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Long-Term Care Coverage in Europe

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The need for long-term care (LTC) services in Europe continues to rise, as in the United States, with the aging of the populations. According to Eurostat data, the 75 or older population in Europe could increase by 64 percent between 2015 and 2040. Germany and Spain should reach a dependency ratio[1] exceeding 50 percent in less than 50 years. In contrast, the U.K. should just exceed 40 percent.

LTC coverage in each country is still marked by its past, with a hybrid of Beveridgean and Bismarckian systems, as well as the conservative traditions of some countries, and family traditions of European countries.

- In the Bismarckian model—named after the German Chancellor Otto von Bismark—LTC protection 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. Like most other countries, this model provides a safety net for individuals under the poverty level.

- In countries with the Beveridgean model—named after the British economist William Beveridge—social protection is supported by the national government, unrelated to employment, and it strives for egalitarianism through uniform benefits. The social protection is financed by taxes. This model is also referred to as "social democratic," and while it is primarily funded by a central government, it decentralizes implementation to municipalities. The Spanish LTC system also has elements of a Beveridgean model.

- Conservative traditions provide greater recourse to a market-based system. The U.K. government, as in nearly all countries, has put in place a safety net for the poor. A version of this system can be found in the U.K., where health care is provided through a national tax supported system.

- The family tradition model in southern Europe has long left LTC responsibilities on families. This collective choice has been progressively challenged with rising female employment rates.

LONG-TERM CARE SYSTEMS IN GERMANY, SPAIN, AND THE UNITED KINGDOM

The following table illustrates the ratio of the number of beneficiaries of dependency benefits to the over-65 population of each country.

	Germany	Spain	U.K
1: Beneficiaries of at least one Long-Term Care benefit in 2014 (estimated, in million)	2.4	0.7	1.3
2: Total population 2014 (million)	80.8	46.9	64.3
3: Over 65 in 2014 (million)	16.8	8.4	11.3
Ratio 1/3	14%	8%	12%

MODEL 1: LONG-TERM CARE COVERAGE PRINCIPALLY THROUGH PUBLIC PROGRAMS

Public LTC coverage is financed either by taxes, as in the Nordic countries, or through social LTC insurance schemes.

GERMANY

General principle

A 1994 law established LTC as a mandatory fifth branch of 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, local social assistance 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, the law distinguishes four levels of dependency according to which services (personal care or home care) are needed. Beneficiaries of public funds may choose between benefits in kind, delivered at home or nursing facilities, and cash benefits, or may take a combination of the two. To receive LTC insurance benefits, applicants have to be 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 time of the day;
- Level III: those whose dependence is absolute and permanent and need help 24/7.

People receiving home care, and unable to perform most ADLs, may be entitled to an additional allowance. Since 2013, persons under the care level "0" may also be eligible.

In addition, LTC funds support the costs of specialized equipment (a hospital bed, for example) and costs related to home modifications, subject to a deductible. 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 LTC insurance.

Financing

The Social Security program requires compulsory LTC insurance. As a result, 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 LTC 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 beginning in 1995. People who do not have children pay an additional contribution (0.25 percent) and retirees participate in the financing of LTC Insurance by paying a contribution proportional to their assets. Financing of social services is provided by the municipalities.

LTC coverage in each country is still marked by its past, with a hybrid of Beveridgean and Bismarckian systems, as well as the conservative traditions of some countries, and family traditions of European countries.

MODEL 2: LONG-TERM CARE COVERAGE COMBINED WITH THE SUBSIDIARITY PRINCIPLE

The second model of LTC coverage, used in Spain, includes a "hybrid system" with several elements supporting a basic income. Benefits are usually capped, and public financing complements the revenues and assets of the dependent elderly.

SPAIN

General principle

The 2006 Law No. 39 on the promotion of personal autonomy and care for dependent persons provided for the implementation of a national LTC program which 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. The law also determines the list of benefits in kind (from technical devices facilitating home stay to residency in a specialized establishment) which are 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.

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, as 1.4 million people—including a large majority of women (77 percent)—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 local authorities. Furthermore, beneficiaries participate in the financing of the program according to their ability to pay (based on their income and assets).

MODEL 3: LONG-TERM CARE COVERAGE BASED ON SOCIAL ASSISTANCE

The third model, adopted by the U.K., is based on a means-tested minimum safety net. The following description applies mainly to England as benefits differ in other regions. Scotland, for instance, provides free personal care.

UNITED KINGDOM (England)

General principle

The 1990 Law on the National Health Service and Community Care Act made 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 LTC services 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. This benefit is paid after a six months 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 LTC by paying an additional aid of £101 per week for nursing facility costs.

Local authorities may support some LTC costs based on a person's needs as well as resources, including their home. Local service coordinators must plan and manage how services are provided, but they do not have an obligation to provide them directly. The coordinators may 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 £26,500 (in 2013). 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 a £1 copay for every £250 of assets.

Financing

Funding is provided by the national government through tax.

CONCLUSION AND DEVELOPMENTS

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

- A regulation coordinating social security systems. LTC cash benefits are exportable, but not benefits in kind, when an insured person changes member country residency;
- A regulation on the mobility of patients mentions LTC only for the exclusion to the scope of its regulation. This exclusion is an important part of the political compromise that has prevailed.

In Spain the law on assistance to dependent persons is not yet fully implemented. Germany provides better LTC management for the elderly. The U.K. system is particularly complex, and the organization of services by local authorities results in a wide disparity of services provided to the elderly population.

Points of convergence

There are some similarities between the three programs:

- An emphasis on home care
- The development of cash benefits instead of benefits in kind, in the form of allocation of hours of 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 towards the free choice of providers, even for benefits in kind granted under the auspices of public authorities;
- A more limited role for private insurance. The role of private insurance is generally small in terms of the population covered.

In Germany, besides mandated and supplemental health insurance products, the life insurance industry has also developed LTC insurance products. The annuity model has become prevalent, just as in other European life insurance markets. Private LTC 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 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 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 LTC insurance is backed by a savings product that requires a signif-

icant 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 U.S.), the beneficiary receives a loan on the property with the possibility of the loan being repaid after death.

Diversity of funding

When analyzing LTC 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.

Private funding is significant in Germany and in Spain where benefits follow a fixed guideline. Private funding is low in the Nordic countries where the ceiling for households' participation and a minimum benefit for the "remaining life expectancy" protect the poor, both at home and in institutions.

Expense projections

Public expenditure management of LTC in 2010 averaged about 1.5 percent of GDP in OECD countries, excluding institutional residence expenses. Projections give a very significant increase in these costs by 2050. The baseline average for OECD countries should reach 2.4 percent.

A variety of definitions

Apart from financing, which will be a major challenge in the coming years, it would be helpful to agree on a shared set of definitions for LTC and its measurement. As examples:

- A distinction of functional dependency and cognitive impairment. With the exception of France and the U.K. that mandate an age requirement, other countries aggregate physical and mental disability, or criteria for "duration and care "and "care utilization", as proxies for Activities of Daily Living.
- Countries differ in their definitions not only of the level of dependency, but on the nature of service and the delivery system. In Sweden, for example, LTC is supplied not according to the concept of dependency, but according to one's needs;
- The recognition and evaluation of the level of dependency differs by country:

Germany	Based on the assessment of local health care funds, using national guidelines (a grid) Classifications from Level 0 (low) to Level III (high) Case specific for high dependence No age or income requirement Enforces Filial Support laws
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. Recovery of assets
U.K.	Regional evaluation based on a national standard of need evaluation Age and income requirement Limits assistance to a maximum asset level

ENDNOTES

[1] A measure showing the number of dependents (aged 0-14 and over the age of 65) to the total working age population (aged 15-64).

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