Social Protection Reform Project
中国-欧盟社会保障改革项目

Panel Discussion Report

The Development of Old Age Services and Long-Term Care System

Ministry of Finance, P. R. China

Tuesday, September 5th, 2017
RENMIN UNIVERSITY
Qiushi Building, Meeting Room No.320

INTRODUCTION

On 5th September 2017, the EU-China Social Protection Reform Project- Component 2 held a Panel Discussion at Renmin University on the topic "The Development of Old Age Services and Long-Term Care System" (topic 2.1.6) in cooperation with the Medical Insurance Division and Veteran Benefit Division of the Ministry of Finance, P. R. China. The Division Director, Mr. Jiang Yu, and the C2 Resident Expert, Mr. Bruni, chaired the meeting. Prof. Tang Jun, presented the Chinese context and main challenges faced by the Government in developing a comprehensive and efficient LTC system, while the EU experts introduced the experiences of the different EU models of long term care systems (Mr. Marcello Morciano); and the specific LTC system developed in France (Mr. Jean Yves Hocquet), Germany (Mrs. Monika Gabanyi[1]), and Italy (Mr. Vincenzo Atella). Overall, around 30 participants, including representatives from the Medical Insurance Division, Veteran Benefit Division and Actuarial Division of the MoF, Chinese Academy of Social Sciences, Renmin University, Wuhan University, Italian Embassy, and the project team took part in the Panel. The meeting was a successful activity to examine the main challenges faced by the Chinese government and analyze the EU experiences that could be useful for the Chinese context.

The agenda and list of participants are attached as annexes.

[1] Mrs. Gabanyi could not attend the Panel. The main results of the assessment report were presented by the Resident Expert, Michele Bruni.

Mr. Jiang Yu, Division Director of the Veteran Benefits Division, Department of Social Security of MoF, and Mr Bruni, EU Resident Expert of Component 2 and Team Leader, jointly chaired the meeting.

Mr. bruni opened the Panel by welcoming all the participants, expressing his thanks to the MoF, and introducing the experts that contributed to the research outputs. The topic of Long Term Care is very relevant to the Ministry of Finance. After the presentation of prof. Tang Jun on the Chinese context, the EU experts will provide a picture of the solutions adopted by EU countries, in order to find "the Chinese path" in developing a comprehensive long-term care system. Given the wide socio-economic differences among EU countries and China, the EU side can provide insights and information, rather than a solution that can be applied to the Chinese context. Both positive and negative experiences of the EU countries in the field are relevant to China to learn from.

Mr. Jiang Yu followed Michele's welcome speech by introducing MoF representatives attending the meeting, coming from MoF Veteran Benefit Division, Department of General Affairs, Department of Medical Care and Veteran Benefits. Currently, China is facing a rapid ageing trend, which has a strong impact on the society, economics, and on the social security system. Within the C2 of the EU-China SPRP, one of the main topic is the Development of Old Age Services and Long-Term Care System. At present, China's development of the elderly care service is facing a lot of challenges and there are several weak points of the system to be addressed. In the 13th 5 Year Plan, it is proposed to establish a LTC system which relies on community care and with social care as a supplement. The 5 YP also encouraged the active exploration of pilot projects on long term care, however the "financial development" on LTC is still very weak.

The Project provides a great opportunity to MoF to learn some good experiences from EU countries, including both positive and negative practices. Even if there are great differences on the development stages among EU countries and China, Mr. Jiang wishes to draw some inspirations for China's policy development.

Through the EU-China SPRP efforts, the EU and Chinese sides have already submitted their reports and provided good achievements. Thanks to the opportunity of the panel discussion, the MOF will have a better understanding of the EU and Chinese policy contexts, and in the next step the MoF hopes to receive some clear and defined policy suggestions to develop the Chinese LTC system.

Finally. Mr. Jiang Yu thanked all the experts for the participation to the project and Renmin university for the support.

Keynote 1: The Development of Old Age Services and Long-Term Care System: the Chinese context *Speaker:* ***Prof. Tang Jun*** *(Professor, Chinese Academy of Social Sciences)*

Since 2002, Prof. Tang Jun has been studying the field of Long Term Care, he wrote a report for the project.

The basic concept of old-age services can be traced back to the definition of health made by the World Health Organization (WHO). According to Su Jingjing, Zhang Daqing, between 1947-1948,

the birth of WHO brought about a new definition of health, as written in English: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

WHO definition of health and other new concepts are more effectively realized by the governments around the world for implementing development strategies and social policies responding to aging. Three words reflect the new definition and concepts: successful aging, healthy aging and active aging. In 1990, the Copenhagen Conference of WHO adopted the strategy for healthy aging. This concept emphasizes the idea that old people can keep their physical, mental, and intelligent wellbeing as long as possible. The latest World Report on Aging and Health says: Healthy Aging does not only mean that one person is without disease. For most aged persons, the maintenance of health functioning is the most important.

In 2002, WHO issued the Active Aging: Policy Framework, in which the concept of Active Aging is defined as “the process of optimizing the health, opportunities to social participation and social security for old people for improving their life quality.” This definition emphasizes the need of multi-partnership action, whose objective is to ensure that old people are always beneficiary resources of their families, communities, and economies.

Against the concept of medical center oriented, the WHO has done a lot of work in this area: in 1990s WHO proposed the concept of healthy ageing, and then the concept of active ageing. In 2000, WHO reached the consensus that long term care is the activity system conducted by the informal care giver in collaboration with social and medical sector.

Since the start of "Twelfth Five-Year Plan", especially after 2013, as China's aging had been accelerating, old-age service had attracted the attention of the leaders of the party and the state. On May 27, 2016, the Political Bureau of the CPC Central Committee held a thirty-second collective study on the situation and countermeasures of population aging. At the meeting, Xi Jinping proposed to "implement policies to support the development of old-age services", and establish “a long-term care system that articulates relevant insurance, welfare and social assistance schemes.”

This "long-term care system" proposed by Xi is undoubtedly a new concept, which may involve social insurance, commercial insurance, social welfare, social assistance. It is a concept that reflects the Chinese reality and characteristics.

There could be two ways to interpret this. The first is that insurance, welfare and social assistance schemes are three ways of social protection. Insurance and social assistance schemes are mainly for funding the LTC system, while welfare schemes focus on the service. This means that LTC must balance financing and service provision. Firstly, LTC system should adopt the term “security”, which helps the system to articulate insurance and allowance for funding the system, with services of care, nursing and rehabilitation. Secondly, social insurance, commercial insurance, government subsidy, social assistance, and charity should all be involved to fund the system, forming a new and mixed model that can provide funding sources to social groups of different income levels. Thirdly, old-age service agencies should be directed to integrate institutional, community and home cares and provide community and households with professional and quality services based on small, appropriate and middle-class facilities. Fourthly, there should be organizational arrangement to

guarantee the implementation of the grand security of LTC, which requires government agencies, including the Ministry of Finance, Ministry of Human Resources and Social Security, Ministry of Civil Affairs and the National Commission of Health and Family Plan to thoroughly cooperate with each other, and therefore gain benefit for every partner.

In recent years, Chinese aging process has been so fast that the society was generally in panic. The media often describe Chinese aging level as “the most serious in the world”, largely misleading the public. Obviously, " the most serious in the world" is not the truth.

In Chinese official statistics, the support rate for old people is usually adopted as an important indicator. Setting the old people as those over 65 years old and working people as those aged between 15-64 years, from 2006 to 2015, the support rate of Chinese old people has increased from 11.0% to 14.3%.[2] According to the 2026 forecast of the Office of National Committee on Aging, generally from 2030 to 2050 the support rate of Chinese old people will keep around 40-50%, which indicates that this period sees the most serious aging.

LTC should fall in the social services, usually provided in institutions or at home, instead than at the hospital. If we regard the care of elderly and rehabilitation into medical care we cannot afford it, it would be too expensive. Elderly care will be a field of the social sector, we will establish LTC insurance to support this sector.

However, some people have made some mistakes, established pilots using funds of medical care to support the elderly care. The medical insurance system is financed by the institutes and individual without the support of the government. There is a popular concept of combining social care and medical care, however this is not the general practice in the international context.

There are three departments of Chinese Government that relate to LTC: Ministry of Labour, Ministry of Civil Affairs and Ministry of Health.

In Japan, for showing the difference with clinical nursing activity in medical service, LTC is called “jiehu”, which specifically means elderly care. The Japanese concept, on the one hand, means assistance to daily life, including clothing, dining, living and traveling; and on the other hand, it also includes assistance to medical care, nursing and rehabilitation.

Looking at the effective demand of LTC, in 2016, the average pension for a retired (from enterprises) was 3400 to 4000 yuan per month among the cities of Beijing, Shanghai, Guangzhou and Shenzhen. However, the average cost of an institution providing elderly care services was from 5000-6000 yuan per month.

We should divide the groups of disable elderly. One group including those that have lost their whole living activities, paralyzed in bed or unable to recognize relatives (3%), the second including those that have lost part of their living activities, cannot bath or move in the house by themeselves (3%), the third including those that lost their social activities, cannot buy things or don’t have a home (10-20%). There are three levels in the financing model of LTC system, and these three levels

[2] 《人口结构与抚养比》，国家统计局网站（http://data.stats.gov.cn/easyquery.htm?cn=C01）。

have different importance and focus. The first level is the most important. It should be implemented in the first step. From the perspective of life development of old people, the three levels are respectively corresponding to the different stages of function losing, meeting different needs. Therefore, the three levels should also be integrated as a whole system.

Elderly service agencies should have the ability of self-survival and self-development. Elderly service agencies with 200 beds, when reaching a full amount of elderly, can make a profit of 5 to 8 percent, when with excellent business, it can make a profit of 12 percent. We should enable the market to play its role. The elderly service operators should integrate all the sectors of business (health, home, partial disability, community services, total disability, agency ageing service.), with a good funding we can create a net with ageing care, and functional rehabilitation.

Keynote 2: Long-term care in Europe: A review and synthesis of the most recent evidence -

Speaker: ***Mr. Marcello Morciano*** *(Research Fellow, Health Economics Group, School of Medicine, Health Policy & Practice, University of East Anglia, UK)*

The report's aims were: to provide an overview of the system of care and support for elderly people in Europe; to stress on the relevance of social protection against the risk of LTC needs in modern societies; to identify existing practices in place in Europe, their level of sustainability and of adequacy; to draw policy messages that could be relevant also for China; to stimulate a discussion within the members of the EU-China Social Protection Reform Project and further cooperation in the LTC field.

Long-term care (LTC) is a range of services required by persons with reduced degree of functional (physical or cognitive) capacity, and who need help to meet their basic personal needs. Most LTC is not medical care: it is care for chronic illness/disability instead of treatment of acute illness. Caring for chronic illness lasts as long as the recipient is alive. Most LTC is assistance with the basic personal tasks of everyday life: bathing, eating, taking medication, etc. Most LTC is provided informally (whereas acute care is provided by professionals): Informal care may affect caregiver's labour supply. LTC market dominated by for-profit facilities facing excess demand: little incentive to improve quality of care to remain competitive. Comprehensive acute care insurance but little private LTC policies. Demographic transitions will affect the LTC industry even more than acute care.

It is important to understand the drivers and demand of LTC. The population is ageing globally, but the effect is more severe in the EU. 70% of people turning age 65 can expect to use some form of LTC during their lives. Percentage of population above 65 years in the EU region is much higher than China. Today it accounts for 18% of the total population, in 2060 may rise to 30%. The risk of becoming dependent on LTC rises steeply from the age of 80. Percentage of population above 80 years in the EU region 1960 was 1%, now 5% and is predicted to reach 12% in 2060.

Although the size of the older population influences LTC demand and cost, it is the difficulties in undertaking basic activities for self-care that are the major drivers of the need for support. EU citizens aged 65 could expect less than half of their remaining years to be free from conditions affecting their ability to manage daily living activities but ageing of the big generations of

baby-boomers increases the number of those potentially in needs. Trends in disability in EU are not always clear. The chance of living a healthy life is profoundly unequal not only across EU countries. Birth-cohort trends in older-age functional disability and their relationship with socio-economic status in the UK.

Are the policies closing the socio-economic gaps among the elderly? This may influence the affordability of LTC services. Factors that influence the supply of care. Relatives and friends provide the first and more relevant form of support. Informal (unpaid) care is important in all EU countries, but is more common in some than in others. Formal and informal care can be substitutes or complements, depending on the type of care and needs provided.

The future sustainability of a model based on the provision of informal LTC support faces the question: will future cohort of people in needs of LTC be as likely to have a spouse or children that provide care for them? By 2050, there will be just two working age people per one elderly person in Europe. The role of migrant is fundamental to support formal/ informal ltc services.

In EU, there is no a single LTC system. Instead we have different LTC systems inherently linked with different cultural/social values, institutional setting and traditional welfare regimes in place. Very often, current LTC policies are the result of the stratification of unsystematic reforms aiming at facing emerging socio-economic pressures.

EU-LTC models differ in many important dimensions: the financing mode; the level of spending; the definition of needs; the public/private mix; the mix between cash-benefits and services; the freedom to choose the LTC providers; the balance between public and private providers; the quality assurance; the level of integration and coordination of care among different LTC institutions.

First cluster of countries is the Northern EU: Formal-care (FC) oriented provision; generous, accessible and affordable; financed from general revenue allocations to LA; high public and low private spending on FC; low Informal care (IC) use, high IC support; modest cash-benefits.

Second cluster, including Germany: FC of medium accessibility; some IC orientation in provision; obligatory social insurance financed from contributions; medium public and low private FC spending; high IC use, high IC support; modest cash-benefits.

Third cluster, including France: FC of medium accessibility; medium IC orientation in provision; Medium coverage financed from contributions\general revenue; medium public and private FC spending; high IC use, high IC support; high cash-benefits.

Fourth cluster, including Italy Low FC accessibility; strong IC orientation in provision; modest social insurance against LTC risks; low public and high private FC financing; high IC use, low IC support; high cash-benefits.

Fifth cluster, east EU: Very low FC accessibility; (almost) exclusive IC orientation; little social insurance against LTC risks; very low public FC spending; very high IC use, little to no IC support; modest/low cash-benefits.

EU-countries have different LTC systems but share common socio-demographic and economic pressures.

Against a background of rising demand for LTC, the fiscal sustainability and the ability to deliver LTC services that match the rising expectations of the populations are daunting policy challenges.

There is a window of opportunity for designing efficient, equitable and sustainable LTC system. Countries with universal coverage and high formal care provision have good coverage/quality but relatively high public LTC expenditure (burden for the long-term sustainability of public finances).

Countries with low public LTC expenditure relies heavily on: out-of-pocket payments (unaffordability, sub-optimal consumption, catastrophic costs); informal care (effects on labour market participation of the carer).

Means-tested programmes are targeted to disabled in financial needs (safety-net) but support is restricted to those below a certain income/asset threshold (high admin costs, cliff-edge effects, exhaustion personal-assets, sub-optimal saving, significant unmet needs).

Mixed models reduce the risk of non-take-up but requires coordination and co-operation among institutions. Countries with a strong emphasis on: Social insurance model: contributions levied on a narrower tax base than general revenue, tax distortions on employment. Tax-based model: funds levied on a bigger tax base that is ageing.

Drawing the conclusion, following are some recommendations. An efficient LTC system: could reduce hospitalization and subsequent associated costs; should support delivering: LTC services at home rather than in institutional setting when appropriate; support care recipient to remain independent; and support informal care giver.

Key choices in implementing LTC reforms: building consensus on the role of individuals & State; providing clear & accessible information on the LTC system; promoting a transparent & comprehensible funding mechanism; avoiding “unequal treatment of equals” & “equal treatment of unequal”; improving governance by coordination & co-operation between different agents/authorities involved & between States with similar LTC systems.

The regulatory framework should strengthen incentive mechanisms; monitoring, collecting & sharing data: Policy reforms should be assessed and evaluated ex-ante and ex-post in a systematic and formalized way based on evidence.

Keynote 3: Long term care in France: In search for a balanced policy - ***Speaker: Mr. Jean Yves Hocquet*** *(Administrateur Général, Head of Mission at the General Secretary of the French Ministry for Social Affairs)*

1. Context

The demographic evolution implies a proactive policy. France now ranks high on the list of countries with low mortality at high ages, with Japan, Canada, Australia and Switzerland. The dependency rate will increase, people over 80 at risk for needing LTC will triple. Relevant is the

threat of supply from carers with the decline of working age population and decline of informal home care; as well as the pressure of the baby boom generation on quality standards and public expenditure.

The state is subsidiary with means tested benefits as security net, but there is no pure model: France belongs to countries where the responsibility is still on the family (as Greece and Italy) with a large scope of responsibilities and services (maintenance obligation).

A voluntarist policy illustrated by the law of adaptation of society to aging of 28/12/2015: to make the ageing person the manager of his/her autonomy, it is necessary a coordinated management of autonomy policies associating notably local and regional authorities, health, medico-social and social support actors; development of the territory, adaptation of housing, fight against social isolation, reflections on mobility issues.

France has strong inequalities in life expectancy by sex and occupational category: inequalities in the quality of life are due to various disabilities; inequalities related to educational attainment have increased for both men and women; certain social inequalities in mortality are also greater in France than in other European countries.

2. A traditional action in favor of financial autonomy

The government implemented a poverty reduction policy in favor of financial autonomy: to provide decent retirement income / social minimum; to empower choices (retirement à la carte, pension saving). The outcome is: a relatively favorable situation for retirees; the average amount of the pension reaches 1,306 euros monthly; the median income was € 1,563 for pensioners; (The median income in France is estimated at 1,712 euros.); about two-thirds of the pensioners are owners of their dwelling.

3. The state of play

A few diverse actors until recently: the structuring of the sector was carried out around identified institutions (hospitals and religious congregations); the relatively restricted and standardized nomenclature of facilities and services in the mode of care (in comparison with the disability sector). More recently, private commercial investment in the field of housing for the elderly, although public management remains predominant.

4. Policies under evolution

Recent policies try to prevent the loss of autonomy and preserve the capacity as long as possible:
- avoid avoidable and often deleterious hospitalizations in terms of autonomy;
- shorten unnecessarily long hospitalizations by facilitating the return home as soon as it is indicated on a medical level;
- optimize the use of collectively available resources for a better matching of support and care to the needs.

A change in policies that integrates demographic projections and the notion of dependency:
-Development of home-based services, promotion of services for elderly dependents; development

of information for people and those around them, local information and coordination center for medical; reform of the tariffs of the facilities;

-National plans (National Heatwave Plan, Aging and Solidarity Plan, Grand Solidarity Plan, Alzheimer's Plan for Palliative Care development);

-Action on living conditions: Humanization of hospices; change in the role of the hospital; home support;

-Various trials regarding the financing and the individual benefits.

There has been progressive convergence in certain issues of care for the elderly and the disabled: the rise of home-care services linked to the "life-project" approach already at work with disabled people.
-long-term care pathway: chronic aged patients; people with disabilities requiring care that highlights similar difficulties as situations of "danger" or potential maltreatment
- a near similarity of situation in the advanced ages.

France is developing a global, medical, psychological, social and environmental approach, based on the multidisciplinary nature of the actors and involving an interdepartmental approach taking into account the different fields concerned, which meets the needs of the people but also takes into account the scarcity of the resources (money, human resources, providers).

5. Offer in diversification

Development of diversified services, which include: Facilities and services for the elderly, in particular residential accommodation for the elderly, whether dependent or not (EHPAD, EHPA); Home Care Nursing Services (SSIAD); Home Assistance and Accompaniment Services (SAAD); Multipurpose Home Care and Support Services (SPASAD). -Services implementing protective measures for adults ordered by the judicial authority, safeguarding of justice, curatorship, guardianship or judicial accompaniment; -Resource centers, information and coordination centers or community service centers, implementing screening, assistance, support, training or information, advice, expertise or coordination for the benefit of users or other institutions and services, in particular Local Information and Coordination Centers (LINCs), which have the task of coordinating support for home support.

The traditional offer is still dominated by the public sector (and charities), with significant growth in the private sector in some specific niches. The scope of the various services and facilities which could be sponsored by the public authorities is still relatively narrow.

6. Voluntary caregivers: a major challenge

The lack of voluntary caregivers is a major challenge. Elderly helped by their partner amount to 2.540.000; elderly helped by their child amount to 738.000; elderly helped by another relative: 164.000. 47% of caregivers are employed or apprentices, 7% are unemployed, 33% are retired, 13% are non-working. Caregivers are on average 52 years old and two thirds are women.

The law strengthens the recognition and support of voluntary caregivers, their role and situation will have to be systematically taken into account during an APA request or review. Their needs will have to be assessed if necessary in conjunction with the assessment of the needs of the elderly person in order to offer them help, advice, respite and relay arrangements to better ensure their role and prevent their exhaustion.

In order to provide support to caregivers whose presence or assistance is essential to the home life of the beneficiaries of the APA, the law recognizes a right to respite, resulting in the possibility of exceeding the ceiling of the aid plan to help with the use of respite facilities. It also provides the possibility of taking care of the person assisted when his / her caregiver is hospitalized and needs to be relayed by professional structures.

7. Multiple expertise related to the increase in the care burden of the elderly and the accompanying needs.

New service offerings in the form of platforms can bring together several types of accompaniments. The mobilization of multiple financing to take account of the distribution of competences between the various institutional actors and the constraint on public expenditure.

The regional and departmental management, in particular the articulation between the general councils and the Regional health agencies and their territorial delegations, aims to promote the coherence of the planning (regional schemes of medico-social organization and departmental plans of a regional council for social and medico-social organization), programming (PRIAC) and authorizations (calls for projects).

Flexibility and room for maneuver within global envelopes while guaranteeing clarity on public spending i.e. granting of a self-sufficiency package awarded through a multi-annual contract for objectives and resources (CPOM)

An important element is the establishment of a common reference framework for the activities of institutions and services; as well as the daptation of the operational framework of support, in particular with flexible guidelines allowing to adapt the services to the evolutions of the situation.

8. Acting on health

The aging of people with disabilities, the emergence of disabling diseases and Alzheimer's disease require the implementation of sanitary, social and medico-social responses. To give some figures, 5% of personalized independence allocation beneficiaries are under 70 years of age; 75% over 79 years; 50% over 85 years; 25% more than 89.5 years, in total (in 2010): 1 185 000 people.

Dependence is not due exclusively to the appearance of diseases (hospitalization, widowhood, precariousness, isolation). It is important to maintain a balanced diet, regular physical exercise and a structured social bond. Yet, there is a lack of coordination and complementarity of initiatives and achievements in the field of prevention.

9. A financing model still to find

The creation of a fifth social security branch (pension, health/maternity, invalidity, occupational diseases and accident at work), aiming at covering the loss of autonomy for the disabled and the elderly was postponed in reason of the worsening situation of public finances. The main principle is a "mixed public-private financing", combining a "high base level of solidarity" with (non-compulsory) private insurance.

Despite the APA benefit, the remaining cost that users have to meet themselves remains high – between 2200 and 2900 euros a month for institutional care, and 1400 euros on average for home care. Public spending on self-sufficiency was estimated at € 24 billion in 2010:€ 14 billion for healthcare financing, € 5.3 billion for the personalized autonomy allocation (APA); and € 4,7 billion, for housing.

Social security funds are by far the main contributors with an expenditure of approximately € 15 billion (62% of expenditure). Local authorities appear as the second contributor of the expense. The other funders, the National Solidarity Fund For autonomy (CNSA) and the State, account for 15% of the expenditure.

10. Some emerging concerns

Implementation of MDA. "Departmental House of Autonomy" (MDA). The pooling of the reception function, bringing together the evaluation teams (professional cultures but no merger of tools that are regulatory: GEVA and AGGIR grid); Coordination at the sub-departmental level, including support for LINCs, gerontological networks, MAIAs; Establishment of an agreement between the department, the ARS and the pension funds.

National mobilization against the isolation of the elderly: "MONALISA". Suicide is one of the three leading causes of death of the elderly, with cancer and cardiovascular disease. In 2009, 10,464 deaths by suicide, of which one third were among the over 60s, whereas they represented only 22% of the French population. In the over 85 years the prevalence of suicide is twice that of the 25-44 years old. Suicides take place for 70% of them at home.

In conclusion, the LTC system should: have a holistic approach; put an effort to balance efficiency and quality; be presented not as a burden but as an economic opportunity.

The LTC public funding is diverse; the private insurance is still limited because of the difficulty to make accurate forecasts; the high-end part of the demand attracts private providers. Is silver economy a way to make the LTC system sustainable?

Keynote 4: Development of Old Age Services and Long Term Care System in Germany -

Speaker: ***Mr. Michele Bruni*** (*EU-China SPRP, Team Leader-C2 Resident Expert*)

Michele briefly presented the main results of the paper on Long term care in Germany by Monika Gabanyi.

Background

Initially, the main policy issue of the social assistance to the elderly and other vulnerable groups was seen as the need to provide an income sufficient to avoid the situation of poverty that derives from sickness, loss of income due to retirement or other reasons. Later, and this was a veritable change of paradigm, it was deemed essential that all vulnerable groups, but especially the elderly, would benefit from adequate and sufficient care services, and access to these services was extended to the entire population.

The introduction of LTC

In 1995 Germany introduced in its insurance system the Long-Term Care insurance. Main reasons were: 1. the number of elderly people was growing rapidly; their needs were twofold: social care and medical care; 2. the health system was overburdened by elderly people demands through long term stay in hospitals; 3. elderly people face a high risk to lapse into deeper poverty because with their low pensions they cannot afford to pay for social care services; 4. all the members of the population run the risk to become dependent.

Main characteristics are: the German social care system is compulsory; each citizen is covered and has the right for social care services as soon as eligibility criteria are fulfilled; a team of independent professionals assesses eligibility. Overall, 90% of the population is covered by the LTC insurance scheme and 9% by private LTC insurance.

The LTC Insurance funds are affiliated to the corresponding social health insurance funds. Administration is given to the mandatory health insurance; financial planning is strictly separated. In contrast to the health insurance fund, that can decide about the contribution rate on their own, LTC contribution rate is fixed by the Ministry of Health. Contributions are paid by employers and employees For retired 50% pension fund and 50% pensioners.

Criteria of eligibility

As per the eligibility criteria, between 1995 and 2015, entitlements were focused on physical incapability by which a person could not manage the activities of daily living (ADL). Starting in 2015, the criteria were extended to include mental problems (dementia, Alzheimer, etc.). In 2017, a comprehensive reform has been implemented by which the assessment is not based on the concept of incapability, but on that of self-dependency. The assessment is conducted by a team of independent professional composed by doctors and nurses at the home of the potential beneficiaries. Any link of the team members to the funding agent is prohibited to avoid conflicts of interest.

Assessment

The assessment allowed defining the level of dependency. There were three levels of dependency and each level was associated to a package of services, the staff needed and therefore a level of costs. Reassessment was (and is) done every six months.

Benefit Package.

Benefits are in kind, in cash or a mix of both options. Benefits in kind are provided to beneficiaries living in residential institutions. Benefits in cash can be chosen when a beneficiary is staying at

home and the family or another person is taking care of him. Home care can be supported by benefits both in kind and cash, when a person decides to use a professional provider for some care activities, while enjoying cash benefit for the family caregiver. Short term care in an institution is provided for maximum six months per year. It should be underlined that benefits in kind in social care institutions cover only the care package; accommodation, food, investment costs and training have to be paid out of pocket.

Service Providers.

Social care providers can be public or private entities but have to fulfill certain determined standards in order to get licensed. The standards pertain to: quality of the structure (personnel, management, compliance of service packages with legal regulations; quality of the process (care cycle:(anamnesis, care plan, activated care, frequent re-assessments etc.).

Care providers constitute a big industry, dominated by private providers; in 2013 there were 12,745 care institutions providing home care and 13,030 providing residential care.

What is new.

New regulation on benefits and services systematically implement the aims of the new definition of long-term care needs – providing assistance in maintaining independence and making the most of a person's remaining abilities. The previous system was based on three categories of care connected with time will be replaced by five uniformly valid grades of care applicable to all persons in need of long-term care. Now physical, mental and psychological impairments will be rated in the recording and assessment process. The assessment will serve to measure the degree of a person's independence in six different areas that will – on the basis of different weightings – be subsequently combined to form an overall assessment.

Keynote 5: Development of Old Age Services and Long-Term Care System in Italy - *Speaker:* ***Prof. Vincenzo Atella*** *(Professor, Department of Economics and Finance, University of Roma "Tor Vergata")*

Financing LTC and elderly care in Italy

The Italian LTC financing is managed through three institutional levels: Central, Regional and Community based. The Central Government, through Social Security, administers the so called "indemnities for caring", cash benefits amounting to € 507 per capita provided to invalid people, 80% of whom are elderly. Checks are granted in relation to the health condition of the recipient and independently from his/her economic position.

Regions are responsible for delivering LTC services: they manage and allocate resources devoted to LTC. The source of funding is the Regional Health Fund, autonomously administered by each region. Community services are managed by the municipalities, whose financing is mainly provided by communities' direct taxation.

Public spending on LTCs includes three different types of benefits:

i) health care for those who are not self-sufficient, i.e. those who, due to chronic illness, age, and mental limitations, need continued assistance,

ii) accompanying allowances

iii) the socio-assistance benefits provided by local authorities, in particular municipalities, for the benefit of the disabled, elderly people who are not self-sufficient and people dependent on alcohol and drugs.

As far as healthcare services are concerned, they can simply be aggregated into three main categories, based on the type of recipient and their modes of delivery: 1) residential care for the elderly and disabled; non-residential care (semi-residential and home care facilities) for the same category of subjects; assistance, in whatever form, to dependents (alcoholics and drug addicts) or psychiatric disorders. These benefits are all "in-kind" and are provided by NHS entities independently.

Accompanying allowances are specific monetary benefits foreseen in the case of so-called “civil disability”, that is, invalidity which does not arise from causes of service, war or labor.

It is the benefit of civilian invalids (civilian blinds and deaf people), who can access them without any minimum payment of social security contributions and regardless of their income.

Indemnities are paid directly to the beneficiaries, irrespective of their actual use in the purchase of goods and services useful for improving their living conditions (the delivery is not subject to the certification of the purchase of the benefit).

Social welfare benefits are granted to elderly individuals who are not self-sufficient, disabled, with psychic disorders and to persons with alcohol and drug-related problems.

These benefits differ from one another, are predominantly "in nature", means tested and provided by the local authorities, mainly by the municipalities.

IN Italy, we spend 7 % of the total social expenditure on Long term care. Italy is divided in 20 regions, the picture between the regional expenditure is quite different especially among southern and northern regions.

LTC regional programs can be put into practice using “in kind” services or money transfers such as “Buoni/voucher sociali" or “Assegni di cura". In general, these programs, which integrate the Accompanying indemnity, the only existing national program, focus on: activating or strengthening the taking over of the non-self-sufficient person through personalized health and socio-assistance plans; strengthening support for the non-self-sufficient person and his/her family through the increase of home care, even in terms of hours of assistance and personal care; supporting the person who is not self-sufficient in the purchase of home care and health care services; to support the family (or another informal care giver) who directly provides care.

The access to any of these forms of LTC requires a certain degree of interaction between the applicant and the provider institution. A common approach describes this interaction in three ways: the availability of the service; its accessibility and its use (i.e., access realized) by the applicant.

The assessment of the availability concerns the existence of a LTC supply in the fragile elderly residential area; accessibility refers to the circumstances (typically, health conditions and socio-economic status) that determine whether or not an individual can benefit from a nursing program; finally, the use refers to the extent to which an individual can benefit from a program, as access has been granted.

The access regulation generally includes at least two sequential and compulsory phases that have been implemented after the individual (or whoever is doing it) has inquired the institution responsible for the care program (health district, municipal social services, Single Access Points): the elderly social-health profile is evaluated by a Multidisciplinary Assessment Unit (assessment of needs); is assessed (following criteria defined at regional, municipal or healthcare level) as "at risk" and, therefore, he/she is eligible for assistance. Therefore, the notion of eligibility incorporates two aspects: the extensive margin discriminates between those who have access to the care system or not, while the intensive margin determines the amount of benefits (or services) the individual has the right.

Establishing when a vulnerability occurs is, of course, a medical and philosophical issue, linked to the concept of human dignity. From an empirical point of view, although vulnerability is an undesirable condition, it is essentially a phenomenon that cannot be directly observed. Hence it emerges the need to develop models and methods that are able to provide a thorough estimate of the severity of the phenomenon, with the aim of putting countermeasures that can slow them down, delay or prevent them from worsening. Medical literature has produced a rich and extensive debate on the nature of fragility, but despite numerous single- and multi-dimensional indices being proposed in recent years, it cannot be asserted that today there is an evaluation methodology which is universally recognized.

Against this background, it is quite evident that the absence of a standardized definition may result into a broad heterogeneity in the definitions (and consequently the assessment methods) of vulnerabilities adopted by regional lawmakers in care program regulations.

The resulting generation of "non-self-sufficiency" concepts, in turn, implies eligibility criteria and coverage rates that are potentially very different from program to program.

Conclusions

LTC is growing, though it is still a small sector of the economy. Although the LTC covers people of all ages, over 65 and especially over 80, are those with the highest chance of receiving LTC services. Among them, women are the main recipients of services.

The LTC is a highly labor-intensive sector, largely funded by public funds, with an average of 1.5% of GDP across the OECD and about 1.3% of the total OECD workforce is estimated to be engaged in this type of activity.

Most of the assistance is provided by informal care, especially women who work part-time in most countries.

Due to the variety of service recipients, governance, service delivery, and the workforce employed, LTC services are often fragmented and almost always the connection to the healthcare systems is poor.

There are big differences in size, benefits, target groups, use, supply, governance, and financing of LTC care across countries and, in countries, between regions.

Discussion, Q & A

From Michele Bruni.

Mr. Bruni provides a graph showing the ratio of people aged 25-69 for every 70+ people, should China worry about ageing? Yes, we should worry, but China should worry about the decline of working age population.

Regarding the issue of migrants and caregiver: the ILO forecast for China only includes emigration, not immigration. Should we also address the human capital issue, how many care givers will China need in the next years, where do we find them?

From Prof. Li Zhen.

1) Issue about migration: last week we also met other foreign experts, and they also believe maybe the Chinese government will relax the policy on migration. Personally, I do not think immigration is the solution for LTC provision. First China has a large population. Secondly, we need to consider the technology development, especially, robots: today a lot of services are easily accessible, if you know how to use an app, you can order drink and drugs, and they can deliver them to you, so I think the technology development will help to support the services.
2) I appreciate the project brings a lot of experts to share EU experiences. Having listened to the presentation we see that LTC systems are different among the EU countries. If this meeting was held 3 years ago maybe the system in China today would be different. Maybe we cannot find the best model but maybe the one that is more applicable to our country.

3) Regarding the Chinese context, I agree with Tang Jun overall description on the paper. There is a point I do not agree, that is about the financing mechanism. In the past, the main stream of financing model is to use social insurance as the main base, complemented by private insurance, plus social assistance. This ideal structure affected our policy, last year MOHRSS issued a policy on LTC social insurance pilot program, that was promoted at the local level. In my opinion, issuing social insurance to solve the LTC problem is not possible in China, as prof. Morciano showed, the LTC system depends on family, society and the government. I really agree on that. In China our situation is like this: in microeconomic we are at the initial stage of socialism, our GDP ranks the second but GDP per capita is 69th, so China is not a high income country, we still are trying to get out from the middle income trap. China is an atypical country with dual structure, a part living in urban area, a part in rural area. China has two features differences at the macro level, the Chinese household savings is high, 90% families in urban are holding 20% of savings, in rural area the

family that hold the same proportion are 60%. According to statistics 95% urban households have assets. Hence, with the combination of assets and cash savings an elderly can have the support for LTC.

It is also important to mention the Chinese social value, the filial piety, according to which the child must support the parents. This is a formalized law in China in two acts, where all the sons have to support the parents for the whole life. Another important issue is that in China there are no taxes on the heritage. According to all of this, we should have an order of priority following the road of Singapore, the order of responsibility: the primary is the individual, then family, then society, then government. I think that for this issue we should learn from the EU on how to classify the disable (physical, mental, economic), we should avoid two dimensions of the financing model, now we are trapped by the mentality that as the private market is not working well, we can experiment mutual insurance system both characterized by social insurance and commercial insurance.

Open question that were addressed:

Why only Germany and Luxemburg are the only countries that have introduced LTC insurance system? In France the high taxation in social security could not let fit in an additional insurance scheme, but only an independent system. We cannot increase complimentary insurance system, private insurance do not function in France, old people do not have high income, capacity are high, they rely on their own savings to face LTC issues.

From Prof. Tang Jun.

Two points are determinant to the life of a retired person: 1. how large is the wealth the society can produce? 2. How does the government distribute the wealth? Technology could solve some problems, in the future the wealth will not only depend on the labor supply, this will be relevant to productive efficiency. The robots could be used to support old people, yet the care should be based on human, love, not on robots. I think one point is that currently China has a large labor force, if we well prepare for the future, LTC will not be a problem.

MoF, Mr. Shen Wei:

Now in China we want to build a LTC insurance model, the realistic problem is how can we establish this system. This relates to many concrete issues: coverage rate, funding, contribution (individual/ company), etc.

How should the treatment design be planned: cash and in kind like in the EU? And in terms of service delivery and eligibility I hope we can learn from the EU experience. This is an aspect I hope you can cover in the research report.

The second issue is the sustainability of LTC. In your country specific report are mentioned subsidies and insurance model, yet the sustainability is a big issue, but did not have exact data, especially regarding the Germany case.

We want to learn from the EU what measures and policies are established to support the sustainability of LTC.

MoF, Mr. Wang Hui:

1. In EU countries the government improves the elderly care demand, from the supply side does the government play any role in supporting? I didn't find info on this aspect in the report.
2. EU countries have high level market based services: in LTC service provision, the market plays a big role, China is at a starting point, it is very important to promote the supply side, we can learn from the experiences of the EU, especially on how to promote the LTC supply, how to cultivate the growth of LTC services, etc.
3. Regarding the supply side, it is necessary to providing high quality services, it is true that China lacks human resources, besides the immigration solution, do you have any other suggestion on this regard?
4. How can China support the development of private Long-Term Care Insurance?

ANNEX I

PANEL DISCUSSION AGENDA

EU-CHINA
Social Protection Reform Project
中国-欧盟社会保障改革项目

Component 2

第二部分

Panel Discussion

小组讨论

The Development of Old Age Services and Long-Term Care System

老年服务和长期护理制度的发展

Ministry of Finance, P. R. China

中华人民共和国财政部

Tuesday, September 5th, 2017

2017 年 9 月 5 日，星期二

Beijing, Renmin University, Qiushi Building, Meeting Room No.320

北京，中国人民大学求是楼 320 会议室

8:30-9:00	**签到 Registration**
9:00-9:30	欢迎致辞: ◆ **姜 宇** (财政部社会保障司优抚救济处处长) ◆ **米凯乐·布鲁尼** （中欧社保改革项目第二部分欧方常驻专家） Welcome Speeches by Mr. Jiang Yu (Division Director, Veteran Benefits Division, Department of Social Security, Ministry of Finance) and Mr. Michele Bruni (*EU-China SPRP, Team Leader-C2 Resident Expert*)
9:30-10:15	***主持人：李珍（中国人民大学，社会保障研究所所长）*** ***Moderator: Prof. Li Zhen (Director of Social Security Research Institute, Renmin University of China)*** 主题发言1：中国的老年服务和长期护理制度的发展 *发言人：**唐钧** （中国社会科学院，教授）* Keynote 1: The Development of Old Age Services and Long-Term Care System: the Chinese context *Speaker: **Prof. Tang Jun** (Professor, Chinese Academy of Social Sciences)*
10:15-11:00	主题发言2：欧洲长期护理制度：最新证据的重新审视和整合 *发言人：**马澈罗·莫嘉诺** （东英吉利大学医，药医疗政策和实践学院，健康经济学研究组研究员）* Keynote 2: Long-term care in Europe: A review and synthesis of the most recent evidence - *Speaker: **Mr. Marcello Morciano** (Research Fellow, Health Economics Group, School of Medicine, Health Policy & Practice, University of East Anglia, UK)*
11:00-11:30	**茶歇 Tea Break**
11:30-12:15	主题发言 3：法国长期护理：寻求平衡政策 *发言人：**让·伊夫·欧凯**（法国社会事务部总秘书处长官）* Keynote 3: Long term care in France: In search for a balanced policy - ***Speaker**: **Mr. Jean Yves Hocquet** (Administrateur Général, Head of Mission at the General Secretary of the French Ministry for Social Affairs)*

12:00-13:30	午餐休息 Lunch Break
13:30-14:15	主题发言 4：德国老年服务和长期护理的发展 发言人：**米凯乐·布鲁尼** （*中欧社保改革项目第二部分欧方常驻专家*） Keynote 4: Development of Old Age Services and Long Term Care System in Germany - *Speaker:* ***Mr. Michele Bruni*** (*EU-China SPRP, Team Leader-C2 Resident Expert*)
14:15-15:00	主题发言 5：意大利老年服务和长期护理的发展 *发言人：**文千佐·阿特拉**（罗马杜维加大学经济财政系，教授）* Keynote 5: Development of Old Age Services and Long-Term Care System in Italy - *Speaker:* ***Prof. Vincenzo Atella*** *(Professor, Department of Economics and Finance, University of Roma "Tor Vergata")*
15:00-15:30	**茶歇 Tea Break**
15:30-16:00	讨论问答 Discussion, Q & A

ANNEX II

LIST OF PARTICIPANTS

List of participants
参会名单

EU-CHINA SPRP Component 2
Panel Discussion
on
中国-欧盟社会保障改革项目第二部分组座谈会

Topic 2.1.6 The Development of Old Age Services and Long-Term Care System
老年服务和长期护理制度的发展

Ministry of Finance, Beijing, September 5, 2017
2017 年 9 月 5 日，北京,财政部

No 序号	Name of the participants 姓名	Institution/organization 机构/组织
Ministry of Finance 财政部		
1.	王　蕾 Ms.Wang Lei	财政部社会保障司医疗保障处处长 Division Director, Medical Insurance Division, Department of Social Security, Ministry of Finance
2.	姜　宇 Mr Jiang Yu	财政部社会保障司优抚救济处处长 Division Director, Veteran Benefits Division, Department of Social Security, Ministry of Finance
3.	沈　维 Mr. Shen Wei	财政部社会保障司医疗保障处副处长 Deputy Director, Medical Insurance Division, Department of Social Security, Ministry of Finance
4.	王　晖 Mr Wang Hui	财政部社会保障司优抚救济处副处长 Deputy Director, Veteran Benefits Division, Department of Social Security, Ministry of Finance
5.	王海霞 Ms. Wang Haixia	财政部社会保障司制度精算处主任科员 Principal Staff Member, Actuarial Division, Department of Social Security, Ministry of Finance
6.	张晓东 Mr.Zhang Xiaodong	财政部社会保障司优抚救济处主任科员 Principal Staff Member, Veteran Benefits Division, Department of Social Security, Ministry of Finance
EU-China SPRP Representatives 中欧社会保障改革项目办及国际组织代表		
7.	Mr Michele Bruni 米凯尔·布鲁尼	EU Resident Expert Component 2/Team Leader, EU-CHINA SPRP 中国－欧盟社会保障改革项目第二部分欧方常驻专家 / 项目领导人
8.	Mr. Jean Victor Gruat 圭亚	EU Resident Expert Component 1, EU-CHINA SPRP 中国－欧盟社会保障改革项目第一部分欧方常驻专家
9.	Ms Marzena Breza 马哲娜	EU Resident Expert Component 3, EU-CHINA SPRP 中国－欧盟社会保障改革项目第三部分欧方常驻专家

10.	Ms Valentina Pignotti 毕若华	Assistant to Component 2 / Team Leader, EU-CHINA SPRP 中国－欧盟社会保障改革项目第二部分 / 项目领导人助理
11.	Mr Lin Guowang 林国旺	Interpreter, EU-CHINA SPRP 中国－欧盟社会保障改革项目翻译
12.	Ms Ma Lan 马岚	Project Assistant，EU-CHINA SPRP 中国－欧盟社会保障改革项目助理
Experts 专家学者		
13.	唐钧 Prof. Tang Jun	中国社会科学院，教授 Professor, Chinese Academy of Social Sciences
14.	李珍 Prof.Li Zhen	中国人民大学，社会保障研究所所长 Professor and Director of social security research institute, Renmin University of China
15.	马澈罗・莫嘉诺 Mr. Marcello Morciano	东英吉利大学医，药医疗政策和实践学院，健康经济学研究组研究员 Research Fellow, Health Economics Group, School of Medicine, Health Policy & Practice, University of East Anglia, UK
16.	让・伊夫・欧凯 Mr. Jean Yves Hocquet	法国社会事务部总秘书处长官 AdministrateurGénéral, Head of Mission at the General Secretary of the French Ministry for Social Affairs
17.	文千佐・阿特拉 Prof. Vincenzo Atella	罗马杜维加大学经济财政系,教授 Professor, Department of Economics and Finance, University of Roma “Tor Vergata”
18.	赵斌 Mr. Zhao Bin	中华人民共和国人力资源和社会保障部　社会保障研究所　助理研究员 Assistant Research Fellow, Social Security Research Institute, Ministry of Human Resources And Social Security of The People's Republic of China
19.	胡宏伟 Mr. Hu Hong Wei	中国人民大学公共管理学院　副教授 Associate Professor, School of Public Administration And Policy RenMin University of China
20.	赵青 Ms. Zhao Qing	武汉大学 政治与公共管理学院　师资博士后 Postdoctoral Fellow, School of Political Science And Public Administration WuHan University
21.	黄万丁 Mr. Huang Wan Ding	云南省人力资源和社会保障厅　主任科员 Principal Staff Member, Department of Human Resources and Social Security of Yunnan province
Participants from Other Institutions		
22.	Lina Tao 陶丽娜	Political Officer, British Embassy, Beijing 英国驻华大使馆，政务处，官员
23.	Enrico Berti 贝迪	First Secretary, Economic and Commercial Office, Italian Embassy, Beijing 意大利大使馆，一等秘书，经济商务处
24.	Elisa Sales 艾丽莎	Financial Attaché- Bank of Italy Representative, Beijing 意大利大使馆，财政专员，意大利银行代表
25.	Raffaele Costa 柯思潭	Treasury Attache’, Italian Embassy, Beijing 意大利大使馆，意大利财政部代表
26.	Federico Roberto Antonelli 菲德利克	Legal Affairs Attaché- Italian Embassy, Beijing 意大利大使馆，法律参赞