1.3.7 - COVERAGE FOR LONG TERM CARE

Component 1

OF DEPENDENT ELDERLY

One of the objectives of the Government is to establish in China a moderately affluent society where no category will suffer from excessive inequalities. To achieve this goal, it is necessary than parents of single-child family be granted financial and daily autonomy, to avoid an excessive burden on the younger generation. There is a growing concern about the lack of institutional care of a decent level, the difficulty in accessing public transportation or local administrations for ageing persons with decreasing mobility, the growing isolation of elderly persons in urban or rural residential areas.

To take Shanghai as an example, over the past 5 years the number of aged persons above 80 grew by 5.5% annually. In the city, over 1 million aged persons live alone. In the near future, 80% of the aged persons will be parents with only one child – while 13% of those aged 80+ cannot take care of themselves. The Chinese Government is therefore considering as a priority to establish a long term care dependency insurance – for which pilots are on-going in several locations – for which European experience is of great interest and value.

1. Demographic ageing is a factor common to most European countries – China is still below European levels but may be catching up rapidly.

2010 % of the population	F	Ge	UK	I	Dk	Sp	Nl	PRC
Over 65	16.6	20.7	16.3	20.3	16.1	16.9	15.3	8.2
Over 80	5.2	5.1	4.6	5.8	4.1	4.9	3.9	1.34
Dep.ratio OA	25.81	31.7	24.72	30.99	24.98	24.43	22.82	11.3

2. Change in age structure of the population has important implications for social protection as a whole – not only for pensions financing.
3. Notably dependency is a critical challenge for old age. It relates to the situation where the elderly person cannot care for him/herself without more or less constant assistance from a third party. Dependency grows in number and severity with age. In some cases it requires specialized assistance, in some cases simple family help is sufficient. Modern trend is to try to avoid institutionalization of old age dependent persons. In some countries cost of support to dependency (financing assistance, compensating family members for loss of income, subsidizing specialized institutions) is ensured through a special insurance part of social security (France, Germany, Spain, the Netherlands, Belgium Flanders, etc.). Other provisions exist

within social security: pension supplements for constant care attendance; increase in basic pension passed a certain age.

4. The Ageing report, which is compiled and published regularly by the European Commission Directorate General for Economic and Financial Affairs submits long-term projections of the budgetary impact of population ageing (currently over the period 2013 – 2060). This report includes a specific section on long-term care. This document is available from http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

5. The European Commission and its Social Protection Committee have published in 2014 a report on Adequate social protection for long-term care needs in an ageing society (http://ec.europa.eu/social/BlobServlet?docId=12808&langId=en) that provides a detailed description of the challenges confronting European countries in this field, and of existing provisions in all of the 28 member states.

6. Long-term care is defined as a range of services required by persons with reduced degree of functional capacity who are consequently dependent for an extended period of time on help with basic and/or instrumental activities of daily living. Basic activities of daily living or personal care services are frequently provided in combination with help with basic medical services. Instrumental activities of daily living are mostly linked to home help.

7. Specific methodologies have been developed to assess the degree of dependency of insured persons for long-term care provision[1]. Long term care public expenditure represent on average 1.10% of GDP in European countries (28 MS). Those expenditure consist of benefits in kind (mostly stays in residential homes) and benefits in cash (mostly help to purchase services with third parties).

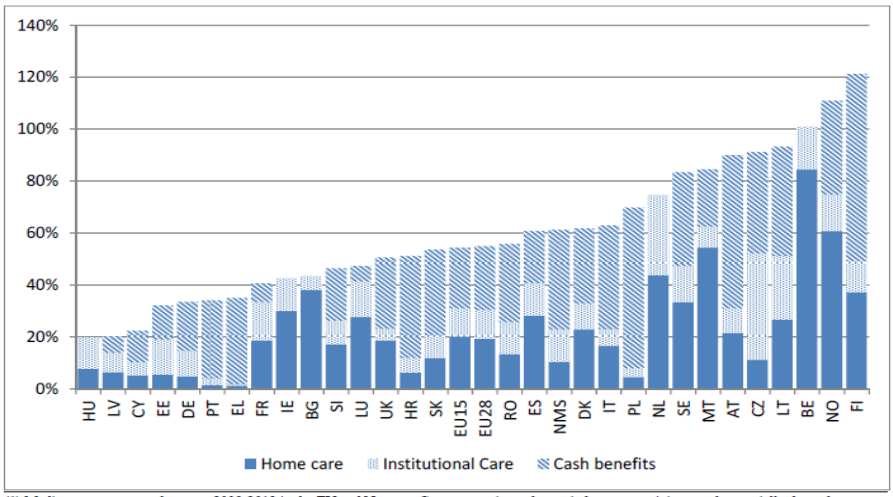
Long-term care public expenditure (health and social components), as share of GDP, 2011

EU M. States	Health LTC	Social LTC	Total
Netherlands	2.7	1.0	3.7
Sweden	0.7	2.9	3.6
Denmark	2.4	:	2.4
Finland	0.7	1.4	2.1
Belgium	2.0	:	2.0
France	1.2	0.5	1.8
Austria	1.2	:	1.2
Luxembourg	1.1	0.1	1.2
Slovenia	0.7	0.2	1.0
Germany	1.0	:	1.0
Spain	0.6	0.1	0.7
Poland	0.4	0.0	0.4
Czech Republic	0.3	:	0.3
Hungary	0.2	:	0.2
Estonia	0.2	:	0.2
Portugal	0.2	:	0.2

[1] The ANCIEN project (Assessing needs of care in European Nations), concluded in 2012, documented several of these assessment methods. See http://www.ancien-longtermcare.eu/

Greece	0.0	:	0.0

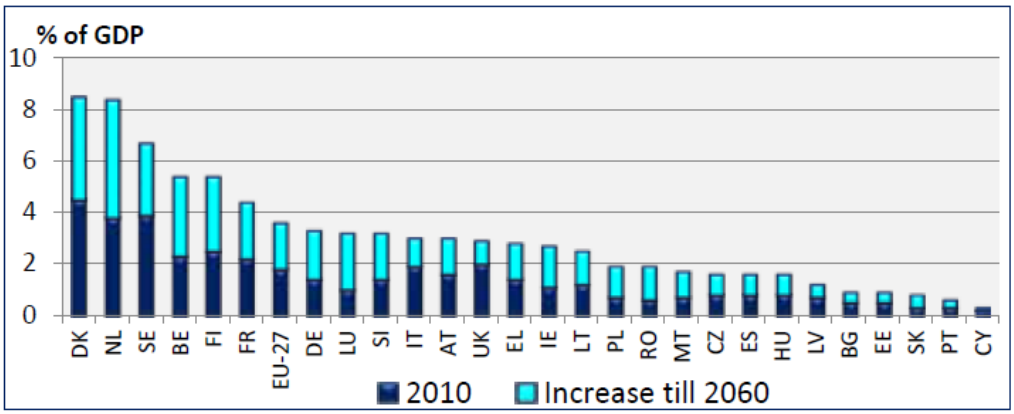
8. Rates of coverage (percentage of persons accessing benefits as a ratio of theoretically eligible population) varies significantly among countries as can be seen from graph below. Usage of benefits depends on a number of factors, like accessibility, quality and affordability of institutions, and eligibility criteria for cash benefits which are often means tested. Ratio can be over 100% since some beneficiaries receive benefits in kind and benefits in cash at different periods of the same reference year – and may therefore be counted twice.



(1) Median coverage rates between 2009-2013 in the EU and Norway; Coverage estimated as ratio between recipients and potentially dependent population; Recipient data, as provided by Member States; Coverage may be above 100%, as some recipients may receive cash benefits and in-kind benefits at the same time, which is not corrected for in this graph. Population of potentially dependent based on EU-SILC data on "self-perceived longstanding limitation in activities because of health problems [for at least the last 6 months]" is used.
Source: European Commission, EPC

8. Projected levels of expenditure (2013-2060) show in a number of countries a marked increase in long term care expenditure expressed as percentage of GDP, the increase appearing as being in a sense sharper when initial expenditures were higher. Sone countries therefore already started considering policies to constrain the cost of their long term care policies since projected expenditure may represent up to 50% of projected expenditure on pension benefits to which they have to be added (the cases of Denmark or of the Netherlands are systematic – where in 2013 public pension programmes represented some 8 and 6% of GDP respectively, with an additional approximately 4% for long term care projected to overcome 8% by the year 2060 (i.e. more than the current share for pensions).

LTC spending as % of GP, 2010 - 2060



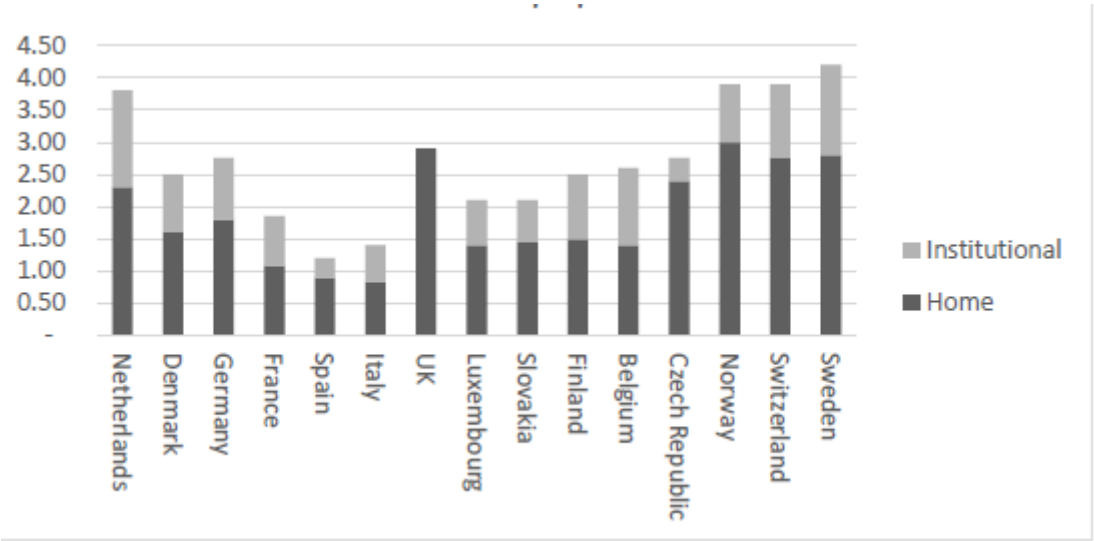
9. Cost containment measures envisaged may affect eligibility provisions, concern overall financial limitations on the programmes (which growth might for example be indexed on price increases only, demographic effects having to be addressed through other means) or result from preventative measures limiting the need for institutional care.
10. Governments and Social security programmes (which are not necessarily dedicated to long term care)in fact represent the most part of financing for LTC measures in European member states. Co-payments or out-of-pocket expenditure may however remain very high which may result in a de facto exclusion of the most vulnerable groups from long term care protection.

Long-term care expenditures by sources of funding, 2007

Countries	General gov. (excl. SS)	Social security funds	Private insurance	Out-of-pocket	Other	Non-profit NGOs	Corpora-tions
Portugal	2	51.4	1.1	45.4	0	0	0
Germany	12.5	54.7	1.7	30.4	0.7	0.6	0.1
Spain	61.7	10.2	0	28.1	0	0	0
Slovenia	18.3	57.1	0.5	24	0	0	0
Austria	81.1	0.7	0	17.1	1	1	0
Finland	77.2	7.6	0	14.2	1	1	0
Estonia	48.2	39.3	0.1	12.4	0	0	0
Denmark	89.6	0	0	10.4	0	0	0
Hungary	60.1	30.2	0.9	2.4	6.4	6.4	0
Sweden	99.2	0	0	0.8	0	0	0
France	44.8	54.4	0.4	0.4	0	0	0
Poland	43.1	49.2	0	0.3	7.4	7.4	0
Belgium	31.4	58.7	9.8	0.2	0	0	0
Czech R.	30.5	69.5	0	0	0	0	0
Netherlands	9.5	90.4	0	0	0.1	0	0.1

11. In May 2016, the US based Society of Actuaries published a study on Long term care coverage in Europe [2]which distinguishes three basic institutional models :
    - Long-Term Care Coverage Principally through Public Programs, where Public long-term care coverage is financed either by taxes or through social long-term care insurance schemes (case studies The Netherlands, Denmark, Germany).
    - Long-Term Care Coverage Combined with the Subsidiarity Principle, where the system may be called "hybrid " with several elements supporting a basic income. Benefits are usually capped. Public financing complements the revenues and assets of the dependent elderly (case studies France, Spain, Italy)
    - Long-Term Care Coverage Based on Social Assistance, which corresponds to a means-tested minimum safety net (case study: England – provisions vary according to regions of the United Kingdom).
12. The above-quoted study points to convergence in the following areas among the variety of schemes in force across Europe:

    - Priority to home care contrasting with the spell on institutional care prevailing a few decades ago (see OECD data, 2010 report of the Commission on European Affairs)



    - Development of cash benefits instead of benefits in kind in the form of allocation of hours services, which 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.

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9 August 2016.

[2] Edith Bocquaire, https://www.soa.org/Files/Pubs/pub-2016-05-ltc-coverage-europe.pdf