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Financing Long-Term Care in Asia and the Pacific

KEY POINTS

- Financing is a fundamental component of any long-term care (LTC) system. It is key to defining who will be covered, what they will be covered for, and what people must pay out of pocket.
- Government-raised revenue for LTC usually comes from two sources: general taxation and obligatory social security contributions. There are benefits and challenges to each.
- Pooling is a critical element within LTC financing, enabling financial risk to be spread across a population as well as protecting individuals from catastrophic costs. Social insurance schemes and tax-based systems have a strong pooling element. Means-testing limits risk pooling.
- Strategic purchasing can help drive efficiency and access to services within LTC systems. Purchasing approaches to shape LTC markets include directing service provision, setting prices, using service-level agreements and competitive tendering, and adopting capitated budgets.
- As LTC systems develop, and capacity and fiscal space increase, the dimensions of coverage—population, services, financial—can be adjusted using cost data and LTC modeling.

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INTRODUCTION

As a result of increased longevity and decreased fertility rates, the number of older people is increasing in absolute terms and as a proportion of the population. This transition is happening at an unprecedented pace in the Asia and Pacific region. Population aging has major economic and social implications, including raising concerns about who will provide care for growing numbers of older people with more long-term and complex care needs.[1]

Traditionally, care for older people has been provided for by families. However, with the increasing complexity of care needs and key socioeconomic developments and trends—such as migration, urbanization, increased female workforce participation, and smaller family sizes—this is no longer sufficient nor sustainable. Countries areas in the region are now increasingly considering how they can address the large gap emerging between the need for aged care and its supply.

Long-term care (LTC) refers to the support provided and the activities undertaken by informal caregivers (including family, friends, or neighbors) or by public, for profit and nonprofit service providers to ensure that an older person can optimize his or her functional ability and maintain the highest possible quality of life.[2] An LTC system consists of all organizations, institutions, resources, and people involved in carrying out LTC activities. The Global Strategy and Action Plan on Ageing and Health of the World Health Organization, adopted by the 69th World Health Assembly, highlighted the need for the universal development of sustainable and equitable LTC systems. It stated that every country must have a comprehensive system for LTC that can be provided at home, in communities, or within institutions.

As awareness of the economic and social opportunities and benefits of LTC systems grows, many countries and areas in the region are developing or expanding their systems of LTC including how LTC is financed.

[1] This brief forms part of the outputs of TA 9111: Strengthening Developing Member Countries' Capacity in Elderly Care, with support from the Japan Fund for Poverty Reduction and the Republic of Korea e-Asia and Knowledge Partnership Fund. The brief was developed under the supervision of Meredith Wyse, senior social development specialist (aging and care), Sustainable Development and Climate Change Department (SDCC), and Wendy Walker, chief of Social Development Thematic Group, SDCC. Technical inputs were provided by Eduardo Banzon, principal health specialist, SDCC, and consultants Peter Chan and Caitlin Littleton.

[2] This is based upon the definitions of LTC found in World Health Organization (WHO). 2000. *Home-Based Long-Term Care: Report of a WHO Study Group*. Geneva; and WHO. 2015. *World Report on Ageing and Health*. Geneva.

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CURRENT STATUS OF LTC FINANCING

In countries of the Organisation for Economic Co-operation and Development (OECD), the average proportion of gross domestic product (GDP) spent on LTC services is 1.7%, ranging from 0.2% in Hungary and Estonia to about 3.7% in the Netherlands—reflecting demographics and the different systems of formal care and informal care.[3] By 2050, the average is projected to be about 2.5% of GDP; in some OECD countries, this is expected to triple, demonstrating the significance of LTC in the public budget. In all OECD countries, except Switzerland, public expenditure outweighs private expenditure, excluding in-kind unpaid care contributions.

In the majority of developing member countries (DMCs) of the Asian Development Bank, public financing of LTC tends to be very limited. Commonly, there is limited government funding of government-run welfare homes for destitute older people, which focus on providing material needs for residents. Government health budgets may include funding of government-provided LTC-related health services. The majority of financing for LTC in DMCs is from private financing, including through family care, unpaid family labor, volunteer care, and out-of-pocket expenditure for health and social care services or employment of domestic workers to provide care. Unfortunately, there has been no systematic data collection or estimates on how much informal care costs in each DMC.

LTC FINANCING AND COVERAGE

The decisions on the design of a financing system are based on the overall objectives of an LTC system identified by each country or area. The question of coverage is at the heart of financing LTC systems; population coverage (i.e., who will be covered), service coverage (i.e., what they will be covered for), and financial coverage or financial protection (i.e., what people must pay out of pocket) all must be decided. Governments also need to identify the division of financial responsibility among the individual, family, and state, as well as the fairness of financial contributions. The design of a financing system to promote equity in access and to ensure quality of care services must also be considered. Finally, ensuring a sustainable and fiscally affordable system is paramount. Systems must be designed in a cost-efficient manner, and sources of revenue for the system—now and in the future—must be identified. It is therefore important to understand how revenues are raised and pooled, and how these funds purchase LTC services and pay LTC providers.

REVENUE RAISING

Government revenues for LTC systems is usually tax funding complemented by social security contributions. The decision on the funding sources, however, depends on several factors, including political and social context and ideology, existing schemes such as other social security schemes, and key objectives of LTC policy.

The table below shows the funding source for LTC services in some OECD countries in Asia and the Pacific, excluding in-kind unpaid care contributions. Australia and New Zealand have predominantly tax-funded schemes, while Japan and the Republic of Korea have a more even split between tax funding and social security contributions.

Social Security Contributions

The social security contributions or social insurance schemes raise funds through mandatory individual payroll and pension contributions, employer contributions, and public tax-financed contributions.

The key advantages of funding LTC through social security contributions are that the costs are explicitly shared among individuals, the population, and the state. Having a unified system also increases the buying power of government. Moreover, as witnessed in Japan and the Republic of Korea, which introduced LTC insurance schemes in 2000 and 2008, respectively, it encourages the rapid expansion of care service providers. Social insurance schemes tend to have the advantage of being simple to understand, with clearly outlined eligibility and benefit packages.

Most social insurance schemes are "pay-as-you-go" with the current generation of workers paying for the care of the current population in need of care services. Paying for the care of one's parents' generation

Funding Source for Long-Term Care in Asia and the Pacific
(%)

Country	Tax Funding	Social Security Funds	Private Insurance	Household Out of Pocket	Others
Australia	88.9		0.3	8.5	2.3
Japan	44.2	44.8	4.0	7.1	
New Zealand	92.0		1.3	4.4	2.3
Republic of Korea	46.2	30.7		17.8	5.3

Source: F. Colombo, A. Llena-Nozal, J. Mercier, and F. Tjadens. 2011. *Help Wanted? Providing and Paying for Long-Term Care.* Paris: OECD.

[3] LTC expenditure (health and social components) by government and compulsory insurance schemes, as a share of GDP, 2017 (or nearest year) based on OECD Health Statistics 2020. https://www.oecd.org/els/health-systems/long-term-care.htm.

seems fair, to most, which is one reason why Japan's LTC compulsory insurance scheme enrolls those aged 40 years and above. However, with aging populations and the shrinking ratio of younger age groups in comparison to older age groups, the sustainability of this approach is a challenge, and increases in social security contributions can be unpopular and difficult to introduce.

Another issue with social security contributions is finding mechanisms to facilitate people's participation and payment of the contributions. The informal workforce is significant in many DMCs and, in this context, enforcing obligatory contributions to social insurance schemes is challenging.

Examples of social LTC insurance schemes are found in Germany, Japan, the Republic of Korea, Luxembourg, and the Netherlands. It should be noted that in all, the primary health financing scheme is a social health insurance system. Therefore, each has had prior experience and administrative capacity to implement a social LTC insurance scheme. In the Netherlands and the Republic of Korea, both health and LTC insurance is managed by the same administrator; in Germany and Japan, the administration of the health and LTC schemes are separate.

The People's Republic of China (PRC) is currently piloting different LTC insurance schemes in 12 cities across the country and is exploring the option of having health and LTC insurance integrated into one scheme or having them administered separately. In 2020, Singapore introduced CareShield Life, a new compulsory LTC scheme that will help families fund the care for their parents.

Tax Funding

LTC is also partly or fully funded by taxes through central, regional, or local government budgets. LTC in Australia and New Zealand is funded jointly by national and state government tax funding. Thailand's community-based LTC is funded with the general tax revenues, while Japan's LTC is partly funded by national and municipal tax revenues. Tax-funded LTC clearly requires a clear responsibility for the division of tax-based revenue generation between national and subnational authorities.

Besides general taxes, specific earmarked taxes have also been used to raise revenue for LTC. In the PRC, revenue from the Public Welfare Lottery Fund is allocated to elderly welfare schemes. Fifty percent of profits from the welfare lottery and sports lottery schemes are divided among national, provincial, and district authorities, with the majority going to provincial and district authorities. In 2014, the Public Welfare Lottery Fund generated an estimated CNY19 billion ($2.4 billion) for the PRC's elderly welfare programs.[4]

Pooling collects prepaid financing to "spread financial risk across the population so that no individual carries the full burden of paying for care."

The advantages of tax funding include a broader population base to source the tax revenues, and the flexibility and adaptability in providing LTC benefits. Conversely, this flexibility and adaptability can also be a disadvantage, as it makes tax funding and the budgets they fund subject to fiscal and political pressures, and disparities in local government budgets and capacity can lead to divergence in eligibility criteria and services.

POOLING

Both social insurance schemes and tax-based systems have a strong pooling element. Pooling collects prepaid financing to "spread financial risk across the population so that no individual carries the full burden of paying for care."[5] This is important for LTC, because while the overall care need can be estimated for specific population cohorts at an individual level, it is uncertain who will need care, for how long, and what services will be required. For some individuals, requiring care for an extensive period of time or in a residential home can quickly accumulate costs and be catastrophic.

However, the pooling function of tax-based systems is weakened if eligibility to LTC is means-tested. While they are still redistributive in the way that they pool general revenue to redistribute it to persons without the means to pay for their own care, the risks for the population are not as well covered, with those in the "middle"—between the poorest and those who can afford care—missing out. In many DMCs, this is currently the case, with public financed care supporting only the poorest older people.

Recognizing the limited risk pooling in means-tested schemes, supplementary approaches have been adopted in some countries and areas to provide more protection against catastrophic expenditure on care. One proposal from the United Kingdom is to cap an individual's lifetime expenditure liability, so that after a set value of care has been incurred by an individual, public financing would cover the excess expenditure.

Private LTC insurance also includes a degree of risk pooling, but its stand-alone coverage and low take-up rates provide a challenge to achieving equity.[6] Unlike health insurance, in which

[4] E. Glinskaya and Z. Feng. 2018. *Options for Aged Care in China: Building an Efficient and Sustainable Aged Care System*. Directions in Development. Washington, DC: World Bank.

[5] WHO. Pooling revenues and reducing fragmentation. https://www.who.int/activities/pooling.

[6] Five percent in the United States in 2015. F. Colombo, A. Llena-Nozal, J. Mercier, and F. Tjadens. 2011. *Help Wanted? Providing and Paying for Long-Term Care*. Paris: OECD. Chapter 8.

an individual is assumed at some point to require health services and therefore may consider private insurance, the uncertainty about future utilization of care services makes voluntary LTC insurance unpopular. However, private insurance in cases of opting out of social insurance (e.g., Germany) and providing additional coverage for benefits not covered in public schemes (e.g., Belgium, France, Germany, and Singapore) provides an alternative pooling mechanism.

Purchasing—how funds are allocated to providers of care—can play an important role in driving efficiency and access to services within LTC systems.

PURCHASING

Purchasing—how funds are allocated to providers of care—can play an important role in driving efficiency and access to services within LTC systems. Decisions on purchasing can direct the utilization of LTC to more cost-effective services and be used to promote the performance of LTC providers. Compared to health financing systems, the allocation of funds to individual consumers to purchase services directly is more commonly used within LTC, alongside direct purchasing from care providers.

The "commissioner" or purchaser of LTC services is often identified at a subnational or local level. For example, in Thailand, local health boards are the purchasers at the subdistrict level, while in New Zealand, this is done by district health boards.

In most LTC systems, the proportion of publicly run service providers is diminishing, with most services being provided by private and nonprofit organizations. Therefore, unlike in health financing schemes, there is a purchaser–provider split in most cases.

Moving from Passive to Strategic Purchasing

In the nascent stages of developing an LTC financing system when data is limited and information on the quality and outcomes of services provided is difficult to obtain, the allocation of pooled funds to providers is often passive. Basing annual budget allocations to residential homes on historical annual budgets is an example of passive purchasing. In the PRC, some subsidies available to service providers can be considered passive. Several provinces have construction subsidies of CNY120 ($17) for every residential care bed built, and operational subsidies of CNY100 ($14) per residential care bed per year; these are not necessarily linked to the utilization of beds (footnote 4). However, as data and information systems improve, purchasers have greater ability to design funding allocations more strategically. Different approaches used within strategic purchasing are outlined below.

Directing service provision. Purchasers can determine where and what services are provided, based on needs, cost efficiencies, and outcomes. Across OECD countries, 67% of care users receive services at home, but spending on institutional care accounts for 62% of total expenditure (footnote 4). Home and community care are usually more cost-effective than residential care when people have lower levels of care need. Therefore, increasingly, purchasers are directing pooled funds to home and community care services, increasing demand for these services.

In Japan, residential care can only be considered for people with a level of care requiring full assistance for standing, walking, eating, toileting, and bathing. Japan also limits access to the market for some types of residential homes to nonprofit providers. In Australia, the government uses strategic purchasing through national and regional targets for the purchase of residential and home care packages per 1,000 population over age 70 years. Over the coming years, the mix between packages will be altered, with reduction in residential targets and increases in home care and other new packages such as the Short-Term Restorative Care Program.[7]

Setting prices and fee schedules. In Japan, the costs of LTC services are set on a fee schedule revised every 3 years by the Ministry of Health, Labour and Welfare, based on recommendations by the Social Security Council. Service providers who do not follow the fee schedule are not eligible for reimbursement from LTC insurance. New Zealand also uses a fee schedule for aged care services.[8] In Hong Kong, China, pricing is determined by a funding service agreement or service contract between the government and providers. In Australia, to cover the additional costs incurred in providing care services in rural and remote areas, there is an additional "viability payment" available for providers.

Service-level agreements and competitive tendering. The purchasing agency in Hong Kong, China—the Social Welfare Department—buys a set number of services from for-profit and nonprofit providers by publishing a service-level agreement defining services required, followed by a competitive tendering process, based on quality and cost. This allows the purchaser to stipulate services required (i.e., home care, day care, community care, dementia care), for how many persons and with what care needs, and expected quality standards. These agreements are used to improve the quality of care through financial rewards to service

[7] Government of Australia, Department of Health. About the Short-Term Restorative Care (STRC) Programme. https://www.health.gov.au/initiatives-and-programs/short-term-restorative-care-strc-programme/about-the-short-term-restorative-care-strc-programme.

[8] Government of New Zealand. Paying for residential care. https://www.govt.nz/browse/health/residential-care/pay-for-residential-care/.

providers implementing quality improvement initiatives, conducting ongoing training and professional development of staff members, as well as meeting minimum thresholds on certain quality indicators such as number of avoidable falls and pressure sores.

In Singapore, to encourage integrated care services, the purchasers—regional health boards—issue tenders for "bundled care." These tenders force service providers or a consortium of service providers to demonstrate how they can provide a range of coordinated services over a continuum of care, such as home care and day care centers together, rather than in separate purchasing agreements.

Paying providers by capitation. The use of capitation as a payment method for providers of LTC services is increasing. In Thailand, local health boards receive a capitated budget from the National Health Security Office, the fund manager of the Universal Coverage Scheme. The budget is based on the number of older people in a locality with a certain level of need. The local health boards then purchase nationally defined care services from health centers or elderly care centers. Any remaining funds at the end of the year are carried forward. In Singapore, to encourage a focus on population health outcomes, regional health boards receive a capitated budget to provide all health and care services to their entire populations, based on both their numbers and profiles. The rationale is to incentivize wider population health prevention, strengthen primary care and home- and community-based care, and improve system integration. There is a focus on performance-related outcomes on identified and agreed indicators of population health.

Consumer-directed care. Increasingly, a number of LTC schemes have introduced consumer-directed care (CDC) models which offer cash benefits to individuals instead of directly purchased services, to provide flexibility to individuals to allocate these funds to meet their needs and preferences. CDC models strive to create market efficiencies through creating demand where it is most needed and guard against the overutilization of services. Cash benefits are sometimes set at a lower cost than the cost of equivalent services and are thereby cheaper to provide as well as administratively easier to manage. Cash benefits, rather than vouchers, also allow older people to pay for care from other informal sources such as a family member, friend, or neighbor. Cash entitlements for care are specifically designed to support the provision of care and support, and are separate from other social welfare benefits such as social pensions, disability allowances, and caregivers' allowance, which are designed to ensure income security.

In the Republic of Korea, cash benefits are used to purchase support in areas where access to formal service providers is limited, such as small islands and rural areas, although whether this succeeds in providing adequate substitution for professional care requires further study. In Singapore, the CareShield Life LTC insurance scheme provides a monthly cash payout, aimed to provide basic financial support for persons with severe disability, rather than comprehensive financial support to cover all LTC costs.[9] In Japan, where an objective of its LTC insurance scheme is to support female workforce participation, there are no cash payments.[10] In the PRC, major cities such as Beijing and Shanghai operate a voucher system instead of cash, to ensure that the money is spent on care and to support the developing care industry.

In Australia, all home care packages are delivered through a CDC model. Instead of a direct cash payment, the eligible individual identifies a service provider with whom to work with to identify care needs and decide how best to spend the funding package. The provider then coordinates the services and manages the individual budget.[11]

Some key considerations in providing cash benefits include

- the availability and costs of services in different areas where the cash benefit is provided;
- availability of alternative care;
- information and transparency about the price and quality of service providers to allow for informed choice; and
- how the cash benefit will operate, including options to take cash or services. The option to choose for direct service provision instead of cash is important as many older people and their families may not be confident or have the capacity to manage their own care.

COVERED POPULATION, SERVICES, AND COSTS

Benefit package design is at the center of an LTC financing system and involves deciding how resources that have been raised and pooled are used and defining any conditions attached. Population coverage (i.e., who will be covered), service coverage (i.e., what they will be covered for), and financial protection (i.e., what amount will be covered and which people will have to pay out of pocket) all need to be agreed upon. These are essentially decisions about rationing.

Such decisions need to be informed by data. The unit costs of different LTC services, such as the cost per month of residential care and cost per hour of home help, allows governments to optimize service packages based on funding availability. Modeling for LTC, which accounts for variables in the cost drivers of LTC (e.g., prevalence of chronic disease, age, and living arrangements) and cost-containment measures (e.g., decisions on population coverage) can provide useful information for decision-making on the affordability and sustainability of LTC financing systems.

[9] CareShieldLife. https://www.careshieldlife.gov.sg/careshield-life/about-careshield-life.html.
[10] Various women's groups advocated against cash benefits, as they argued they would pressure women to provide care.
[11] Government of Australia. MyAgedCare. Home Care Packages. https://www.myagedcare.gov.au/help-at-home/home-care-packages.

Population Coverage

Defining the population covered by LTC benefits involves considering various criteria. Age is one factor often considered. Entitlements to benefits in Japan and the Republic of Korea start at age 65 years with some exceptions for medical LTC needs to include those ages 40 and above. In New Zealand, a person must be aged 50–64 years if single and with no dependent children for residential care and over 65 years of age for home support services.[12] Coverage in Australia starts at age 65 years, with the exception of Indigenous Australians and Torres Strait Islanders for whom coverage starts at age 50 years, taking into account lower life expectancies and specific care needs among these groups.[13]

Thailand uses an age criterion of 60 years old, the definition of a senior citizen stipulated in the Constitution. Currently, Thailand's national LTC community program covers citizens entitled to health services under the Universal Coverage Scheme, as this is the funding source of the program. Neither members of the Civil Servants Medical Benefit Scheme nor the Social Security Scheme are eligible, although with local funds, some municipalities are extending services to those covered by these schemes and to younger people.

Across all systems, eligibility is based on meeting certain criteria related to the level of care need, identified through a care assessment. The results of the assessment determine the financial allocation of the benefit package. This process of gatekeeping to establish the financial entitlement should be distinguished from the process of regulating the exact services to be provided under each benefit package, which is determined by the requirements of the individual.

The identification of the care need cutoff point for eligibility for publicly financed LTC services is a key mechanism to control costs. In Thailand, since the national LTC community care program is relatively new and there is limited fiscal space, only persons identified as "bed-bound" are eligible, measured using the Barthel Index for Activities of Daily Living. In Japan, the level of care need an individual must have to be eligible for receiving support is much lower, as the country has prioritized preventative LTC to ensure early interventions are available to help people maintain their functional independence and thereby reduce the need for more intensive care services in the present or future.

Service Coverage

Service coverage refers to the services that are included or excluded from a benefit package. Personal care services that support activities of daily living are those most provided in benefit packages. In Australia and New Zealand, accommodation costs, such as those in residential or nursing homes, are excluded from benefit packages. The benefit packages cover the cost of care and nursing but not food and board, which need to be covered out of pocket, often from pensions.

Benefit package design is at the center of an LTC financing system and involves deciding how resources that have been raised and pooled are used and defining any conditions attached.

Recent trends in service coverage indicate an increasing focus on optimizing service packages. Lower-level and lower-cost interventions that can prevent an escalation of care needs requiring more expensive services are being expanded, such as Australia's Commonwealth Home Support Programme, which provide basic assistance at home, and Japan's LTC preventative care programs. "Reablement" services—an intensive time-bound package of services targeted at older people who have experienced a decline through an accident or hospitalization to regain their independence—are increasingly offered as services. The costs of intensive services are offset by the benefits of the individual regaining independence, thereby avoiding cumulative costs.

In some cases, nonprofessional care support services, such as house cleaning, meal delivery, shopping services, and accompaniment, are not included in benefit packages. They are instead provided by voluntary or community organizations or purchased privately. Ways in which the availability of these service providers can be developed are also an important consideration in achieving service coverage.

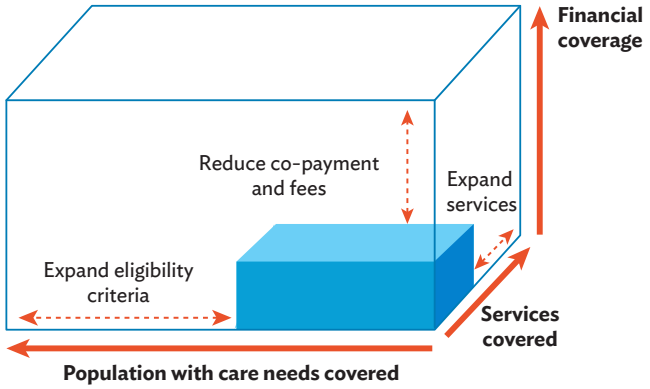
Financial Protection

Financial coverage refers to the level of financial protection in accessing services that will be covered from public funds. It makes explicit the financial obligations of individuals. Out-of-pocket expenditure is a key source of financing LTC; compared with health financing, it is more common to stipulate such payments for LTC services, even in schemes that are not means-tested. For example, the use of co-payments is common in LTC insurance-based systems to minimize expenditure and to prevent overutilization of services. In Japan, co-payments range from 10% to 30% of services, based on an individual's income level, although 90% of users are eligible to pay a 10% co-payment only. The Republic of Korea has a co-payment differential between home- and community-based care (15%) and residential care (20%) to encourage home- and community-based care utilization.

[12] Government of New Zealand, Ministry of Health. 2012. *Long-Term Residential Care for Older People—What You Need to Know* (revised 2019). https://www.health.govt.nz/publication/long-term-residential-care-older-people-what-you-need-know-2012.

[13] Government of Australia, Aged Care Financing Authority. *2016. Fourth Report on the Finding and Financing of the Aged Care Sector*. Canberra.

Three Dimensions of Long-Term Care Coverage



Source: Adapted from WHO. 2010. *Health Systems Financing—The Path to Universal Coverage: World Health Report 2010*. Geneva.

It should be noted that co-payments can be prohibitive for some older people to access services. In Germany, where cash and service provision are offered, the majority of lower-income individuals choose to receive cash rather than services with a co-payment requirement.

New Zealand operates a means-tested scheme in which only persons with eligible care needs and incomes lower than a set amount are eligible for publicly financed services. Australia operates a progressive universal system wherein all those assessed with a certain level of care are entitled to limited care services and a more extensive service package is available for those with limited means or assets. Neither system considers the older person's assets in the means test for home- and community-based care, but assets are included in assessments for residential care. Singapore, meanwhile, considers the income not only of the individual but also the adult children in assessing eligibility for financial support.

Progressive Realization of LTC Coverage

The principles of the universal health coverage cube, reflecting the three dimensions of coverage for universal health care, population coverage, service coverage, and financial coverage, can be applied to LTC coverage, as shown in the figure.

For DMCs at the early stages of developing comprehensive financing systems for LTC, the coverage dimensions of population, service, and finances are key. As the LTC system develops—and capacity and fiscal space increase—adjustments to the dimensions of coverage can be made. Limiting financial coverage is more challenging, as many older persons in need of care will not have the financial resources to contribute out-of-pocket expenses or co-payments.

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Notes:
ADB recognizes "China" as the People's Republic of China.
In this publication, "$" refers to United States dollars and "CNY" to yuan.

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