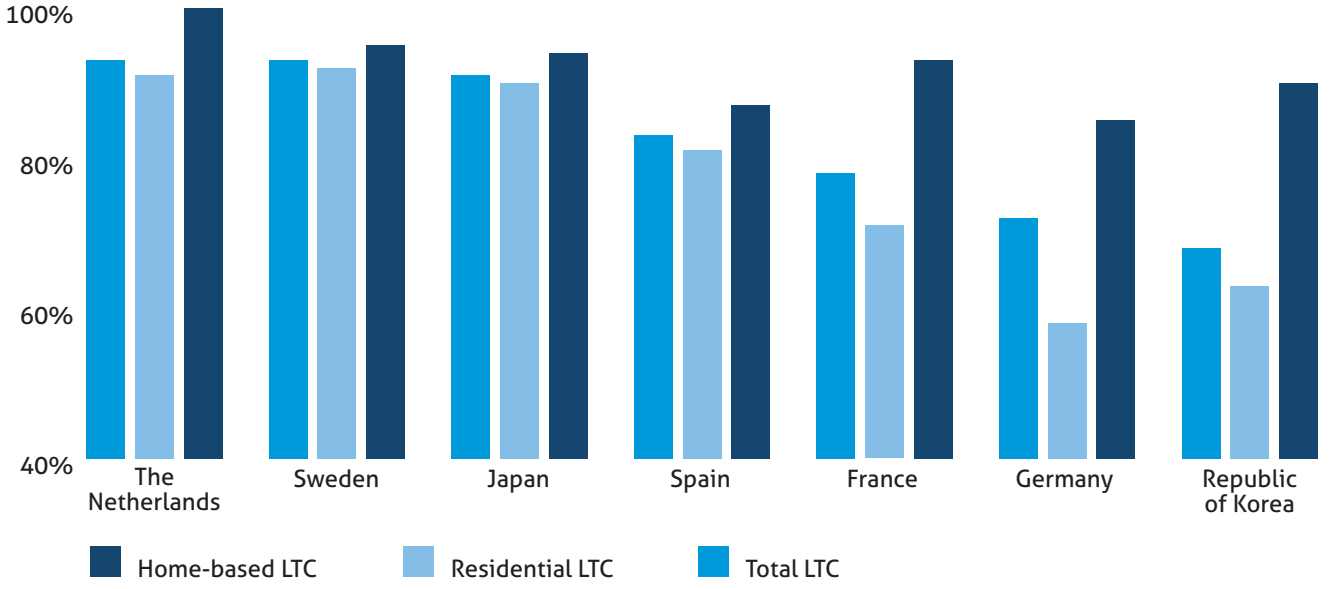



Notes: Germany, Japan and the Republic of Korea do not report social spending.

Source: adapted from OECD (2020).

In countries covered in this study, the costs for the two main modes of provision for LTC – residential care and care provided at home - are covered to a great extent by either a government program or through compulsory insurance (mainly social insurance), with residential care covered less by government or compulsory insurance than home care (Figure 2).

Figure 2. Share of spending for different LTC services financed through public schemes, selected countries, 2018 (or nearest year)




Notes: Germany, Japan and the Republic of Korea do not report social spending.

Source: adapted from OECD (2020).