4 Designing sustainable funding for care

Pooling together existing funding can be an important step towards more integrated care for older people. This chapter discusses the different funding routes chosen by OECD countries to secure sustainable funding for long-term care and which can be considered by Lithuania: setting-up a long-term care insurance, raising social contributions, and relying on additional taxes such as property taxes and value added tax. Finally, this chapter touches on private home equity programmes and their limitations.

Pooling together existing funding can be an important step towards integrated care

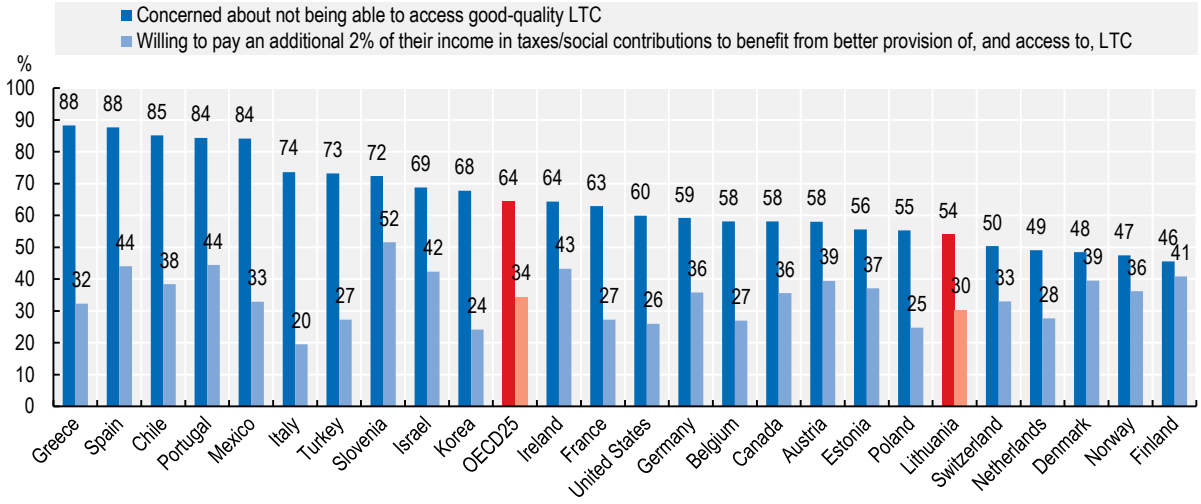
One starting point for Lithuania to establish the integrated long-term care (LTC) system would be to have a dedicated budget. Pooled funding is perhaps the most commonly used manner to finance integrated care for older people (OECD, 2015[1]). In a pooled funding scheme, each body involved in service delivery contributes to a common fund to be spent on pooled functions or agreed services. Pooling existing funds to one well-defined budget can improve transparency and facilitate the distribution of existing funds in a more effective and efficient manner. It can help to reduce unnecessary activities, overuse of services, and duplication of effort and cost shifting (Lonsdale et al., 2015[2]).

France is a country that exemplifies how different funding streams are being turned into a pooled funding scheme. France transferred the vast majority of its LTC funding schemes towards one public institution (CNSA) in 2020 to substantially strengthen the supply of LTC by 2030 and facilitate the collection and the distribution of funding. In addition, it will receive an additional share of funding from the tax "Generalised Social Contribution" (CSG) to finance the LTC services covered before by the Statutory Health Insurance from 2024. This share of the Generalised Social Contribution is currently allocated to the reimbursement of the public social debt. The CNSA budget was EUR 31.6 billion for 2021. Reallocating the social contributions and taxes was possible in France because the funding routes were already outlined in the annual law "Financing Social Security" that aims to monitor the annual EUR 500 billion expenditure of the Social Security (pensions, health, family and child benefits, assistance benefits, etc.).[1] As part of the law, the parliament votes a provisional budget every year – "ONDAM" – for medical LTC providers (including skilled nursing facilities – which are equivalent to nursing hospitals in Lithuania), residential nursing homes and home nursing services for adults with disability and older dependent people.

Growing needs call for considering diverse funding routes to ensure sustainability

Across OECD countries, citizens support more spending on LTC to secure better services, even if this would mean increasing their taxes and social contributions. Between about 45% to nearly 90% of people reported that they are concerned about not being able to access good-quality LTC, according to the OECD Risks that Matter Survey. In addition, between 20% to about 50% of people would be ready to pay an additional 2% of their income in taxes and social contributions to fund more public support for LTC (Figure 4.1).

Figure 4.1. Over one-third of people are willing to pay more taxes to fund LTC across 25 OECD countries



Source: OECD Risks that Matter Survey (data refer to 2020).

Avenues to fund more LTC in Lithuania may rely on diverse and broad-base funding routes. They comprise LTC insurance, taxes and social contributions on incomes and assets. Only a few countries rely mainly on an LTC insurance (Belgium, Germany, Japan, Korea, Luxembourg, and the Netherlands), while the rest rely on tax-based system solely or mixed funding (social contributions and taxes). In Germany, LTC insurance was introduced in 1995 mirroring the pre-existing health insurance and ensuring a large and well-developed base to levy money. Public and private insurances co-exist in Germany. Advantages of LTC insurance include more transparency in managing the funds and horizontal justice. Transparency is improved because the introduction of LTC insurance links funds to specific policies. Horizontal justice would see that the services are the same for everyone, independent on the income of the people in need, while the contribution level increases with the income of contributors. A drawback of an LTC insurance is the reliance on employee's contributions, which can have negative impact on equity and employment. Unless the insurance is extended to the unemployed and the self-employed, it will have a limited tax base, which raises issues regarding equity. For those who are not working, the LTC insurance contribution would still need to be paid from taxes. An LTC public insurance also raises many questions about the amount of premiums to be paid and by whom to limit the possible negative impact on employment (discussed in the next subsection) and take into consideration intergenerational fairness. In addition, LTC insurance can create the expectation that anyone should access LTC, meaning that people would expect to be entitled to the benefits even if demand were to increase. If the LTC insurance fund were to be insufficient, countries would have to complement it with taxes and social contributions and/or borrow to meet citizens' expectations.

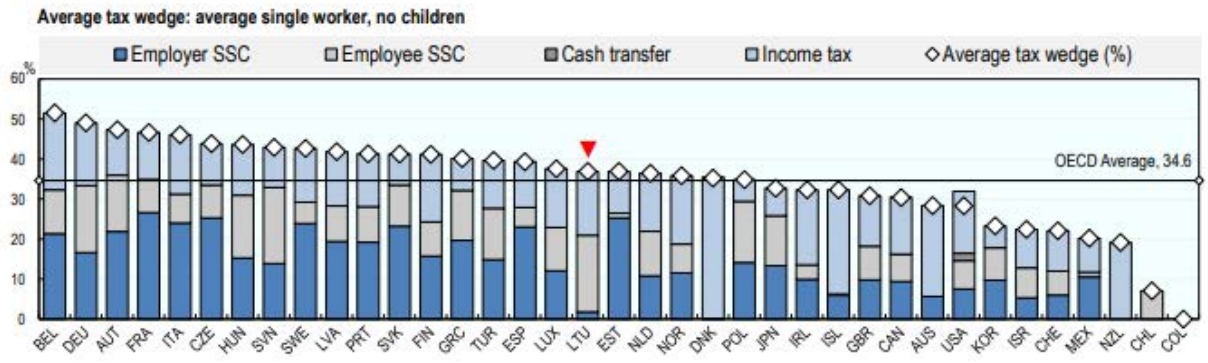
The main advantages of tax-based funding for LTC systems are that taxes can be broad-based and citizens may expect that benefit expenditure aligns with the public financial resources. However, there are sometimes concerns about fluctuations in funding, especially during an economic recession, as well as a lack of transparency in the allocation of funds. Tax-based funding for LTC systems exist in many OECD countries, including in Austria, Scandinavian countries and Spain.

Funding can also come from a mix of social contributions and taxes and, in this case, countries typically levy money on a base broader than the labour incomes. For example, in France, funding stems mostly from social contributions and taxes that cover a base that go well beyond labour income.[2] In many Central and East European countries, LTC funding from the social sector is more tax-based while LTC funding from the health care sector is more mixed. In Scandinavian countries, municipal taxes play a significant role in financing LTC and transfers from the central government budget redistribute funding between municipalities with different income structures and needs profile. In Denmark, municipalities are financed by a combination of state block grants and local income and land tax, albeit within overall limits for all municipalities (Kvist, 2018[3]). In Sweden, approximately 85% of LTC funding comes from municipal/county taxes, and another 10% comes from national taxes. Taxes redistributed to municipalities are not earmarked for flexibility reasons (Schön and Heap, 2018[4]).

In Lithuania, the scope for raising contributions and relying on income tax to fund LTC is limited

Working-age population could contribute to funding LTC in Lithuania to a limited extent. The tax wedge is already slightly higher than the OECD average. The tax wedge for the average single worker was 36.9% in Lithuania compared with 34.6% for the OECD average in 2020 (Figure 4.2). In the future, the pool of workers will decrease along with population ageing and further limit avenues for relying on taxable incomes among the working age population. The old-age dependency rate – the number of older people per 100 working-age people – will almost double in Lithuania between 2019 and 2050, moving from 30% to nearly 60% over this period.

Figure 4.2. The average tax wedge for single childfree workers in Lithuania is slightly higher than OECD average

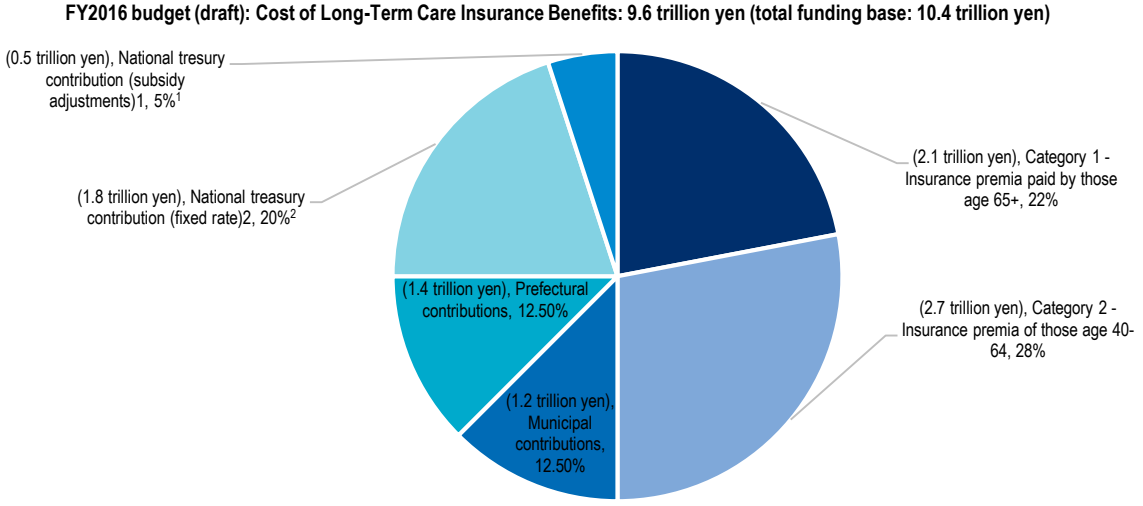


Note: The tax wedge is a measure of the tax on labour income, which includes the tax paid by both the employee and the employer.
Source: OECD Centre for Tax Policy and Administration (2021[5]), Taxing wages – Lithuania, https://www.oecd.org/tax/tax-policy/taxing-wages-lithuania.pdf.

Setting an LTC insurance would secure substantial resources but likely needs to be complemented through other sources

Japan is an interesting model for Lithuania because public spending is split more or less evenly between LTC insurance and taxation, including taxation at the municipal level (Figure 4.3). Similarly to Lithuania, municipalities are also important actors in the assessment and provision of LTC. The Japanese LTC insurance relies on premiums which are different for the people aged 40-64 and those aged 65 and over. Municipalities set the premiums every 3 years based on their projected expenditure. The average premiums are 1.73% on gross labour income for the 40-64. For unemployed people, the premiums are progressive levied as a share on their personal income (7 levels of premiums, 7 levels of income). For older people (65+), the premiums are also based on personal income (7 levels). They are automatically deducted from pensions (Japanese Government, n.d.[6]; Japan Health Policy NOW, n.d.[7]). Taxes enable to broaden the base beyond personal income, and above all, labour income. Income taxes are not earmarked to the LTC insurance. Local governments raise about 1/3 of taxes, and then 2/3 comes from national taxes. Once collected, the ministry redistributes all these funds to municipalities, with the exception of Tokyo.

Figure 4.3. In Japan, insurance premiums and taxes cover each about 50% of LTC benefits



Note: Insurance premia cover 50%, public financing covers 50%. Starting in 2015, a dedicated amount of public money has been appropriated to alleviating the burden of insurance premia on low-income patients. This sum is disbursed by the national government, prefectures, and municipalities. The proportions for Category 1 and 2 are calculated by dividing the number of enrolees in long-term care insurance over the total population every 3 years. For Category 2, public finances to premia contributed 0.6 trillion, Japan Health Insurance Association contributed 0.2 trillion, National Health Insurance contributed 0.3 trillion, prefectures contributed 0.1 trillion. Numbers may not total 100% due to rounding. 1. Subsidy adjusted according to the proportion of age 75 or older people among Category 1 insured persons, and per income level. 2. Proportion of grant each source contributes: National treasury (fixed rate): 15%, Prefectures (17.5%).
Source: (Japanese Government, n.d.[6]; Japan Health Policy NOW, n.d.[7]).

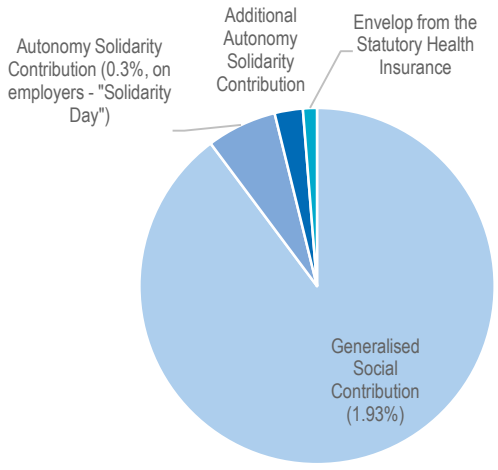
In Germany, the premium for the LTC insurance are set differently than in Japan. The premium is 3.05% of the gross wage, and is shared equally between employees and employers. Those without children pay a surcharge of 0.35 percentage points. The premium is also on unemployment benefits. Premiums are reviewed at least once or twice every four years. Every two years, there is also an increase in the services available and thus premiums are reviewed as a consequence. The methodology to establish premiums is based on a number of factors and data from the main research institutes and the Ministry of Labour are taken into account. The framework is calculated by the Ministry of Health twice a year, under the supervision of the Ministry of Economics.

All the countries with a public LTC insurance supplement it through additional funding via taxes. Even in Germany, an ageing population, an increase in the number of people with high LTC needs and staff shortages are putting pressure on the LTC funding system. The public LTC fund received EUR 1.8-2 billion in 2020-22 from the federal government – i.e. funding from taxes – to cover the increase in spending related to the COVID-19 pandemic. In addition to that, in a law passed in 2021, it was agreed that the government would transfer about 1 billion per year from non-earmarked taxes. The increase aims to cover wage increases, with the goal to reduce staff shortages. The LTC insurance fund and the ministry agreed on this decision because of insufficient funding from the fund to cover wage increases. Even though the amount is very small relative to total LTC expenditure of about EUR 50 billion, this was the first time that Germany decided to rely on taxes to cover increases in spending.

Slovenia is taking a similar approach to Japan and Germany, aiming to fund LTC in part with a new LTC insurance. The 2021 LTC Act states that some funds will come from the pension insurance and the health insurance, based on funds that are currently targeted for the support older dependent people. In addition, the Act states that Slovenia will have to adopt an act for a compulsory LTC insurance by 2025. In the meantime, the additional budget will originate from the state budget. New legislation is foreseen for 2023 to clarify the funding routes.

In France, the public organisation (CNSA) allocates essentially a 2% share of the Generalised Social Contribution to the local authorities or "départements" and to the Regional Health Centres (ARS). The Generalised Social Contribution (CSG) is a unique social contribution across OECD countries – it does not exist elsewhere. It relies on a very broad base and has low rates. It levies about over 100 billion revenues every year – more than personal income taxes. It was implemented in the early 1990s to shift the financing of social protection from wages alone to all incomes (capital income, pensions, unemployment, etc.). The rates vary by type of revenue and revenue brackets. It is considered as less progressive than the personal income tax because the rates vary less by revenue bracket than the personal income tax. However, the general public and the public political debates tend to focus much more on the personal income taxes than the CSG. The CNSA also collects its own finances, mostly through the "Solidarity Day", a social contribution created by introducing an unpaid working day in 2006. The share for the different funding sources are presented in Figure 4.4.

Figure 4.4. The French Autonomy Fund had revenues of over EUR 31 billion in 2021



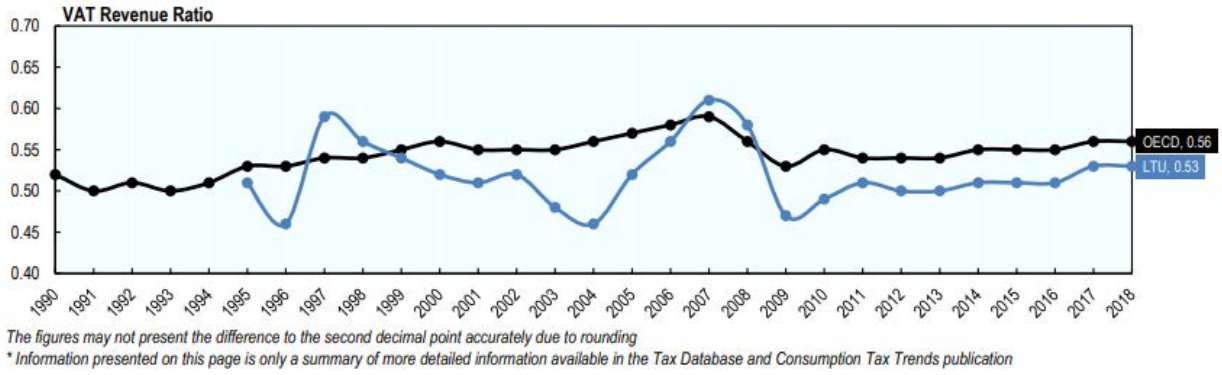
Source: CNSA, Dossier de presse du conseil du 1er décembre 2020 [1 December 2020 Council Press Kit], https://www.cnsa.fr/documentation-et-donnees-espace-presse/2020/dossier-de-presse-du-conseil-du-1er-decembre-2020.

Relying on property taxes and value-added tax (VAT) are good options to diversify sources

As an alternative funding source for Lithuania to consider for additional LTC budget would be property taxes. Lithuania could increase property taxation from 0.3% of GDP to closer to the Latvian's rate of 0.9% or the EU average of 1.6%. In Lithuania, the real estate tax ranges from 0.5% to 2% when the property value is at least over EUR 150 000. Private real estate is taxed at 1% on the property value that exceeds EUR 300 000. This threshold is increased to EUR 390 000 for families with three or more underage children or a child with disabilities who requires permanent care (Ministry of Finance of the Republic of Lithuania, 2021[8]).

Lithuania could maintain the standard VAT rate at its current level, but reduce the number of goods and services with reduced VAT rates or exemptions. The standard VAT rate in Lithuania is equal to 21%, close to the EU average of 22%. It is identical in Latvia, but at 23% in Poland. Lithuania has increased its standard VAT rate in 2010, from 19% to 21%. Compared with the OECD average, there is scope to narrow down the number of goods and services eligible to the reduced VAT rates or exemptions, or move goods and services across reduced rate categories, or increase the reduced rates. The VAT Revenue Ratio (VRR) for Lithuania was 0.53 in 2018, below the OECD average of 0.56 (Figure 4.5). The VRR is a measure of the revenue raising performance of a VAT system. A ratio of 1 would reflect a VAT system that applies a single VAT rate to a comprehensive base of all expenditure on goods and services consumed in an economy, with perfect enforcement of the tax. Reduced VAT rates or exempts apply to a number of goods and services. The reduced VAT rates were 5% and 9% in 2021. In comparison, it was 5% and 12% in Latvia and 5% and 8% in Poland in 2021.

Figure 4.5. The VAT Revenue Ratio in Lithuania could be closer to OECD average

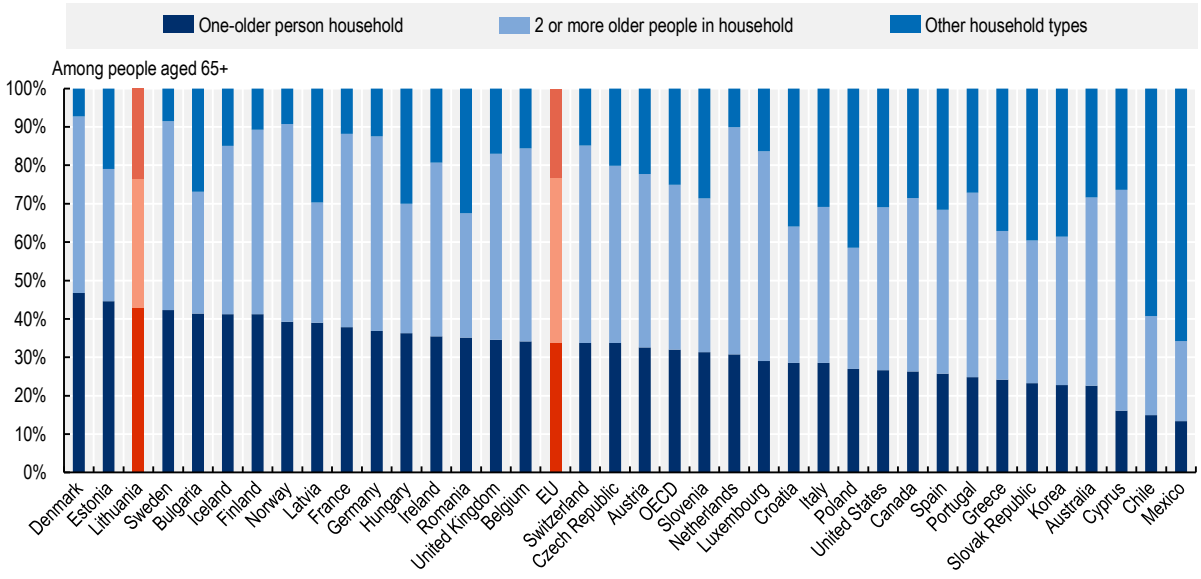


Source: extracted from OECD Consumption Trends 2020, https://www.oecd.org/tax/consumption/consumption-tax-trends-lithuania.pdf.

Private home equity programmes have a very limited potential

Over 40% of older people in Lithuania live alone (Figure 4.6) and over 90% of older people own their home in Lithuania (with or without mortgage).[3] This means that a number of Lithuanians have immovable assets like houses and flats which could be used to contribute to LTC costs if unoccupied.

Figure 4.6. Over 40% of older people live alone in Lithuania



Note: 1. No data available for Japan, New Zealand and Republic of Türkiye due to data limitations. The present publication presents time series which end before the United Kingdom's withdrawal from the European Union on 1 February 2020. The EU aggregate presented here therefore refers to the EU including the United Kingdom. In future publications, as soon as the time series presented extend to periods beyond the UK withdrawal (February 2020 for monthly, Q1 2020 for quarterly, 2020 for annual data), the "European Union" aggregate will change to reflect the new EU country composition.

Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU SILC) survey 2019 except for Iceland, Ireland, Italy, and the United Kingdom (2018; the German Socio-economic Panel (GSOEP) for Germany till 2014, the Household, Income and Labour Dynamics Survey (HILDA) for Australia (2019); the Survey of Labour and Income Dynamics (SLID) for Canada (2011); Encuesta de Caracterización Socioeconómica Nacional (CASEN) for Chile (2017); the Korean Housing Survey (2019); Encuesta Nacional de Ingresos y Gastos de los Hogares (ENIGH) for Mexico (2018); American Community Survey (ACS) for the United States (2019).

Lithuania could encourage the use of home equity programmes such as reverse mortgages or home reversion, but the potential of such a programme for funding LTC is very limited. Home equity programmes are typically not very developed in terms of housing market share and number of providers across most OECD countries. In general, home equity programmes still seem to be more products of last resort than well-thought purchases as part of a retirement plan or a health care plan. This is explained by several challenges on the supply and the demand sides. For example, in the United Kingdom, the small reverse mortgage market is concentrated where house prices are high. However, there is a strong demand in other parts of the country where both real estate and non-real estate wealth are lower. The risks faced by suppliers limit market development as providers need high house price growth to make profit on reverse mortgages (Sharma, French and McKillop, 2020[9]).

The market is more developed in the United States, partly because of the stringent eligibility criteria to access public support for residential care. Eligibility criteria for people relying on Medicaid include an asset test on the primary residence: one cannot own a home that they do not live in. Therefore, a single person is required to sell their home to receive Medicaid support (including their primary residence, but it is not applicable if a spouse remains in). Reverse mortgage is attractive to borrowers when the reverse mortgage can be used to pay for in-home care over a relatively long period. The United States has also one of the strongest regulations for the government-insured scheme. The insurance guarantees that the borrower's debt will never exceed the property value and that borrowers will receive regular payments from the loan even if the property loses value or the lender becomes insolvent. (Paying for senior care, 2020[10]; Bridge et al., 2009[11]).

Preventive and rehabilitation services can contribute to funding sustainability

Scandinavian countries and some other OECD countries have well-developed preventive and rehabilitation services that can contribute to improving quality of life and potentially be cost-efficient. Preventive and rehabilitation services can help to postpone LTC needs, thus potentially containing LTC expenditure. Across countries, day centres typically offer preventive services, among others (Box 4.1).

Denmark and Norway provide interesting examples of preventive measures. In Denmark, municipalities provide preventive home visits and activities to everyone aged above 75. The offer is also extended to people aged 65-75 who are in a special risk group – those who are widows, live in a secluded area, or are recently discharged from hospital. As of 2016, municipalities can organise group visits instead of individual visits as an alternative to those who usually decline home visits. In 2016, 93 424 persons received a preventative home visit, down from 122 794 in 2010. Municipalities also provide activities that vary in terms of scope and type (workshops, education, talks, and sports) (Kvist, 2018[3]). In Norway, a health care worker – typically a nurse – evaluates the older person's physical and mental health condition, assesses the appropriateness of their home environment and recommends solutions and measures to prevent foreseen problems. The introduction of a preventive home visits programme significantly lowers the probability to use nursing homes, while increasing the probability to use home care. A survey showed that care in nursing home was reduced by 1.4 percentage points among the people aged 80 and over, from a baseline of 19%. The decline was partly matched by an increase in home-based care, from a baseline of 35%. In addition, hospital admissions decreased by about 7%, and mortality rates declined by nearly 5% in the years following the introduction of the preventive home visits (Bannenberg et al., 2021[12]).

Box 4.1. Day centres typically offer preventive services

Even though "day centre" is a generic term, day centres can be defined as community building-based services that provide care and/or health-related services and/or activities specifically for older people with disability and/or who are in need, which people can attend for a whole day or part of a day. Interventions with evidence of positive outcome are presented.

Table 4.1. List of programmes

Programme type	Programmes
Providing social and preventive services	Humour-based programme
	Transport, exercise and self-help programme
	Organised volunteering
	Psychosocial group work
	Brain fitness activities
	Discussion groups to promote social engagement and learning
	Health screening/Hearing screening
	Education-focused falls prevention
Promoting physical activity	Moderate-intensity weight-bearing exercise
	Core stability and flexibility exercise
Supporting health and daily living needs	Blood pressure monitoring
	Self-management education
	Behavioural intervention to increase walking and reduce urinary incontinence (UI)
	Pelvic floor muscle training (Kegel exercises) to reduce UI
	Medication reviews by pharmacy students
	Programme of low-impact exercise, nutrition education and weight management for people with multiple chronic conditions

Source: Orellana, Manthorpe and Tinker, (2018[13]), Day centres for older people: a systematically conducted scoping review of literature about their benefits, purposes and how they are perceived, https://doi.org/10.1017/S0144686X18000843.

In addition, Danish municipalities have to offer a rehabilitation programme prior to assessing the need for home help. The programme is short-term and intensive (4-10 weeks). The rehabilitation programme comprises one or more of the following elements: training in everyday activities (personal care), physical training, assistive devices, and adaption of the home, with the aim of maintaining or even gaining functionality (Kvist, 2018[3]). In 2018, 4.3% of people aged 65 and over followed the rehabilitation programme, instead of, or together with home help (Rostgaard, 2021[14]). Danish evidence suggests improvement in functional ability, better evaluation of working conditions and work motivation among staff. Local reports indicate good user outcomes and some studies show a lower use of home care (Rostgaard, n.d.[15]). Some preliminary results seem to be aligned with these findings, as the probability of using home care has decreased from 2007 to 2017 in Denmark. The probability of receiving home care for frail people aged 67-87 years decreased from over 35% to about 25% (Rostgaard, 2021[14])). This could be the result of targeting more home care towards the most frail and personal care. While the programme may be cost-efficient, there has not been any systematic documentation of expenditure and user outcomes.

Price controls for LTC services might also be useful tools for sustainability

Certain countries such as the Netherlands and Spain rely on defined or maximum prices for services in each care setting. The Netherlands relies on maximum prices to finance LTC provision. The 31 Dutch regional purchasing offices are in charge of contracting provision with providers, within the budget constraint, and respect the maximum prices set by the Dutch Health Care Authority (Nza) (Milstein, Mueller and Lorenzoni, 2021[16]). The care an individual is entitled is determined by his or her care profile (there are 10 care profiles). Maximum prices for each care profile are differentiated based on whether treatment is provided by the nursing home. Moreover, the Nza sets separate maximum prices for a substantial number of additional activities, including additional services like transport (Table 4.2). Maximum prices are based on empirical research based on a survey that covered about half of providers delivering care financed by social long-term care insurance in 2017 (Kelders and de Vaan, 2018[17]; Bakx, Schut and Wouterse, 2021[18]).

Table 4.2. Maximum price per day per care package in the Netherlands

Care package	Description	Users (in-kind)[a]	Users (cash benefit)[a]	Price per day (EUR)[b]
1	Assisted living with some support	350[c]	0	100
2	Assisted living with support or personal care	1015[c]	0	128
3	Assisted living with intensive support and extensive nursing	2110[c]	0	183
4	Assisted living with intensive support and extensive nursing	26445	2235	197
5	Nursing home care with extensive dementia care	60290	5400	250
6	Nursing home care with extensive personal care and nursing	27885	1750	251
7	Nursing home care with intensive care, with focus on supervision (often behavioural problems)	10635	290	293
8	Nursing home care with intensive care, with focus on personal care/nursing (problems with ADL and cognitive)	2150	355	331
9[b]	Rehabilitative treatment[d]	825	55	300
10	Protected living and palliative care	255	25	354

Note: A. Number of users in 2018. B. Regulated maximum price for 2019, including day care and treatment. C. Access to care packages 1-3 were abolished in 2012; only cases prior to 2012 remain. D. Rehabilitative treatment for individuals already living in a nursing home.
Source: Bakx, Schut and Wouterse (2021[18]), Price setting and contracting help to ensure equitable access in the Netherlands, https://extranet.who.int/kobe_centre/en/project-details/.

Spain relies on tariffs, rather than maximum prices, and co-payments decided at the regional level, within a national binding framework. In Spain, the regional Health Departments undertake contracts with both public and private providers. The central government sets minimum criteria for benefits and also reference costs of services. In many cases, tariffs and reference costs are static and based on historical values. The regions are free to set their own prices, but they have to finance the difference in case of higher costs. The average price of public home care was about EUR 15 per hour and the average user's co-payment 11% in 2019. Average hourly prices of home care varied between around EUR 9.00 in Extremadura and Galicia to EUR 17.00 in Aragón and Illes Balears. As for co-payment, it ranged from 1.6% in Andalucía and 44.2% in Murcia (Flores, 2021[19]). With respect to day centres, prices per user depend on the user's degree of dependency and the type of provider. On average, annual prices per user were EUR 9 077 in public centres with a co-payment of 24% and EUR 10 078 in private subsidised centres with a co-payment of 22% per user in 2019. (Flores, 2021[19]). In residential care centres, prices per user depend on the type of provider

(public of private subsidised "charter" centres). For instance, in 2019, on average, annual prices per user were EUR 20 686 in public centres with a co-payment of 36% (EUR 7 500) and EUR 19 324 in private subsidised "charter" centres with a co-payment of 40% (EUR 7 810). There are also large differences across regions both in prices and co-payments. For example, annual prices per user in public centres ranged from EUR 10 460 in La Rioja to EUR 28 145 in Madrid. Co-payment in public centres was highest in Navarra as a percentage (81%) but in País Vasco as an absolute figure (EUR 13 110) (Flores, 2021[19]).

Lithuania could consider introducing maximum prices or tariffs as in the above-mentioned countries. If the prices are set on services rather than hours, the price should factor in the hours of care needed to deliver the services and the complexity of the tasks (i.e. the wage). If the prices are set in hours, it would be important to take into account the complexity of the tasks (and the wage implications). Because of the risks of setting prices without previous field research, it is probably more realistic to rely on historical prices in Lithuania (see the section on needs assessment to understand the value of field research).

An alternative is to use a point system to set prices and to control spending such as in Germany and France. Each service has a number of points, which have a base value. The points and the base values can be set at the national or subnational level, but providers can set up contracts with the public bodies. This system allows for price adjustments to take into account differences across subnational levels, but it is also more complex. The pricing system also depends on the setting – home care, day care and residential care. For residential care, both countries differentiate between non-accommodation costs and accommodation costs. Accommodation costs are less monitored and providers can make more profit on this strand. Co-payment applies at least for residential care in both countries.

In Germany, prices for home care follow a point system different in each *länder*. Services are translated into points depending on the time intensity of the services provided and/or their complexity. The base value is around EUR 5-6 per 100 points (Table 4.3) (Milstein, Mueller and Lorenzoni, 2021[16]). Prices are negotiated individually on a regional or state level between a care setting, welfare organisations and LTC funds, whose enrolees contribute at least 5% of the residential home days (Pflegesatzverhandlungen). Prices are negotiated separately for nursing services, board and accommodation and investment costs. Board and accommodation and investment costs are the same for all residents, but nursing costs and reimbursements grow by increasing care degree with some exceptions. Nursing costs are largely based on the number of nurses per beneficiary and vary depending on the beneficiary's care degree.

Table 4.3. Prices of selected services in two German *länder*

	Brandensburg		Bavaria	
	Points	Price (in EUR)	Points	Price (in EUR)
First visit	450	22.64	1000	60.50
Journey (mobility)	84	4.23	-	4.54
Washing hair	129	6.49	100	6.05
Changing bedsheets	50	2.52	80	4.84
Cooking main dish	240	12.07	300	18.15

Note: data refer to 2019.
Source: Milstein, Mueller and Lorenzoni (2021[16]), Germany's difficult balancing act: Universality, consumer choice and quality long-term care for older persons https://extranet.who.int/kobe_centre/sites/default/files/OECD_2021_Germany.pdf.

In France, the pricing method for nursing homes also uses a point system for the medical care and the dependency care packages. The pricing method of care institutions is composed of the medical care package, the dependency care package and the accommodation fee (Or and Penneau, 2021[20]). The medical care package is calculated for each facility using a synthetic indicator, which corresponds to the average care needs and dependency level of people living in the facility. For each of these condition-profiles, eight resource groups were identified (physician, psychiatrist, nursing, rehabilitation, psychometrics, biology,

imaging and pharmacy) that define the level of care resources required. This care bundle is also adjusted according to the dependency level (six levels of LTC needs). The amount of the medical care package for each facility is the weighted average score multiplied by a reference/index price per point defined at the national level by the Ministry of Health. In practice, the Regional Health Centres are constrained in their LTC funding by the ONDAM a priori budget, and care institutions may not receive the amount calculated with this pricing method (Or and Penneau, 2021[20]). The dependency care package is set in a similar way, but is funded by the local authorities. The payment is calculated according to the GMP (average dependency score) of the facility and the value of the departmental dependency score's point decided by the local council. Across local authorities, the point ranges from EUR 5.7 in the Alpes-Maritimes to EUR 9.4 in the south of Corsica. In 2017, the price for dependency bundle was on average EUR 5.5/day for low dependency persons, EUR 12.9/day for moderate level of dependency and EUR 20.4/day for highly dependent persons (Or and Penneau, 2021[20]). The accommodation fee of places eligible for public support are set by the local authorities – around 85% of care institutions have places eligible for public support. The maximum price varies between EUR 49/day in the first decile of prices of residential care to EUR 67/day at the 9th decile. The prices of places that are not eligible for public support are set freely, although the rate of increase is monitored each year and regulated by the central government (Or and Penneau, 2021[20]).

Interestingly for Lithuania and its nursing hospitals, until 2017, skilled nursing facilities in France were only funded by annual prospective global budgets in the public and private non-profit sectors and through a fixed daily rate in private for-profit facilities. Since 2017, the global budgets have been adjusted to take into account the volume and case-mix of the patients treated. In 2020, about 10% of the budget came directly from activity-based payments using GME reference tariffs. The tariffs include all staff costs and there is 70-day threshold which allows facilities to bill some of the costs gradually for longer stays. The tariffs are also weighted by a geographic coefficient. Since 2018, skilled nursing facilities can also benefit from the small pay-for-performance scheme focussed mostly on patient safety indicators (Or and Penneau, 2021[20]).

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Notes

[1] In comparison, the State annual budget is about EUR 250 billion. The parliament also votes it every year, together with the Law on Finances.

[2] France's Generalised Social Contribution has relatively low rates and relies on a very broad base (labour income, capital income, pensions, unemployment benefits, etc.).

[3] Eurostat, Income and Living Conditions database, indicator ilc_lvho02.