3 Determining eligibility for public benefits

LTC typically comprises a package of services to individuals with an increased level of dependency on a continued or recurrent basis and over an extended period. The greater the dependency level, the more comprehensive the set of services included in the package. A continuum of care can be tracked from more intensive medical or nursing services through personal care services to assistive services and social care.

Given that the dependency level is a determinant of benefits, needs assessments are applied to restrict or enable access to public benefits and determine the level of services for which beneficiaries are eligible. Needs assessments recognize the heterogeneity in health needs across the spectrum of older persons and identify health needs that trigger government entitlements and services. Some LTC programs also take account financial means, including income and assets, to determine the level of support that they receive.

3.1. Needs assessments

In all the countries studied, needs assessments are conducted to identify eligibility by evaluating health and functional status. Such assessments are administered regardless of whether the LTC approach is universal or functioning as a social safety net; however, the latter programs tend to have stricter needs eligibility criteria because cost control is one objective of the programs. In selected countries, needs assessments are also used to determine whether benefits should be covered under the health insurance or LTCI programs.

In each of the case studies, eligibility is established based on level of complexity of the health condition, physical functioning and medical needs (Table 3). For example, in France, the care package in nursing homes is calculated based on the iso-weighted care group (GPMS) scores, which generate 238 condition-profiles corresponding with the average care needs and dependency level of people living in the facility. The average level of resources required for the 238 profiles was defined by specialists and reported as points per cost item. This instrument uses ten variables measuring physical and mental capacities and seven variables for domestic and social activities (i.e. cooking, household tasks and mobility). For people living at home, medical and social care services are provided and paid for separately.

Eligibility is established through a dependency threshold to identify those persons with care needs. Once need is established, these systems also identify the level of need typically through a graded dependency assessment. In the example of France, the dependency level is determined on the basis of 10 variables concerning physical and mental activity and seven variables related to domestic and social activity, with category 1 being the most dependent and requiring higher levels of care. Similarly, in Germany, evaluations of patient need are based on physical, medical, cognitive and psychological assessments, and the ability to live independently. These assessments are graded on a scale from 0 to 100, which is divided into five stages of need. The level of benefits received thus depends on the level of need.

Table 3 indicates substantial variation and details in the needs assessments. Clearly defined eligibility criteria can result in greater transparency in resource allocation and ensure that people understand their right to care. In this case, resource allocations are linked to health and social care needs. Governments commonly adjust the price and payment level based on the level of complexity of the health condition, physical functioning, medical needs, and financial means. More detailed and strict criteria may be better for controlling expenditures; however, it is unclear whether there is also an impact on unmet needs, and systematic monitoring and evaluation of needs assessment systems and criteria are lacking.

Table 3. Needs assessments to determine eligibility and funding

Country	Individual needs assessments
Australia	An independent comprehensive assessment is conducted for access to govenrment-subsidised home care, residential care and short-term re-ablement and respite programs. Assessments are conducted in the older person's home environment or in hospital; they test physical and psychological functioning, their physical environment and availability of social support. If the older person is deemed to require residential care, their service provider will conduct a further assessment to determine the level of government subsidy using the Aged Care Funding Instrument. It is based on 12 areas including ADLs; behavioral and cognitive ability; and complex care needs.
France	Personal autonomy allowance (APA) eligibility is defined by the national dependency score (GIR) based on 10 variables of physical and mental activity and seven variables of domestic and social activities of living. Only mid-to high dependency persons are eligible (the first four levels of GIR). Assessment is made by departmental teams. For home-based services, the allocation amount is calculated by multidisciplinary teams of local authorities based on GIR score and the "care plan" that they define. APA amount in nursing homes is calculated according to the average GIR score (GMP) of the facility and the value or price of the GIR point fixed by the local council (Conseil départemental).
Germany	Individuals take a uniform needs-based assessment test, which assigns them to one out of five potential "care stages" (Pflegegrade) ranging from 1 – "little impairment of independence" to 5 – "hardship". The stages define the amount of benefits the individual receives. The assessment is based on six elements: mobility; behaviour and psychological issues; cognitive and communication skills; self-care; coping and dealing independently with illness and treatment-related demands and stresses; planning day-to-day living and maintaining social contact. For people in the statutory LTCI, this assessment is carried out by the Medical Service of the German SHI providers (Medizinischer Dienst der Krankenversicherung). For people in the private LTCI, it's carried out by its counterpart, called MEDICPROOF.
Japan	Based on questions on functional status and mental function. Based on responses, applicants are qualified as either ineligible or assigned to one of the seven levels of eligibility. The final decision is taken by an expert committee.
Republic of Korea	Six levels based on functional status and mental function (grades 1-5 plus cognitive assistant grade) in LTCI

Country	Individual needs assessments
The Netherlands	Social LTC insurance: For nursing homes, independent needs assessment are based on functional limitations requiring permanent supervision or 24-hour access to LTC. For peronal care and nursing, needs assessment by providers are based on functional limitations. For home care assistance, needs assessment by municipalities are based on functional limitations. Moreover, the applicant needs to be ineligible for a nursing home admission. Municipalities may set rules about limiting eligibility for assistance when informal care is available
Spain	Eligibility depends on an assessment of the degree of dependency, evaluated on the basis of the Scale of Dependency. The scale measures limitations with various (I)ADLs. Each single activity receives a specific weight and a coefficient indicating the required level of support and supervision. The final assessment is expressed as a numerical score, from 0 to 100. Individuals with a score below 25 are not entitled to any service or financial benefits from the SAAD. There are three degrees of dependency: Degree I (Moderate Dependency, 25-49 points), Degree II (Severe Dependency, 50-74 points), and Degree III (High dependency, 75-100 points). Responsibility for assessing the degree of dependency and benefit entitlement lies with the regions (ACs).
United States: Medicaid	Functional eligibility for Medicaid-covered LTSS is determined using functional assessment tools. Depending on the state, the entity responsible for conducting the Medicaid eligibility functional assessment may be the state or local health department, an area agency on aging, an aging and disability resource center, or a contracted vendor
	Home health care eligibility determined by several criteria including: being homebound; a physician must certify a patient's eligibility for home health care. For skilled nursing facilities, a preceding hospital stay is required

Sources: BOE (2011), CIZ (2019), Department of Health, Government of Australia (2020), MACPAC (2019), Medicare Payment Advisory Commission (2021), MEDICPROOF (2021), Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen e.V. (MDS), GKV-Spitzenverband (2021), Ministerio de Sanidad, Política Social e Igualdad (2011), Ministry of Health, the Netherlands (2021a, 2021b), Ministry of Health, Republic of France (2021), NHIS (2020).

The entity conducting the assessment may be the service provider (e.g. to assess care needs to determine the level of funding service providers are paid for residential care in Australia), a multidisciplinary team of local authorities (e.g. personal and assistance care in France), the Medical Service of the German SHI providers, an investigator of the municipal government (e.g. Japan), a national government agency (e.g. nursing homes care in the Netherlands and the Long-term Care Bureau of National Health Insurance Services (NHIS) in the Republic of Korea), the regional or local social or health department (Spain), the state or local health department, an area agency on ageing, an ageing and disability resource center, or a contracted vendor (e.g. Medicaid in the USA).

3.2. Means-testing

In countries that offer LTC as a social safety net, means-testing is applied to identify whether people are eligible for benefits based on income and/or assets. This applies to the USA Medicaid program, where federal criteria identify low-income individuals receiving Supplemental Security Income as eligible. Means tested systems may result in significant unmet needs and be perceived as unfair in penalizing those with savings or provide incentives to deplete their assets (Fernandez et al. 2009).

In countries that provide universal access to care based on needs, means testing is used to estimate the users' contribution to the cost of care. In Australia, residents make a means-tested contribution to the cost of their care, and this amount is deducted from the level of subsidy paid by the government. Residents pay a set rate for their basic daily services (set at 85% of the single age pension) as well as fees for any additional services that facilities may offer at market prices. For home care, an income tested care fee is applied as a reduction to the home care subsidy paid by government, with annual and lifetime caps to the out-of-pocket costs paid by individuals.

In France, the amount of the personal allowance for autonomy (*Allocation personnalisée d'autonomie* - APA) paid by the local government to meet personal care and assistance needs at home or in residential facilities is adjusted based on the income of the recipient. The full amount of the allowance is paid to individuals with a monthly income below US$ 968, whereas only 10% of the allowance is paid to beneficiaries with a monthly income of US$ 3567 and above.

3.3. Out-of-pocket costs

People are usually expected to make some contribution towards the cost of their care from their own resources. These out-of-pocket costs could represent a given percentage of LTC costs, and link to the level of needs or the user's financial means. Monthly or annual ceilings for out-of-pocket costs may be set.

Most countries set levels of co-payments dependent on income, while some, including Australia, France, Spain and the USA, also consider a person's assets when determining co-payments or eligibility, particularly for food and accommodation in residential care (Cravo Oliveira Hashiguchi and Llena-Nozal 2020). The countries in the study also use very diverse approaches regarding the maximum amounts taken into consideration to calculate user cost sharing, the income/asset components taken into account, and the proportion of income/assets that the cost sharing represents.

In the Republic of Korea, cost sharing represents 15% of the total payment of home-based care services, but it represents 20% of facility-based payment. In Japan, 90% of beneficiaries of LTC services pay a 10% cost sharing, whereas the remaining 10% pay from 20% to 30%. Japan places a cap on the monthly amount paid, which is combined with health care services on an annual basis. In contrast, in the Republic of Korea, there is no cap, but exemptions for low-income persons. In the Netherlands, cost sharing for social assistance is €19 (US$ 22.60) per month (in 2021), and personal care and nursing provided at home are fully paid by SHI.

In Sweden, recipients' cost-sharing represents a small part of the total costs. A ceiling is set annually by the government, representing the maximum amount that a recipient can be charged. This ceiling is set without means-testing in principle, but it may be reduced if the recipient's monthly income is below the minimum cost of living (the "reserve amount") as annually defined by the government. The reserve amount is the minimum amount to cover daily costs, rent and long-term additional costs due to individual needs. Within these rules, each municipality will determine their own schedule of cost-sharing for recipients.

In Germany, the nationally defined benefits schedule is paid directly to providers of residential care. It covers part, but not all, of the negotiated price. People in need of care are invoiced for those parts of the receipt that exceed the defined coverage of the care insurance, the costs for accommodation and meals and a contribution to investment costs. The amount that an individual has to pay depends on the total cost of their care.

In the Netherlands, in 2020, income- and wealth-related copayments were a maximum of €2419 (US$ 2763) per month for residential care or €881 (US$ 1006) per month for substitute care provided outside of a nursing home. In Spain, household contributions are determined by each autonomous region and differentiated according to the care setting and type of service. The extent of cost sharing depends on an assessment of financial capacity, which typically considers available capital, the estate of the beneficiary, as well as household income. Beneficiaries are expected to use no more than 90% of their income.

Under the USA Medicaid program, beneficiaries receiving LTC services in an institution or in the community qualifying through certain eligibility groups are required to apply their income exceeding specified amounts toward the cost of their care[5]. Within federal guidelines, a beneficiary may retain a certain amount of income for personal use based on the services one receives (Colello 2017).

5 These rules are commonly referred to as the post-eligibility treatment of income (PETI) rules.