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Long-Term Care Financing

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Synonyms

Financing long-term care; Long-term care cost; Long-term care fund

Definition

Long-term care (LTC) financing refers to the collection, management, and distribution of funds by legal approaches (private insurances, co-payments, taxes, social insurances, etc.) to support the LTC insurance and services for older adults who may require assistance with daily living activities (Stone 2000; Ranci and Pavolini 2013; European Commission 2015) and to ensure the quality and appropriateness of LTC services (Organisation for Economic Co-operation and Development (OECD)/European Commission 2013; Feng 2019). In most countries, LTC funds can pay for the range of home- and community-based services, including personal care (bathing, toileting, or eating) and supportive services (house cleaning, meal preparation, or shopping) as well as traditional home healthcare (nursing, therapy, and home health aide care) and community services (home-delivered meals and adult daycare) (Ikegami and Campbell 2002; Manton et al. 2006; Ranci and Pavolini 2013; World Health Organization 2015; Brugiavini et al. 2017). As the definitions and services of LTC vary across countries (World Health Organization and Milbank Memorial Fund 2000), the scope of LTC financing that should be included varies across countries, or even within a country over time, because of different socioeconomic and policy-based considerations. Regardless of its varying scope, LTC financing usually consists of four important components: coverage, financing sources, management, and payment.

Overview

In tandem with aging populations, the demand for LTC services for a growing number of older people with disabilities or chronic illnesses is increasing rapidly worldwide (O'Leary and Chow 2016). For example, in Europe, the demand is projected to grow from 27 million people in

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2013 to 35 million by the year 2060 (European Commission 2015). The increase of LTC needs has imposed great challenges for the provision of care. Families are the major responsibility of eldercare in virtually all nations (Colombo et al. 2011; Feng 2019; see also Formal and Informal Care in this volume). This traditional source of informal care is increasingly strained and unattainable amid increasing life expectancy and health conditions, changing demographic structures, shrinking family size, and changing intergenerational relations and living arrangements (Gu and Vlosky 2008; Case and Deaton 2015; Feng 2019; United Nations 2019). LTC as the primary formal care is an important supplement to informal care, but it is expensive and unaffordable for most older adults and their families at market prices, because most individuals are unprepared for the loss of ability in old age and do not save enough for the high and prolonged expenses necessary to afford LTC (Brugiavini et al. 2017). Even in the United States, only a small portion of middle-aged and older adults have considered how they would obtain the supportive services they would need if they experience disability, chronic disease, or cognitive impairment, mainly due to their lack of knowledge and uncertainties about costs (Mara and Olson 2008; Schmitz and Giese 2019).

Many countries have explored ways to increase the funding of LTC to help older adults to afford long-term care (Ranci and Pavolini 2013). For example, Nordic countries (e.g., Denmark, Finland, Norway, and Sweden) have increased their government budget and taxation to help finance LTC (Brugiavini et al. 2017). Some countries, such as Germany and Japan, adopted a universal public LTC insurance approach to enlarge the pool (Gleckman 2010; Colombo et al. 2011; Ikegami 2019). The United States has adopted private LTC insurances and some means-tested ways (e.g., Medicaid) to help low-income populations afford LTC (Frank 2012; Schmitz and Giese 2019). And many other developed countries (e.g., Australia, France, Greece, Ireland, Italy, New Zealand, Poland, Spain, and Switzerland) have implemented universal personal-care benefits (cash or in-kind) to support the care of older adults (Colombo et al. 2011).

Although the past decade has witnessed a steady increase in funding for long-term care, the financing of LTC is a global challenge. The anticipated growth in total LTC cost exposes governments in all OECD countries to unprecedented challenges about how to finance future LTC expenditures (Colombo and Mercier 2012). In the United States, there are significant unmet demand (O'Leary and Chow 2016) and a significant degree of inequality among different socioeconomic groups (Case and Deaton 2015), calling for reforms in financing. In the Netherlands, the world's first country to implement a modern LTC insurance program (World Health Organization and Milbank Memorial Fund 2000), rising long-term care costs are threatening the sustainability of Dutch public finances (Wouterse and Smid 2017). It is thus a daunting challenge to find a comprehensive solution to financing LTC services to make them widely accessible, affordable, and equitable for all in need globally (Feng and Glinskaya 2019).

Coverage of LTC Financing

The coverage of LTC financing is often divided into three forms: universal coverage within a single program, mixed systems, and means-tested safety-net systems (Colombo et al. 2011; World Health Organization 2015). Universal coverage within a single program means that all people (or all older adults) have the right to access LTC services. For instance, in Nordic countries, everyone has the same right/entitlement to have LTC insurance, regardless of income or assets (Brugiavini et al. 2017). In Japan, LTC services are available to all Japanese adults age 65 and older identified as the primary insured persons and the secondary insured persons age 40–64 who are participants of healthcare insurance and need daily care for being bedridden, having dementia, or needing housework to support daily life (Olivares-Tirado and Tamiya 2014). In the Republic of Korea, LTC insurance is provided to

all Korean adults aged 65 and older, regardless of income (Song et al. 2014; Joen and Kwon 2017).

The means-tested safety-net system means that LTC services are publicly funded and offer protections to individuals who are means-tested (i.e., low income) to pay for the high costs of LTC services (Mor and Maresso 2019). For example, in the United Kingdom, the LTC system has been regarded as a "safety-net" system that only supports those with very high needs who are unable to pay the costs of their care (Comas-Herrera et al. 2010). The United States adopts a means-tested program via Medicaid to provide LTC only for those who meet strict income and asset tests, and people are required to deplete their resources before becoming eligible for public support (Calmus 2013, also see Medicaid; Medicaid for People with Disability in this volume). However, the use of means-tested systems creates a group of people not poor enough to qualify for public funding and not rich enough to pay for the costs of needed care, raising concerns about fairness and equity in LTC access (Colombo and Mercier 2012).

The LTC coverage in mixed systems applies to older adults who meet the assessment of care needs or a mix of universal and means-tested LTC entitlements. The care needs are evaluated by an assessment team (medical doctor, nurse, and/or social worker) to determine eligibility for LTC services and to develop a care package of the amount and duration of care needed based on the level of disability and unmet needs of the older adults (Manton et al. 2006; Kraus et al. 2010; European Commission 2015). For disability, the applicant must have difficulty in activities of daily living (ADLs) (such as eating, dressing, bathing, getting in and out of the bed, inside transferring, and toileting) or in instrumental activities of daily living (IADLs) (such as walking around, laundry, housekeeping, phone use, meal preparation, shopping, walking distance, and managing money) that lasts for at least 6 months. For unmet needs, the applicant must have at least two unmet needs for assistance in ADLs and IADLs (Pickard et al. 2007). In many OECD countries, LTC emphasizes targeted services to older people with disabilities, and as a result, public LTC systems are closely related to both ADLs and IADLs (Colombo and Mercier 2012). There are some differences in the definition of unmet needs across countries in terms of the number of ADLs included. In Austria and Germany (before 1 January 2017) and in Spain, unmet needs include items from both ADL and IADL, whereas in the newly reformed German system (since 2017) and in the French program, both do not include IADL in the eligibility criterion; and the United Kingdom does not distinguish between ADLs and IADLs (AgeUK 2017). Besides ADLs and IADLs, all programs include assessments of cognitive function and mental abilities and are often combined with assessments of behavioral risks (Eisen and Sloan 1996; De Vries et al. 2011; Brugiavini et al. 2017). Table 1 lists types of coverage together with other characteristics of the LTC financing system for selected countries.

Sources of LTC Financing

In general, there are three models regarding the sources of LTC financing insurance: government systems, compulsory health insurance, and private savings. The government system model is mainly financed by government budgets, taxation, and fiscal transfers. The tax-financed fund is one that the federal government and state governments use tax revenues to provide and finance LTC services or LTC facilities, such as in Nordic countries (e.g., Denmark, Finland, Norway, and Sweden) (Brugiavini et al. 2017). The fiscal transfer model means that LTC financing is transferred from other public funds (such as medical insurance funds, public health insurance funds, or other social welfare funds) to the LTC fund (Yang et al. 2016). For example, the LTC fund in Shanghai, China, is transferred from public health services, while the LTC insurance fund in Qingdao (a city of Shandong Province) is transferred from the medical insurance fund (Lu et al. 2017; Yang et al. 2016; The Ministry of Human Resources and Social Security of the People's Republic of China 2016).

The compulsory insurance model, or public LTC insurance model, is a payroll tax or

Long-Term Care Financing, Table 1 Characteristics of LTC financing systems for selected countries

Countries	Coverage	Main source	Expenditures	Management
The United States	Subpopulation meeting means-tested evaluation	General revenue/ individual saving	Services/ limited cash	Government (Medicaid)/private LTC insurance
The United Kingdom	Mixed systems[a]	General revenue	Services or cash	Government/National Health Service
Canada	Mixed systems[a]	Mixed systems	Services or cash	Government/National Health Insurance
Germany	Universal	Payroll tax	Services or cash	Government/public LTC insurance
Japan	Universal for 65+	Payroll tax General revenue/ Income-related Premium	Services only	Ministry of Health, Labour and Welfare/ public LTC insurance
Netherlands	Universal	Income-related taxes/means-tested co-payments/ individual saving	Cash or services	Government/mandatory LTC insurance
Singapore	Subpopulation meeting means-tested evaluation	Individual saving	Services	The Central Provident Fund Board administers "3M"/voluntary welfare organizations
France	Universal/ steep income-related coinsurance	General revenue	Cash only	Government/personal allowance for autonomy
China	Mixed system[a]	Transfer from other public funds	Cash or services	Government/public LTC insurance

Sources: authors' summary from the literature
[a]mixed systems refer to a hybrid of the universal and the means-tested

the age-related LTC insurance paid by employees and employers (Colombo et al. 2011). In Germany, the premiums for LTC social insurance are compulsory by current law to be at 1.7% (and 2.55% after 2017) of the total wages of employees, equally shared by employees and the employers. Retirees pay only half of the premium and the other half is paid by their pension fund (Büscher et al. 2011; European Commission 2019; Nadash et al. 2018). In Japan, the contribution rate for those aged 40 to 64 who are enrolled in the largest social insurance is 1.73% in 2019 (Ikegami 2019). In OECD countries, LTC is financed through a mixture of various sources, such as payroll and direct taxes, social security, public and individual contributions, insurance fees, government grants, and out-of-pocket payments (Colombo et al. 2011).

The private savings model aims to make all citizens liable to insure themselves and their dependents privately against the risk by paying premiums to create financial reserves that are used to pay the cost of those individuals who actually need long-term care (Colombo and Mercier 2012). The United States is a typical private savings model, and its LTC financing provides a voluntary LTC commercial insurance for older adults through a market-based approach (Brugiavini et al. 2017; Schmitz and Giese 2019), which varies greatly in terms of cost, covered benefits, and eligibility criteria, based on the age and health of the individual purchaser

(O'Leary and Chow 2016; Braun et al. 2019). In Singapore, LTC services and supports are financed through a mixture of public and private sources. The public source comprises means-tested public subsidies and government grants to care-providers and charitable donations (Graham and Bilger 2017), whereas the private resource is voluntary LTC insurance. The Singapore government helps individuals create a savings account, and individuals save money into their account for later use. Individuals can also purchase private LTC insurance (Chin and Phua 2016). OECD countries also have private savings accounts to pay for LTC costs, for example, via bonds/equity release systems (e.g., Australia), reverse mortgage systems, and combinations of commercial life insurance and private LTC insurance policies (Colombo et al. 2011).

How LTC financing systems are operated or arranged within different countries is normally defined by three systems: pay-as-you-go, fully capital-funded elements, and partially funded accumulation (Eling 2020). The pay-as-you-go system refers to funds that are collected now and are paid out to support current beneficiaries (Tell and Cohen 2019). This is an intergenerational transfer model that older adults' LTC beneficiaries are directly financed by the current generation of employees. This system works well in countries with growing working populations and economies, yet not so well in countries with stagnating economies (Eling 2020), as the taxes or contribution rate of the working population is determined by the LTC needs of older adults. German and Japanese systems are organized as pay-as-you-go systems (Ikegami 2019; Eling 2020). The fully capital-funded element system refers to funds that are collected now and are set aside to invest and pay for benefits at some point in the future (Tell and Cohen 2019). This model can avoid intergenerational transfers, but it likely reduces the total funds because of financial risks and annual inflation (Wouterse and Smid 2017). The partially funded accumulation system is a mix of the pay-as-you-go system and the fully capital-funded element system. For example, the three-pillar system is one of the partially funded accumulation systems, which is a multi-pillar, mandatory, and voluntary LTC financing system. Switzerland has implemented a three-pillar system for retirement provision, consisting of individual capital-funded occupational retirement plans and tax-subsidized voluntary private retirement savings, which can be used to finance LTC in a sustainable and equitable manner (Eling 2020).

Aside from the three most common systems described above, there are several others. The one implemented by the government of the Netherlands is noteworthy, which has four alternatives to finance the government shortfall of LTC services: a pay-as-you-go system, a savings fund, a pensioner tax (premium raised for the entire working population), and a cohort-specific savings fund (premium only for the age groups that actually use LTC services) (Wouterse and Smid 2017). The pay-as-you-go system and the pensioner tax system have a relatively large intergenerational redistribution of lifetime net benefits, while a cohort-specific savings system and a pensioner tax system both have relatively small intergenerational effects in the Netherlands (Wouterse and Smid 2017).

In sum, there is no universally optimal model for all. The best model depends on the economic, social, cultural, and demographic considerations of the respective country (Wouterse and Smid 2017; Eling 2020).

Expenditures of LTC Financing

The main components of expenditure for the LTC fund are LTC services and LTC facilities. From the perspective of the content of services, it comprises two types of services: (1) services of long-term nursing care (e.g., in the United States, the expenditures of LTC insurance cover a wide range of services, including but not limited to post-acute care, rehabilitation therapy services related to nursing homes, coverage of some medical equipment, caregiver training, and so forth (Ikegami 2019)) and (2) social services of LTC, which are represented by social services for the ill or the physically disabled. For instance, in Japan, the LTC insurance system provides benefit-only services, including services related to home visits,

adult daycare, respite care, home improvements, assistive devices, and on-site services (Ikegami 2019; Olivares-Tirado and Tamiya 2014). In most OECD countries, LTC expenditures cover personal and nursing care (at home and in residential care) and room and board costs in institutional settings (Colombo and Mercier 2012; Ikegami 2019; World Health Organization 2015). In some Nordic countries, it also covers the cost of support, domestic care, and home adaptations and assistive devices (Colombo and Mercier 2012).

From the perspective of social types, LTC expenditures consist of two main elements (Wouterse and Smid 2017): (1) formal services, which are provided by some nonprofit or commercial organizations, including social services, nursing homes, community health services, home care, and daycare services, and (2) informal community services, which are provided by family, friends, or neighbors (Gu and Vlosky 2008; Colombo et al. 2011; World Health Organization 2015; Feng 2019; see Formal and Informal Care in this volume). Only a few low-income countries rely entirely on family or informal arrangements for coverage of LTC costs (e.g., Mexico, Chile, or Turkey) (Colombo and Mercier 2012).

LTC financing mainly includes two types of payments: cash benefits and/or benefits-in-kind. Cash benefits refer to LTC allowances provided by a state financial or LTC insurance management agency to older adults who meet the criteria of LTC insurance, giving enrollees both autonomy and control to purchase services they need from the market (Da Roit and Le Bihan 2010). Benefits-in-kind refer to LTC financing management agencies that directly provide services or purchase services from other institutions for older adults who need assistance (Da Roit and Le Bihan 2010). Some researchers prefer benefits-in-kind over cash benefits because there is a risk that many older people may not use cash to pay for things other than LTC services, whereas others believe that the option of cash benefits supports family care and gives older adults more choices and is efficient in meeting LTC needs (Da Roit and Le Bihan 2010; Colombo and Mercier 2012).

In practice, LTC payment systems vary significantly across countries. For example, Germany has adopted a flexible hybrid approach, in which only cash payments are provided in inpatient care, and the option of cash or service payments for in-home care is decided by older adults; however, the amount of cash payment must be lower than the standard of service support (Büscher et al. 2011). The Japanese LTC insurance system provides benefits only for services and no cash benefits (Olivares-Tirado and Tamiya 2014; Ikegami 2019). In the Republic of Korea, both home care services and institutional care services are paid in-service support, and cash payments can only be paid in remote mountainous areas or islands where there are no formal LTC services (Chon 2012). In the United Kingdom, cash benefits are more common, and the LTC system relies heavily on informal or unpaid care (Pickard et al. 2007).

In most countries, the difference in LTC financing expenditures lies in the composition of public funds and out-of-pocket costs. In the United States, the overall composition of payments for LTC services and supports is as follows: out-of-pocket (53%), federal and state Medicaid programs (34%), Medicare (10%), and private insurance (3%) (O'Leary and Chow 2016) – although, after the spending down of personal assets, Medicaid will serve as a main source of LTC services and supports (Schmitz and Giese 2019). In Japan, LTC is considered a social insurance, regardless of income. The insured pays 10% (after August 2015, 20% for persons with income above a certain level, Ministry of Health, Labour and Welfare (Japan) 2016) from cost-sharing or co-payments of the total cost, and the remaining 90% (or 80%) is covered by LTC insurance; about 50% of funding comes from taxes (the central government is responsible for 25%, the prefecture is responsible for 12.5%, and the municipal government is responsible for 12.5%), and 40% from social contributions (Olivares-Tirado and Tamiya 2014; Ikegami 2019). In the Republic of Korea, LTC insurance is financed jointly through mandatory premium contributions from participants (60–65% of total funds), government subsidies (20%), and out-of-pocket payments (15–20%) (Song et al. 2014).

Management of LTC Financing

The design of a public LTC system is not an easy task. It relies on the extent of political (governmental) supports and welfare programs, the type of private insurance market, and the structure of families involved (Klimaviciute and Pestieau 2018). While most countries have government-managed LTC insurance, some countries are managed by private insurers. The government's support for LTC insurance is primarily welfare payments to older adults, long-term services to disabled individuals, and subsidies for building LTC facilities. Many developed countries rely heavily on local governments to design and administer their LTC systems, with policy guidance from the central government (Brugiavini et al. 2017). For example, in Japan, the LTC system is governed by a law that the central government acts as the main body of management of LTC financing and compulsory insurance programs. The roles of the central government include developing LTC policies, setting the legal framework for LTC, providing funds, tracking the extent of service utilization and spending, and supervising delivery of care (Olivares-Tirado and Tamiya 2014). The roles of the municipalities are insurers, providing persons with long-term healthcare and daily care and supporting the LTC institutional system in finance and management (Olivares-Tirado and Tamiya 2014; Ministry of Health, Labour and Welfare (Japan) 2016). In Sweden, the central government delegates virtually all responsibility for the financing, organization, and administration of LTC to municipalities (Swedish Ministry of Health and Social Affairs 2007). In China, LTC insurance is paid and managed by local governments (Yang et al. 2016; Li and Otani 2018). In England, social care is commissioned by local authorities (Colombo and Mercier 2012). In Germany, the practice is to integrate LTC insurance into social insurance.

Unlike other countries, where healthcare sectors enjoy a large government subsidy, Singapore and the United States emphasize individual responsibility, and the government only focuses on low-income persons who cannot afford the care. In Singapore, the healthcare system is a "3 M" system, Medisave (compulsory personal health savings account, funded by employer and employee contributions), MediShield (a basic, national medical insurance system), and Medifund (an endowment fund for those with low income) (de Castries 2009). However, MediShield does not cover LTC expenses, and Medisave cannot be used for LTC expenses, with the exception of outpatient rehabilitation and inpatient hospice and home palliative care services (Ministry of Health, Singapore 2015). The Central Provident Fund Board administers the Medisave and MediShield systems, while there are other Medisave-approved integrated shield plans that work with private insurers to provide more comprehensive coverage. Government subsidies are only available to voluntary welfare organizations covering LTC costs, while LTC services from private and for-profit providers remain too expensive for many (Chin and Phua 2016).

In the United States, the government management of the healthcare plan is Medicare and Medicaid (see Medicare: Coverage, Evolution, and Challenges; Medicaid in this volume). Medicare pays for the majority of post-acute rehabilitative care and home health services. Medicaid is the primary payer for LTC services and supports but mainly focuses on means-tested individuals (O'Leary and Chow 2016; Braun et al. 2019). Much of the remainder is paid out-of-pocket, either by older adults themselves, by family members, or by private LTC insurance (Gleckman 2010). Private insurers decide which policies are sold through the individual market, which could vary greatly in terms of cost, covered benefits, and eligibility criteria, based on the age of the individual purchaser (O'Leary and Chow 2016; Braun et al. 2019). The United States took modest steps to expand private LTC insurance through tax incentives and government-funded marketing campaigns and by tying this coverage more closely to Medicaid that older individuals are not eligible for long-term care under Medicaid until they spend down their lifesavings as private paying patients (O'Leary and Chow 2016; Schmitz and Giese 2019). These efforts, however, have little success, and participation in private insurance

remains very low; only about 10% of individuals over age 62 have private long-term care insurance (O'Leary and Chow 2016; Braun et al. 2019).

Challenges, Reforms, and Prospects

The primary challenges of LTC financing are concerns about the future sustainability and affordability of LTC and the equity of the current funding mechanisms (Costa-Font and Courbage 2012; Olivares-Tirado and Tamiya 2014; The Long-Term Care Financing Collaborative 2016; Galiana and Haseltine 2019). These challenges could be summarized into four parts. First, it refers to the magnitude of LTC costs. With rapid population aging, coupled with advances in healthcare, and improvements in the quality of care, LTC costs are expected to increase in the foreseeable future. For instance, the overall costs of LTC in the Netherlands, one of the oldest long-term care systems in Europe, have increased from the equivalent of less than €1 billion in 1968 to almost €13 billion in 1998 and more than €27.8 billion in 2014 (Joshua 2017). In the United States, LTC spending accounted for 0.5% of the GDP in 2017 (OECD 2019), and it is projected to over 1% in 2060 (De la Maisonneuve and Martins 2013). Due to funding limitations, most public systems are not able to cover LTC costs for the entire population. Similarly, a private insurance market may not provide full and comprehensive solutions at affordable prices (Costa-Font and Courbage 2012). Thus, to lower LTC costs and improve access to care for older adults, developing managed care and community and home-based care should be highlighted in a country's reform strategy of LTC system (Galiana and Haseltine 2019). In addition, affordable LTC insurance should be considered essential to sustaining the costs of caring for older adults (Galiana and Haseltine 2019). Some countries have been exploring such strategies in their reforms of LTC insurance programs or in some pilot programs. For instance, in Qingdao, China, a national pilot project on LTC services was launched in 2012 to provide affordable LTC services to disabled adults. In the last few years, the out-of-pocket payments for LTC services for disabled older adults in Qingdao have been significantly reduced (Chang et al. 2020). In countries such as the United Kingdom, because costs of long-term care for older people of the future market will likely be affected by the extent of informal care as increasing demand for informal care considerably (Pickard et al. 2007; Galiana and Haseltine 2019), a strategy to develop a more affordable LTC system would be more prominent.

Second, government funding is increasingly burdened by the financing of LTC, especially for countries with social LTC insurance systems. For instance, the percentage of GDP of public LTC expenditures of OECD countries is projected to grow from 0.9% in 2012 to 1.5% in 2030 (Lorenzoni et al. 2015). To lessen these financial burdens, governments have made changes to LTC financing by raising fees and reducing benefits. In the Netherlands, one strategy to meet funding shortfalls was to increase co-payments for middle- and higher-income groups (Joshua 2017). Eligibility criteria were also tightened. In Japan, reforms to the LTC system planned for 2017–2023 focus on maintaining sustainability of the LTC insurance system by increasing co-payment rates to 30% for high-income users of LTC (Ministry of Health and Welfare 2017). The German system, which is based on a pay-as-you-go mechanism, has increased mandatory contributions from 1.7% in 1996 to 3.1% in 2019 (Blank 2019). For countries with means-tested systems such as the United States, more emphasis is on individual responsibility and ability to pay for LTC. To relieve pressure on its Medicaid program, measures that have been explored include incentives of expanding state and federal tax and policies of encouraging consumers to purchase private insurance.

The third challenge relates to the forms of payment for care systems. Since both cash benefits and service benefits have their advantages and disadvantages, the choice of a cash benefit versus a service benefit appears to be extremely important. In the Republic of Korea, cash benefits are provided only in regions where formal services are not available (Seok 2010). The model of benefit-in-kind needs to be supported by trained

caregivers and the mature management of LTC facilities. While only a handful of training programs are operational in the United States, caregivers receive far more extensive support and training in Germany and the Netherlands (Harris-Kojetin et al. 2019). New forms of paying for care have been recently introduced widely in European countries to purchase not only formal but also informal care (León 2014; Deusdad et al. 2016). Informal care is typically provided by unpaid relatives and family members (see Formal and Informal Care in this volume). In the meantime, we are facing a decline in the supply of informal caregivers due to changes in family structure and higher female labor-market participation (Costa-Font et al. 2017). Because the costs of nursing homes have escalated rapidly in recent years, along with older adults' strong preferences for care at home, there has been considerable interest in expanding public funding for home healthcare.

Fourth, how to maintain the fairness of the funding system is another important issue. Since the current system of financing LTC is inadequate under the uncertainty of LTC risk, the debate around fairness of financing LTC is how much individuals should fund their own care and how much they should be publicly funded (Costa-Font and Courbage 2012). Unmet needs are common in many countries (Mazurek et al. 2019; Peng et al. 2015; García-Gómez et al. 2015). In the United States, the limitations of private and public insurance leave most people without any means to plan for or protect themselves against the risks of LTC financing (Cohen and Feder 2018). To balance contributions and benefits, long-term care financing is complex in most countries due to a mix of public and private payers and a wide diversity of stakeholders.

With all of the challenges discussed above, finding a balance between fair access and financial sustainability will be critical. Many countries have started to reform LTC plans and programs. In the future, innovations in healthcare, such as the integration between formal care and informal care, will have a profound impact on LTC financing. To maintain sustainability of LTC financing, economic development and intergenerational equity should be important considerations in reforming LTC systems.

Summary

The demand for LTC is going to increase significantly due to the rapid growth of older adults and disabled populations and an increasing public awareness of the importance of quality of care. Consequently, LTC funding in most countries is facing financial and resource pressure, and many nations are looking for new approaches to alleviate these challenges. For many countries, especially developing countries, the current LTC financing mechanisms are inadequate to meet the needs of older people. Individuals need to take part in LTC insurance programs in advance and save enough money to overcome potential risks at later ages. It is critical that the public sector finds an appropriate financing mechanism to ensure a sustainable source of funding and share the responsibility for care among various stakeholders.

Cross-References

- ▶ Health-Care Financing
- ▶ Medicaid

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