Long-Term Care Coverage in Europe

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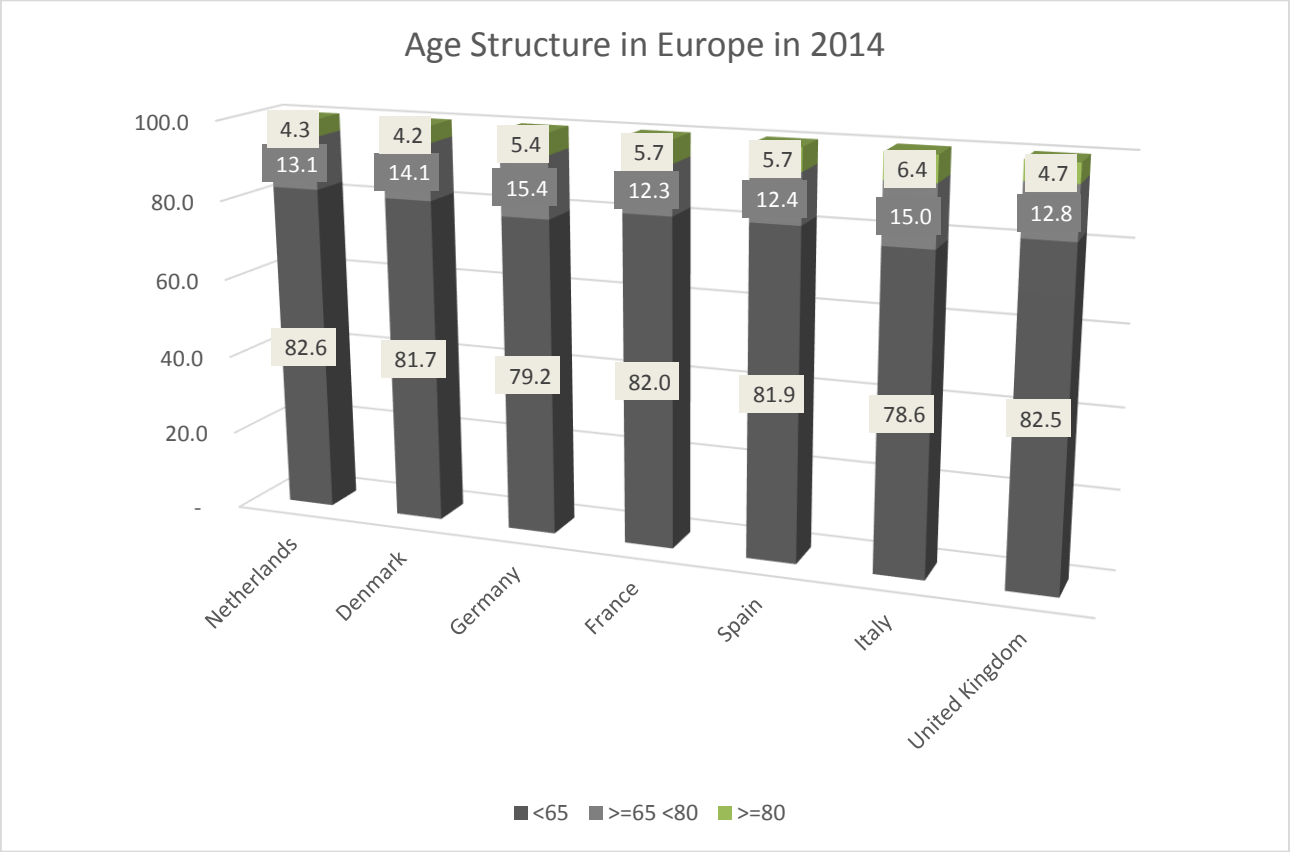
According to Eurostat data, the 75-or-older population in Europe could increase by 64 percent between 2015 and 2040. Given the age structure of each country, growth rates would range from slightly lower in Germany, Italy and Portugal, and higher for Finland, Denmark, the Czech Republic and the Netherlands; France, Spain and the United Kingdom being located slightly above the European average.

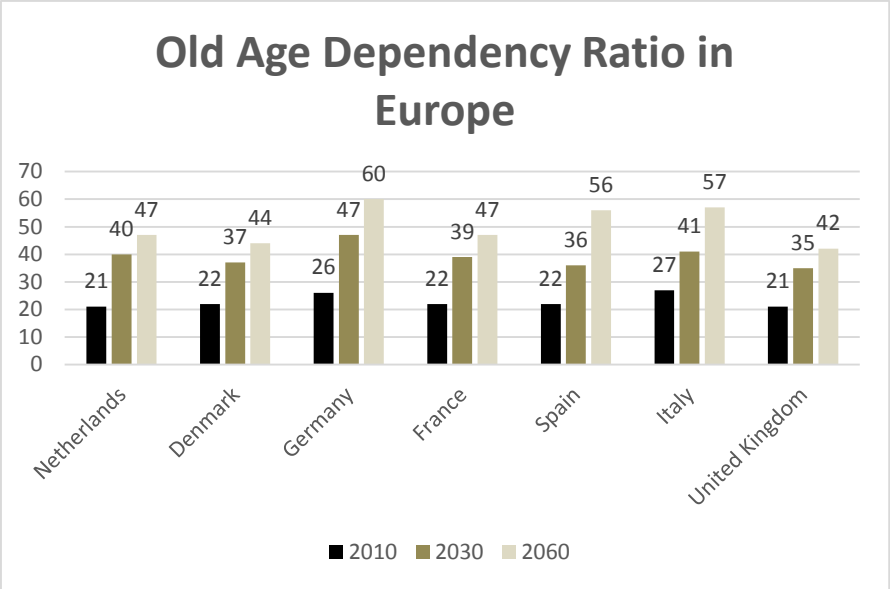
The share of the elderly in the population, and thus potentially that of long-term care needs, varies from one country to another.



Source: Eurostat data

Germany and Italy have the highest proportion of 65 and older, where the under 65 are less than 80 percent of the entire population. The share of population over 80 is the largest in Italy with 6.4 percent. The Netherlands has the largest proportion of population under 65.

The old age dependency ratio here is the ratio of the population 65 and older and the age 15–64 population. A projection to 2030 and 2060 helps to understand the structural changes in the expected population to these dates.



Source: Eurostat data

Germany, Italy and Spain should reach a dependency ratio exceeding 50 percent in less than 50 years. In contrast, the United Kingdom and Denmark should just exceed 40 percent, France being in the middle.

Long-term care coverage in each country is still marked by its past: with a hybrid of Beveridgean[1] and Bismarckian[2] systems, as well as the conservative traditions of some countries, and family traditions of Southern European countries.

- In the Bismarckian model, long-term care protection, like any social insurance, depends on labor and social contributions. Insurance helps contributors (and their families) with proportionality of benefits to contributions, and contributions by employees and employers. Versions of this approach are found in Germany, Denmark and the Netherlands.
- In countries with Beveridgean tradition, social protection is supported by the national government unrelated to employment and it strives for egalitarianism through uniform benefits. It is financed by taxes. This model is also called social democratic, and while it is primarily funded by a central government, it decentralizes implementation to municipalities. The Swedish and Spanish systems are affected by the Beveridgean model.
- Conservative tradition provides greater recourse to the market. A version of this system can be found in the United Kingdom where health care is provided through a national tax-supported system. But the U.K. government, as in nearly all countries, has put in place a safety net for the poor.
- The family tradition model in Southern Europe, finally, has long left long-term care responsibilities on families. This collective choice has been progressively challenged with rising female employment rates, particularly in Italy.

Summary of Long-Term Care Systems by Countries[3]

To set the general framework, the following table estimates the ratio of the number of beneficiaries of dependency benefits to the over-65 population of each country.
One should use caution aggregating the number of beneficiaries at the European level, as compensation schemes and data gathering are not uniform.

	Netherlands	Denmark	Germany	France	Spain	Italy	United Kingdom
1: Beneficiaries of at least one long-term care benefit in 2014 (estimated, in millions)	0.4	0.2	2.4	1.2	0.7	2.3	1.3
2: Total population 2014 (millions)	16.8	5.6	80.8	65.8	46.9	46.5	64.3
3: Over 65 in 2014 (millions)	2.9	1.0	16.8	11.8	8.4	13.0	11.3
Ratio 1/3	14%	20%	14%	10%	8%	18%	12%

Source: Eurostat data

All countries provide an answer to the problem of dependency associated with aging, but to analyze qualitatively, we refer to the classification established by the Organization for Economic Co-operation and Development (OECD), which divides countries into three main long-term care coverage models. The following paragraphs show significant examples of countries corresponding to these models, without aiming to describe the completeness of all European countries.

Model 1: Long-Term Care Coverage Principally through Public Programs

Public long-term care coverage is financed either by taxes, as in the Nordic countries, or through social long-term care insurance schemes.

NETHERLANDS

• General Principle

The first law[4] (1968) addressing long-term care covered "extraordinary health expenses," a mandatory national insurance initially designed to cover heavy and uninsurable risks: long-term care and residential stays, but also nursing and home care. For care and assistance at home, policyholders could, since 1995, opt for a cash benefit (rather than benefits in kind) to enable them to choose their provider.

The rising costs of the program, however, created pressure for reform: A 2007 law[5] on social support transferred to the localities responsibility for all non-medical assistance benefits (social support) and refocused the 1968 law to provide medical benefits for people with serious pathologies. Localities must compensate the long-term care of elderly and disabled persons by providing services to facilitate autonomy, particularly development of housing, meal delivery, domestic help at home, and travel assistance, and offering to the beneficiaries the choice between benefits in kind or in cash. Municipal social services must establish a single process through which to review applications, identify needs and, if necessary, set the level of cash benefits.

Municipalities may require beneficiaries to pay a contribution, for which they are free to set both the level, subject to a ceiling set by regulations, and procedures (fixed or proportional to income, capped or not capped). The share of

a person over 65, who lives alone and whose annual income does not exceed €15,256, is limited to €17.60 for a period of four weeks. In addition, there are plans to shift nursing home care into the health system, which, in the Netherlands, is financed through private insurance.

The Netherlands also has a comparatively high rate of institutionalization for people in need of long-term care.

- **Financing**

The Netherlands has an old system of total dependency financing (elderly and disabled) through taxes and social contributions. Controlling health spending at the national level provides for the gradual transfer of management to municipalities, and a shift toward home support.

Expenditures for the 1968 law are financed by social security contributions at the rate of 12.65 percent applicable to the first €33,363 of income (as of January 2013).

The national government pays a grant to municipalities based on their population profile. Municipalities may use funds available for other purposes if they manage to limit social spending.

- **Global Cost**

Long-term services and supports expenses for the elderly reached about €1.3 billion in 2010.

DENMARK

- **General Principle**

A 1949 act set a universal principle in access to health care for seniors. The law on social services provides that any person can receive free services needed to maintain his or her quality of life, stay at home as long as possible, and maintain his or her physical and intellectual capacities. Management of long-term care is in the logic of the social protection system: It is the result of an extension and a gradual adaptation of health and social services to the needs of an aging population. Since 1987, the law on social services prohibits construction of new nursing homes. However, suitable housing was built. In addition, the law required all new housing to be accessible to disabled people, which benefited the elderly.

Municipalities have the responsibility to implement these services (home help, home furnishings or provision for suitable equivalent housing, day care institution) that are granted free of charge and irrespective of the financial situation of the beneficiaries. Municipal social services determine the nature of services required, but there is no formal need-assessment tool.

In order to educate potential beneficiaries of existing aid, municipalities are obliged to offer two annual visits to every person aged 75, even if they do not receive any assistance. This system is consistent with the national goal of home care. These visits are meant to identify support needs as early as possible, and to provide health information and advice more generally.

No cash benefits are available, but an allowance may be granted to family members who provide assistance.

• **Financing**

Financing of the entire management system of long-term services and supports for the elderly is provided by taxes and by national government subsidies.

About 4 percent of people over 65 live in a facility and are required to contribute 10 percent or 20 percent of their income, based on its level.

• **Global Cost**

Total expenditures were around €5 billion in 2010.

GERMANY

• **General Principle**

The law of May 26, 1994, establishes a mandatory fifth branch, long-term care, to the social security program. Priority is given to home care over institutional care. The amount paid to disabled people and the frail elderly is fixed (and is not adjusted due to income or assets) but varies depending on the level of disability; whether care is provided at home or in an institution; and whether the beneficiary receives benefits as cash rather than in-kind services. Where charges exceed the allocated amount, the recipient is responsible for the payment of the difference and, if he or she cannot, social assistance (administered through the Länder and municipalities) makes up the difference.

Although the majority of Germans fall under the public insurance plan, about 10 percent are covered through private insurance, which is compulsory for people who have private health insurance. Supplemental private insurance is also available, and covers about 4 percent of the population (some of whom have private, and some of whom have public insurance).

The law covers all forms of loss of autonomy, regardless of age. Since January 2013 it distinguishes four levels of dependency, according to which services (personal care, home care) are needed. Beneficiaries of public funds may choose between benefits in kind—delivered at home or in nursing facilities—and cash benefits, or may take a combination of the two. To be entitled to long-term care insurance benefits, applicants must have been insured for at least two years. However, insureds through a private fund may collect indemnity benefits for specific services.

The four disability levels are:

- Level 0: People who, because of dementia, a mental disability or psychological disorder, are severely limited in the exercise of activities of daily living (ADLs), without the level of aid needed for a person described in Level I.
- Level I: Those in need of care at least once a day for bodily care, feeding and mobility.
- Level II: People whose dependence is heavy and need help at least three times a day for basic care and at different times of the day.
- Level III: Those whose dependence is absolute and permanent and who need help 24/7.

People receiving home care, and whose capacity to exercise common ADLs is particularly limited, may be entitled to an additional allowance of up to €100 per month (basic amount) or €200 per month (high amount). Since 2013, persons under the care level "0" may also be eligible. In institutions, in all cases, the Long Term Care Insurance Fund supports a maximum of 75 percent of the amount fixed by the institution.

	Maximum Monthly Benefit as of Jan. 1, 2013			
	Home Care		**Institutional Care**	
Dependency Levels	Cash Benefits (care delivered by family)	Benefits in Kind (care delivered by Social Services)	Part--Time Residency	Permanent Residency
Level 0	€ 120	€ 225		
Level I	€ 305	€ 665	€ 665	€ 1,023
Level II	€ 525	€ 1,250	€ 1,250	€ 1,279
Level III (High)	€ 700	€ 1,550	€ 1,550	€ 1,550
Level III (Low)		€ 1,918		€ 1,918

In addition, long-term care funds support the costs of specialized equipment (hospital beds, for example) and, subject to a deductible of €2,557, costs related to home modifications. Two-thirds of beneficiaries opt for cash payment and live at home. Of these, one-third receives care from private operators, while others are assisted by a family caregiver paid in part through long-term care insurance.

Chapter 7 of Book XII of the Social Code provides, for the lowest incomes, that social assistance can assist a dependent person, including assistance in housing financing and daily expenses.

• **Financing**

Compulsory long-term care insurance is backed by the health insurance social security program. Thus, any person affiliated with the national health plan or with a private insurance plan is automatically affiliated with his or her social security health insurance coverage.

The long-term care branch is funded by a payroll tax rate of 2.05 percent (as of January 2013) shared equally between employees and employers. To compensate the employer's share, a holiday was removed in 1995. People who do not have children pay an additional contribution (0.25 percent) and retirees participate in the financing of long-term care insurance by paying a contribution proportional to their assets.

Financing of social services is provided by the municipalities.

• **Global Cost**

Costs of long-term services and supports for the elderly were about €20 billion in 2010.

Model 2: Long-Term Care Coverage Combined with the Subsidiarity Principle

The second model includes the so-called "hybrid system" with several elements supporting a basic income. France uses this hybrid system with its Personalized Autonomy Allowance (APA); as well as Spain and Italy. Benefits are usually capped. Public financing complements the revenues and assets of the dependent elderly.

FRANCE

- **General Principle**

The 2002 law 2001-647 created a Personalized Allowance for Autonomy (Allocation Personnalisée d'Autonomie, or APA). Major characteristics: Everyone is eligible irrespective of resources. Anyone 60 years old and over, no matter what the level of revenue, can be a beneficiary as soon as loss of autonomy is recognized. It is egalitarian: Its rates and eligibility requirements are set at the national level. However, the benefit is heavily income-adjusted, such that people at higher incomes receive only 10 percent of the full benefit amount.

Dependency level of the claimant is calculated based on the AGGIR grid (Autonomie-Gérontologie Groupe Iso-Ressources, or Equivalent Resource Autonomy-Gerontology Groups) which includes 17 variables, of which 7 are illustrative and 10 are discriminant. Discriminant variables pertain to physical or cognitive loss of autonomy; the others pertain to instrumental and social loss of autonomy. There are six GIR (Groupe Iso-Ressourses, or Equivalent Resources Group) levels.

GIR 1: Persons confined to a bed or armchair, having lost mental, corporal, mobility and social autonomy; requiring the indispensable and continuous presence of caretakers.

GIR 2: Persons confined to a bed or armchair whose mental functions are not totally altered and who require caretaking for the majority of normal ADLs; persons whose mental capacity is altered but who kept their ability to move. For those, moving indoors is possible but toileting and dressing cannot be accomplished, or only partly.

GIR 3: Persons having kept their mental autonomy and their locomotive autonomy partially but who require caretakers several times daily for their corporal care. Toileting and dressing are not completed or only partially. Personal hygiene requires the help of another person.

GIR 4: Persons who cannot accomplish by themselves their transfer but who, once upright, can move indoors. They must be helped for toileting and dressing. Most can eat by themselves. This group also includes persons without locomotive problems but who require help for corporal activities and meals.

GIR 5: Persons moving in their domicile autonomously, and who eat and dress by themselves. They may need regular help for toileting, meal preparation and housekeeping.

GIR 6: Includes persons who did not lose their autonomy for physical and cognitive ADLs.

The monthly cash benefit, APA, can be paid to persons belonging to GIR 1 to GIR 4 levels. The benefit is capped each year, as a function of these four levels. It is not a set amount but an amount calculated as a function of the evaluation of a plan of care, and of the resources of the beneficiary:

- For someone residing at home: The APA allocation paid to the beneficiary is equal to the amount of the care program reduced by the participation of the beneficiary.
- For someone residing in a nursing facility: The APA amount is equal to the monthly benefit corresponding to the GIR of the beneficiary, less the required participation based on income. In principle, the APA is paid to the establishment

Note: For claim evaluation, insurance companies principally use guidelines based on ADLs and cognitive tests. The number of ADLs taken into account for benefit eligibility can vary from one contract to another.

• **Financing**

In 2010, total long-term care (old age and disability) public expenses were financed at 62 percent by the social security health coverage, at 5 percent by the national government, at 22 percent by the regions (départements), and at 11 percent by the Long Term Care National Fund (Caisse Nationale de Solidarité pour l'Autonomie, CNSA).

CNSA is financed through taxation:

- A payroll tax derived from a working holiday: Contribution Solidarité Autonomie (CSA) and "journée de solidarité" (solidarity day, on Pentecost Monday)
- A fraction of the social security payroll tax: Contribution Sociale Généralisée (CSG)
- In 2013 an additional 0.3 percent tax on pensions was added.[6] Lower-income retirees who are not taxed on their income are exempted. This additional revenue is directed to the CNSA fund and amounted to €700 million in 2014.

• **Global Cost**

In 2010, public long-term care services and supports outlay reached €24 billion, €5.3 billion of which for APA benefits paid to 1.2 million individuals. Health expenditures relating to long-term care represented €14 billion, fiscal and social assistance as well as retirement fund assistance represented €2.4 billion, and social assistance for home and residential care amounted to €2.2 billion. About €10 billion were paid by individual resources, some of which through insurance resources.

SPAIN

• General Principle

The 2006 Law No 39 on the promotion of personal autonomy and care for dependent persons provides for the progressive implementation, starting on Jan. 1, 2007, of a national long-term care apparatus that covers all forms of dependence irrespective of causes (age, illness, etc.). Under section 33 of the law, the amount of aid is determined according to the resources of the beneficiary.

The law defines three stages of dependence and subdivides each into two levels. It also determines the list of benefits in kind (from technical devices facilitating home stay to residency in a specialized establishment) to be proposed to the dependent by local social services and, if unavailable, by accredited private providers. The law favors in-kind services over cash, which is granted only if direct services cannot be provided.

Monthly Maximum Benefits 2013	Benefit for Service Reimbursement	Cash Benefit for the Care by Relatives	Benefit for Personal Care	Monthly Minimum Government Contribution
Category III Level 2	€ 833.96	€ 520.69	€ 833.96	€ 266.57
Category III Level 1	€ 625.47	€ 416.98	€ 625.47	€ 181.26
Category II Level 2	€ 462.18	€ 337.25	€ 0.00	€ 103.02
Category II Level 1	€ 401.20	€ 300.90	€ 0.00	€ 70.70
Category I Level 2	€ 0.00	€ 0.00	€ 0.00	€60.00
Category I Level 1	€ 0.00	€ 0.00	€ 0.00	€ 0.00

The System for Autonomy and Attention to Dependence (SAAD) expands and supplements the public program by providing prevention services or reimbursement for services.

The benefit is most often used to pay for home care: 1.4 million people, including a large majority of women (77 percent) who live alone. But this service is also used to cover the costs of accommodation in a specialized institution. Benefits are adjusted based on the beneficiary's income, such that some participants must pay up to 90 percent of the cost of home care and up to 65 percent for other services.

• **Financing**

Financially, the law provides for the cooperation of national and local governments, with financing by local governments to be at least equal to the national government's share.

National contributions are divided into two parts: first a contribution for the dependent person and also an amount negotiated with each local authority. Furthermore, beneficiaries participate in the financing of the program according to their ability to pay (income and assets).

• **Global Cost**

In 2010, national expenditures for long-term services and supports for the elderly were about €1.5 billion. The Long Term Care Oversight department published a study on Dec. 15, 2010, in which it emphasized in particular the lack of national financing, which covers only a third of the total cost of the program.

ITALY

• **General Principle**

The Italian National Social Security Institute[7] delivers long-term care benefits. Since 1984, people 65 and over who are experiencing "persistent difficulties" in performing basic activities of daily life may benefit from a measure previously reserved for the disabled. The allowance for continuous personal assistance is a fixed cash benefit, or €492.97 per month as of January 2013. It does not take into account the level of dependence.

The Local Health Authority[8] and local governments provide reimbursement for services to dependents to cover home care expenses. Tax benefits for hiring an assistant complement the program.

Benefits in kind are provided by regions and municipalities: health services (accommodation in nursing institutions, day care centers, etc.) being provided on a regional basis, and other services by both the regions and municipalities (home accommodation, home care, mobility assistance, etc.). Preventive actions are also conducted. Some regions also provide cash benefits, usually contingent on specific circumstances. Approaches are very different from one region to another and from one municipality to another. In general, the structure and types of services to the elderly are much more developed in the north than in the south.

• **Financing**

Benefits for long-term care are paid without means testing and are financed by taxes. Long-term care expenditures are also financed by local communities and regions based on their general resources and budgets.

• **Global Cost**

In 2007, public spending on long-term services and supports for the elderly was estimated at €17 billion. Cash benefits cover about half of these expenses, accommodation in nursing institutions about 27 percent, and home care 23 percent. Concerning benefits in kind, the national government considers that public spending on long-term services and supports is too heavy, and plans to encourage private insurance.

Model 3: Long-Term Care Coverage Based on Social Assistance

The third model is that of a means-tested minimum safety net. The OECD places the United Kingdom under this model. The following description applies mainly to England as benefits differ in other regions: Scotland provides free personal care.

UNITED KINGDOM (England)

• General Principle

The 1990 law on the National Health Service and Community Care Act makes a clear distinction between health care, which is the responsibility of the National Health Service, and long-term services and supports, which are part of the social care system, and entrusted to local authorities.

Individuals 65 or over who need long-term care can receive the benefit of assistance called "Attendance Allowance." The amount of this benefit depends on the degree of dependency and is not subject to means testing. In 2013 the weekly benefit was £53 or £79.15 (£1 = $1.63 in 2013). This benefit is paid after a six-month waiting period and is meant to be an income supplement. Three-quarters of beneficiaries receive the maximum amount. Assistance from professional caregivers can also be reimbursed.

The National Health Service contributes toward the health care component of long-term care, by paying an additional aid of £101 per week for nursing facility costs.

Local authorities may support some long-term care costs, however, based on a person's needs as well as resources, including the home. Local services must plan and manage how services are provided, but do not have the obligation to provide them directly: They can use private providers or can reimburse the beneficiary for the needed services. For expenses associated with nursing homes in general, costs are fully borne by persons whose assets exceed a certain level, set in 2013 at £26,500. Below £26,500 of assets, the amount of aid corresponds to the difference between the price charged by the nursing home and the income of the elderly, plus £1 of copay for every £250 of assets.

• Financing

Funding is provided by the national government through tax.

• Global Cost

The program is considered expensive with, in 2009, £9 billion of local spending and £13 billion of public spending. Major criticisms include:

- Disparity exists in copayments between jurisdictions.
- Households bear a significant share of the cost.
- The system indirectly penalizes savings.

Since 2000, a substantial financial effort has been made by the national government to develop services aimed at preventing older people from being hospitalized in the absence of more appropriate alternatives, and that entry into an institution should be done at the most appropriate time in an individual's life cycle; in other words, not too soon,

if the health and the loss of independence warrant living in one's home. Moreover, the Care Act of 2014 introduces a cap on lifetime social care costs of £72,000; implementation of the law is planned for 2020.

Conclusion and Developments

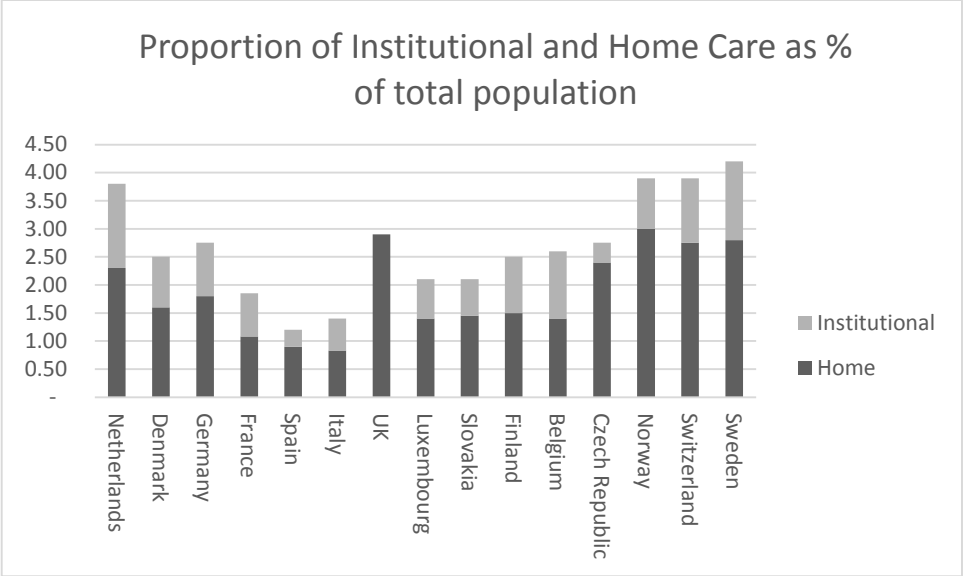
Long-term care policies are very varied in Europe. Each country developed its program based on its unique history, politics and cultural values, resulting in three major social models. Also, the European Union has not intervened in the matter. The only regulations that deal with the issue are about coordination of programs:

- Coordinating regulation of social security systems, which in its new version of Regulation 883/2004 refers to long-term care cash benefits to be exportable, but not benefits in kind, when an insured person changes member country residency.
- Regulation 2011/24/CE on the mobility of patients mentions dependency, or more accurately long-term care to stick to the literal English translation, only for the exclusion to the scope of its regulation. This exclusion is an important part of the political compromise that has prevailed.
  With the exception of Spain, where the law on assistance to dependent persons is not yet fully implemented, countries that provide better long-term care management for the elderly are Germany, Denmark and the Netherlands. The Italian public long-term care system of care remains secondary to family care. As for the English system, it is particularly complex, and the organization of services by local authorities resulted in a wide disparity of services provided to the elderly population.

Points of Convergence

This diversity of circumstances, however, tends to fade, and it is likely that the different systems will converge over a longer horizon, as countries face common challenges. The first elements of convergence are already present in most countries:

- First, priority to home care, which meets the demands of the inhabitants and involves, for most early programs, a break with "the very institutional" 1970;



OECD—2010 Report of the Commission on European Affairs—July 2011

- Development of cash benefits instead of benefits in kind in the form of allocation of hours services; this allows better control by the financing entity (national government, local government and social security) and greater flexibility of use by the beneficiaries, especially for caregivers;
- A trend toward free choice of providers, even for benefits in kind granted under the auspices of public authorities;
- **A limited role for private insurance**. The role of private insurance is generally small and weak in terms of population covered, except for Belgium, Norway and France (7.3 million people with private insurance in France in 2013). In Germany, private health insurance funds, to which are affiliated those Germans who can opt for private insurance, have the obligation to provide long-term care insurance on the same terms as the public plan.

Some Examples of European Insurance Products

In **the Netherlands,** the market is nonexistent due to public funding for long-term care costs in the form of a special fund of the national health insurance program.

In **Denmark**, there are no specific products as public coverage is prevalent.

In Germany, besides mandated and supplemental health insurance products, the life insurance industry has also developed long-term care insurance products. The annuity model has become prevalent, just as in other European life insurance markets. Private long-term care insurance premium depends solely on the issue age (in particular, it cannot depend on gender) and is capped at the maximum public insurance premium. In late 2010, the average long-term care benefit (long-term care supplementary insurance included) averaged €10,856 per year, and for new policies the average benefit was about €13,004.

In **France**, long-term care insurance is mostly through monthly premium individual "risk" contracts, subject to medical underwriting, waiting periods and elimination periods, which guarantee payment of a lifetime annuity in case of total (4 of 5 ADLs or 1-2 GIR) or partial (3 of 5 ADLs or 3-4 GIR) dependence, with premium payment being waived. As of now the average annuity benefit is higher than the average APA benefit.

There are also several types of group insurance, not yet fully developed, using the "savings" approach, without

underwriting. Long-term care coverage can also be included in health contracts, but in this case the benefit level, often in the form of a lump sum, is lower than the above-mentioned benefits where the long-term care coverage is the principal guaranty.

Spanish and Italian markets are more comparable to that of France, as there products are mainly sold as stand-alone insurance.

In **Spain,** several products and benefit types have emerged; benefits may take the form of a lump sum and/or temporary or lifetime income. Nevertheless, and despite the efforts made, penetration of this insurance is low (less than 2.5 million covered).

In **Italy,** insurance is still underdeveloped. Although a score of private insurers have offered long-term care products for several years, demand remains relatively limited. This is explained in part by the leading role still being played by family, although for some time the effects of social change are felt. The design of Italian long-term care insurance products is highly similar to those French products (ADL model).

In the **United Kingdom**, the products offered are varied and innovative: In addition to pure risk contracts (which often take the form of single-premium annuity contracts), in many cases long-term care insurance is backed by a savings product that requires a significant capital contribution. In addition, some contracts provide against the risk of dependency longevity: These contracts have the particularity to cover the already-dependent person who pays a single premium to an insurer in order to have a life annuity (Immediate Care Plans).

In the case of Immediate Care Plans, the beneficiary receives a fixed monthly sum until the end of his care, and in the case of plans based on a property, Release Equity Plan (reverse mortgage in the United States), the beneficiary receives a loan on the property, possibly the loan being repaid after death.

Immediate Care Plans provide certainty: The family inheritance will not be squandered due to the end-of-life cost of the care required by the policyholder.

In **Belgium,** anyone over the age of 25 domiciled in the Flemish territory is required to join a "long-term care fund," for an annual fee of €25. This insurance gives entitlement to an allowance—now fixed at €125 monthly—freely usable for institutional, day care or home care.

In a country like **Norway,** even if private insurance contributes to the overall financing of dependency, there is no "long-term care insurance" because the national insurance scheme is purely egalitarian; regardless of the person, Norwegians pay 80 percent of his or her disposable income while in a nursing home stay. Consequently, the need for long-term care insurance is less felt.

Diversity of Funding

When analyzing long-term care financing more generally, regardless of payer, it appears that in most countries financing is diversified, involving all resources: national and local taxes, social security and private sources whether through the beneficiary's resources or private insurance.

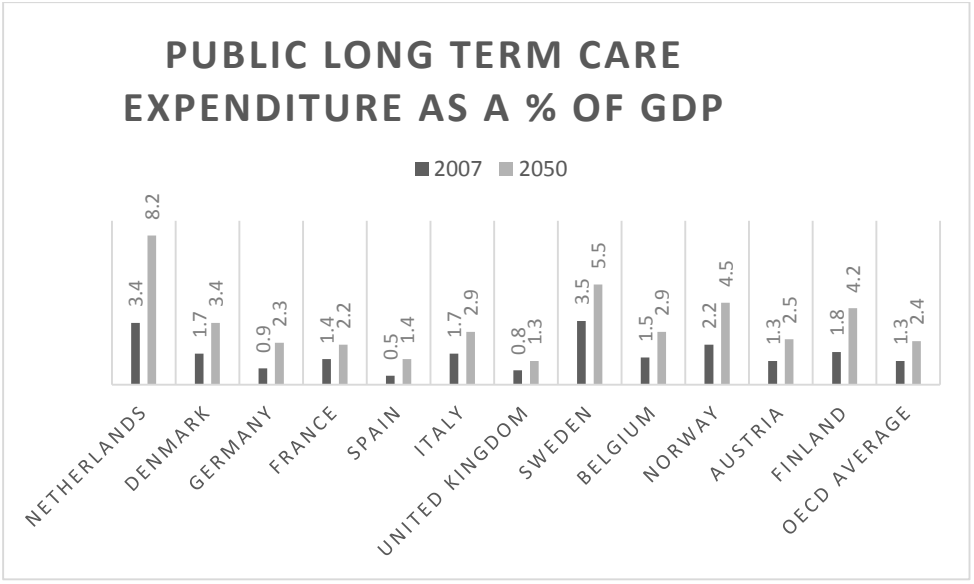
Among European countries, the share of households' responsibility is particularly high in Switzerland and Portugal. Private funding is significant in Germany, in France, and in Spain where benefits follow, as presented above, a fixed guideline.

Private funding is low in the Nordic countries where, as we have seen for the Netherlands, the ceiling for households' participation and a minimum benefit for the "remaining life expectancy," both at home and in institutions, protect the poor.

Expense Projections

Public expenditure management of long-term care in 2010 averaged about 1.5 percent of gross domestic product (GDP) in OECD countries, excluding institutional residence expenses. Dependency criteria are broader than those used in France and notably include disabled persons in institutions.

In this context, France had a rate of 1.7 percent of GDP in 2010. This percentage will increase significantly as a result of demographic changes. It could double or even triple by 2050. In 2007, Sweden and the Netherlands had the highest spending levels in proportion to their GDP, at 3.5 percent and 3.4 percent, respectively, while Portugal (0.1 percent), the Czech Republic (0.2 percent) and Slovakia (0.2 percent) are the countries where the expenditure levels were the lowest.



Center for Strategic Analysis—Referential scenario taken from the Report on European Affairs.

The projections give a very significant increase in these costs in 2050. The average for OECD countries should reach 2.4 percent in median baseline. Costs would exceed 8 percent of GDP in the Netherlands and 5 percent in Sweden. For other countries, spending would increase significantly as a proportion of GDP, as shown in the table above. France, with 2.2 percent of GDP in 2050, would be within the average of OECD countries.

A Variety of Definitions

Apart from the purely financial aspect, which will be a major challenge in the coming years, we should, for better convergence, achieve a shared set of definitions for long-term care and its measurement, for example:

- A distinction of functional dependency and cognitive impairment, because with the exception of France and the United Kingdom that put an age requirement, other countries aggregate physical and mental disability, or criteria for "duration and care" and "care utilization" to accomplish ADLs.
- A convergence is rendered more difficult as benefit measurement depends not only on the level of dependency but on the nature of service and the delivery system.

In Sweden, the approach is not done according to the concept of dependency, but according to one's needs;

- The recognition and evaluation of the level of dependency differ by country:

Netherlands	An independent national organization[9] evaluates care needs for national benefits. Localities develop their own assessment. Benefit levels are subject to income requirements
Denmark	Elderly care is essentially home care, through municipal programs. No classification but case-by-case evaluation. Evaluation teams are coordinated by a qualified case assessor, having pursued a specific formation and with three to seven years of experience in elderly home care. No income requirement.
Germany	Based on the assessment of local health care funds, using national guidelines (grid) Classifications from Level 0 (low) to Level III (high) Case-specific for high dependence No age or income requirement
France	Classification by national grid: GIR 1 (high) to GIR 4 for APA benefit eligibility. GIR 5 and 6 do not trigger benefits. Age and income requirement
Spain	Classification of dependency from Level I (mild) to Level III (high) based on BADL (basic activities of daily living) corresponding to 10 activities Beneficiary participation based on revenue level
Italy	Local branches of the national health program, different grids by regions No age or income requirement
United Kingdom	Regional evaluation based on a national standard of need evaluation Age and income requirement

In addition, a number of countries take into account the income and assets of dependent persons:

- Germany and Belgium enforce filial support laws.
- Spain (locally) and Belgium practice recovery of assets at succession, but not today in France
- The United Kingdom limits assistance to a maximum asset level.
- Sweden and the Netherlands do not practice estate recovery, nor asset maximums, nor filial support.

Finally, future reflections cannot collectively ignore the ethical quality of care and services, the fight against mistreatment, respect for people and their dignity in later life. The choice between "home care" or specialized establishments is deeply structured in terms of values but also in financial terms, with home support for better cost

control. Decisions on “cash benefits” or “benefits in kind” will also need to be made. Aid for home modification is becoming a way to facilitate a home stay.

Caregiver resources, estimated at 20 million people in the European Union, of which 9.6 million deliver care for more than 35 hours per week, require material and psychological support, to avoid overextension. Of 10 workers in the long-term care sector, nine are women. Long-term care sector workers represent about 1.5 percent of the working age population. According to OECD, the manpower demand of the industry should at least double by 2050.

France continues to be on the underdeveloped side of Europe in this field. In contrast, Denmark and Sweden have 100 occupational therapists per 100,000 inhabitants, with 60 for Belgium, 50 for Britain, 40 for Germany and 12 for France.

In OECD countries, more than 1 in 10 adults care for a dependent person, particularly in Italy and Spain. Two-thirds of nonprofessional caregivers are women over 50 years old who spend at least 10 unpaid hours a week caring for a dependent person. Caregivers have a 50 percent higher probability than non-caregivers to be at home and work two hours less per week on regular jobs, and have a 20 percent higher probability to develop mental health problems.

Finally, the subject of coordination of all stakeholders—medical, social, financial, patrimonial and institutional—remains unresolved in all countries despite one-stop access (Germany) or single provider (the Netherlands, Sweden).

NOTES

The study is based primarily on analyses in four main sources:

• "Comparative Analysis of Long-Term Care Programs in the European Union" (L'analyse comparée de la prise en charge de la dépendance dans l'Union européenne), by Florence Kamette, February 2011, for the Robert Schuman Foundation
The Robert Schuman Foundation was created in 1991 after the fall of the Berlin Wall. Recognized as a public service organization by the French government, the Robert Schuman Foundation works for the advancement of the European Union. An information research center, it develops research on the European Union and its policies and promotes results in France, Europe and abroad.

• Report of the Center for Analytic Strategies "Long Term Care Challenges for the Golden Years" (Les défis de l'accompagnement du grand age), by Virginie Gimbert and Guillaume Malochet, June 2011
The report explores the international prospects to inform the national debate on long-term care and highlights the main features of national policies to help home care, reception conditions in institutions, and support for family caregivers, focusing on the financial conditions of support.

• Report on European Affairs (Rapport de la Commission des Affaires Européennes)**,** presented to the House of Representatives, by Deputy Valerie Rosso Debord, July 2011
The findings are based on work done by the OECD (May 2011) and the Center for Strategic Analysis and on the particular study of three programs within the European Union (Germany, the Netherlands and the United Kingdom). According to the commission, "this is the result of pragmatism." The report stresses that under the pressure of common issues (demographic and financial), the various systems tend to converge: priority given to home care, development of financial benefits rather than in-kind, free choice of provider for their people with long-term care, limited role of private insurance.

• Report "Pick Up the Political Challenge of Older Age—International Perspectives" (Relever le défi politique de l'avancée en âge—perspectives internationales), by representative Martine Pinville, March 2013
This report aims to identify and compare internationally interesting and innovative practices that encourage reflections on long-term services and supports components "anticipation—prevention and adaptation of society to the obsolescence of its autonomy law."

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[1] The Beveridgean approach was outlined in a 1942 paper by William Beveridge, '"Social Insurance and Allied Services.".

[2] The Bismarckian model started in Germany in the late 19th century through the policies of the government of Otto von Bismarck

[3] Summarized from the comparative analysis carried out by the Robert Schuman Foundation in February 2011 and the work of the General Directorate of the French Treasury in April 2010, summarized in the report of the European Affairs Committee in July 2011.

[4] AWBZ: Algemene Wet Bijzondere Ziektekosten.

[5] Wet Maatschappelijke Ondersteuning, or WMO.

[6] Contribution Additionnelle de Solidarité pour l'Autonomie (CASA).

[7] Istituto Nazionale Previdenza Sociale (INPS).

[8] Azienda Sanitaria Locale (ASL).

[9] Center for Care Indications (CIZ).

Books written by Edith Brocquaire published in l'Argus de l'assurance:

- *Major Actuarial Principles* (Les grands principes de l'actuariat), May 2015

- *Meeting Long Term Care Insurance Challenges* (Relever les défis de l'assurance dépendance), February 2014
- *Health Insurance, Actors and Guarantees* (Assurances de santé, acteurs et guaranties), December 2012