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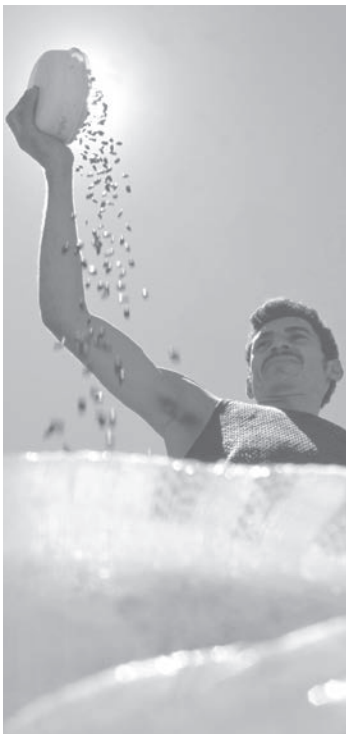
Aging and Long Term Care Systems: A Review of Finance and Governance Arrangements in Europe, North America and Asia-Pacific

Laurie Joshua



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Laurie Joshua

laurie_joshua@hotmail.com

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Abstract:

Population aging is a global issue that is either affecting or will soon affect virtually every country around the world. With large numbers of older people experiencing significant losses of intrinsic capacity, leading a dignified and meaningful life is often only possible with the care and support of others. Long-term care (LTC) has therefore become one of the most rapidly developing policy areas in OECD countries, where significant institutional change and innovation have taken place over the last two decades.

Governance and finance arrangements for the delivery of LTC differ between countries. LTC in the Netherlands, Germany, Japan, The Republic of Korea, the Scandinavian countries (Sweden, Denmark and Finland), England, the United States, France[1] were selected to cover differences between systems. However, across the different systems debates about intergenerational and state responsibilities are increasing evident. The paper delivers an up-to date assessment of design parameters and captures the measures being taken to build financial sustainability into LTC policy and program reforms.

Rapid population aging in low and middle income countries (LMICs) will inevitably generate an increased demand for long-term care (LTC) services. Research and practical experience from high income countries – and the very diverse patterns of LTC in terms of funding mechanism, the balance of formal and informal services, the degree of state participation, and the overall level of provision – hold important lessons.

JEL Classification: I38, I13, J11

Key Words: long term care, demography, aging, public expenditure, social insurance, social assistance, OECD countries, social protection, health care

[1] All of which are members of the Organisation of Economic Cooperation and Development (OECD)

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ACRONYMS AND ABBREVIATIONS

AA	Attendance Allowance
ACAT	Aged Care Assessment Teams
ACTP	Allocation compensatrice pour tierce personne
ADF	Assemblée des Départements de France
ADL	Activities of daily living
ACA	Affordable Care Act
AGGIR	Autonomie Gérontologique – groupes iso-ressources
APA	Allocation Personnalisée d‟ Autonomie
ARS	Agences régionales de santé
AT	Assistive Technology
AWBZ	Algemene Wet Bijzondere Ziektekosten
CA	Carers Allowance
CAAS	Consolidation Act on Social Services
CACP	Community Aged Care Package
CDS	Consumer-Directed Services
CEE	Central and Eastern Europe
CfC	Cash-for-Care
CIZ	Center for Care Assessment
CLASS	Community Living Assistance Supports and Service
CMS	Center for Medicare and Medicaid Services
CNSA	Caisse Nationale de Solidarité pour l‟Autonomie
CoE	Council of Europe
CP	Carers Premium
CSA	Contribution Solidarité Autonomie
CSG	Contribution sociale généralisée
CQC	Care Quality Commission
DHHS	Department of Health and Human Services
DoH	Department of Health
DoHA	Department of Health and Aging
DREES	Direction de la Recherche, des Études, de l'Évaluation et des Statistiques
DP	Direct Payments
DPA	Deferred Payment Agreement
ERS	Equity Release Scheme
EU	European Union
FACS	Fair Access to Care
FHA	Federal Housing Administration
FSA	Financial Services Authority
GBP	Great Britain Pounds
GDP	Gross domestic product
GEVA	Guide d' evaluation des besoins de compensation de la personne handicapée

HACC	Home and Community Care Program
HCBS	Home and Community Based Services
HECM	Home Equity Conversion Mortgage
HUD	Housing and Urban Development
IADL	Instrumental Activities of Daily Living
IB	Individual budgets
INSEE	Institut national de la statistique et des études économiques
ICF	International Classification of Functioning, Disability and Health
KIHSA	Korea Institute for Health and Social Affairs
LA	Local Authorities
LTC	Long-Term Care
LTCI	Long Term Care Insurance
LTSS	Long Teem Services and Supports
MHWF	Ministry of Health Welfare and Family
MFP	Money Follows the Person
NCS	National Care Service
NDF	National Dependency Fund
NDIS	National Disability Insurance Scheme
NFZ	National Health Fund
NGO	Non-Governmental Organisation
NHS	National Health Service
NHIC	National Health Insurance Corporation
NICS	National Insurance Contributions
OECD	Organisation for Economic Co-operation and Development
OPP	Out-of-Pocket
OSR	Own Source Revenues
PCH	Prestation de compensation du handicap
PCELTC	Planning Committee for Elderly Long Term Care
PFLSS	Projet de loi de financement de la sécurité sociale
PSD	Préstation Spécifique Dépendance
SCIE	Social Care Institute for Excellence
UK	United Kingdom
USD	United States Dollar
USA	United States of America

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Summary:

The sustainability of long-term care (LTC) is currently a prominent policy priority in many Organization for Economic Cooperation and Development (OECD) countries. LTC for the growing population of elderly people is one of the most pressing fiscal issues. Rising expectations of the 'baby boom generation' around service provision add to the fiscal pressure.

Policies addressing financial sustainability in LTC – whether through social insurance or general taxation - generally depend either on increasing private funding (e.g., limiting entitlements or increasing out-of-pocket payments) or increasing productivity growth and reducing unit costs. These options come with policy problems. First, many LTC systems depend substantially on informal care. Private payments also cover substantial amounts of care for the elderly. Second, increasing productivity might be difficult due to LTC's dependence on high labor inputs.

Private funding in LTC implies out-of-pocket payments and other private funding arrangements. However, such arrangements may have serious, unintended consequences and are often inaccessible to people with lower incomes. In effect, it might mean that consumers become more dependent on informal caregivers. A growing informal care gap will then emerge, as the demand for informal care is expected to increase faster than its supply. Externalities of informal care on caregivers' health and employment – in the form of opportunity costs or forgone wages – can be quite significant.

This paper examines the challenges of LTC systems, with the aim of illustrating the mechanisms policy-makers have deployed to enhance sustainability. This approach is combined with a targeted review of the literature and a descriptive analysis of selected countries. The analysis describes public-and private funding, informal care and process innovations in LTC. County-specific cases and policies are used to show and compare different approaches towards addressing the long-term sustainability of LTC.

Chapter I

Typology of Long Term Care Programs: Policy Characteristics and Funding Mechanisms

Introduction

By 2050, the share of those aged 80 years and over is expected to increase from 4 percent in 2010 to nearly 10 percent across OECD countries. This population aging is being accompanied by family ties becoming looser. The need for community involvement in the care for frail and disabled seniors is growing and will do so ever more rapidly in OECD countries. In middle and low income countries, however, the pace of ageing of the population structure is much faster. In OECD countries, life expectancy at birth rose by an average of 7.2 years between 1980 and 2016; by contrast, it increased by 20.5 years in India and by 11.3 years in Brazil over the same period. In Russia, however, the increase was only 2.4 years and South Africa lost 1.3 years of life expectancy. In 2015, old-age dependency ratios in Brazil and China were half the OECD average; by 2050 both countries will be rapidly closing in on the average OECD country and by 2075 they will be older than the average OECD country[2].

These developments and trends will challenge long-term care (LTC) services and systems[3]. In the OECD countries the pool of potential family carers is likely to shrink because more women are working, and social policies no longer support early retirement. Currently, between 1 and 2 per cent of the total workforce is employed in providing long-term care. For many countries, this

[2] OECD (2017)

[3] Effectively addressing the economic challenges of population aging is especially difficult. This is primarily due to the fact that countries cannot rely exclusively on their own experience because in any given country changes in population age structure are occurring for the first time. Hence it is essential to learn from societies that have been the first to experience the age transition. Understanding the impact of different ways of governing and funding LTC on access to, and the effectiveness, equity and sustainability of care is of paramount importance. This requires an appreciation of the differences in context and practice between countries, to identify common issues and solutions, and to begin to highlight what is unknown and what might helpfully provide insights.

share will more than double by 2050. Government and private market spending on LTC is as much as 1.5 per cent of GDP on average across the OECD, and will double or triple[4] [5].

Across the OECD, more than one in ten adults aged over 50 years provides (usually unpaid) help with personal care to people with functional limitations. Close to two-thirds of such carers are women. Support for family carers is often tokenistic, provided as recognition that they perform a socially useful and difficult task. But supporting family carers effectively is a win-win solution. It is beneficial for carers. Without support, high-intensity care-giving is associated with a reduction in labor supply for paid work, a higher risk of poverty and a 20 per cent higher prevalence of mental health problems among family carers than for non-carers. It is beneficial for care recipients, because they prefer to be looked after by family and friends. And it is beneficial for public finances, because it involves far less public expenditure for a given amount of care than the estimated economic value of family caring[6].

The demand for (formal and informal) long-term care depends on the number of people in need of care and the ability to perform every-day tasks by themselves. According to the definition of the WHO, OECD and the EU people in need of care are persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extent period of time on help with basic activities of daily living (ADLs), such as bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom. This is frequently provided in combination with basic medical care, prevention, rehabilitation or services of palliative care[7]. Long term care services also include lower-level care related to help with instrumental activities of daily living (IADLs), such as help with housework, meals, shopping and transportation. The need for LTC is not arising from aging itself; it is a consequence of sickness or frailty causing dependency on others[8].

[4] European Commission (2015)
[5] OECD (2015b)
[6] OECD (2011)
[7] Fujisawa and Colombo (2009), OECD (2013)
[8] Clegg *et al* (2013)

The increase in life expectancy may translate in an increase in the number of people and years during which the need for LTC increases and thus costs accumulate. This is the case when longevity is not accompanied by a corresponding improvement in the "quality" of life. As in health care, it is not necessarily age *per se* but the prevalence levels of dependency determining LTC expenditure. Dependency is not disability, which refers to some functional impairment of an individual. Dependency is rather disability translated into the inability to perform daily personal care tasks ADLs and IADLs) and therefore requiring some external assistance. Therefore, one could illustrate the causality on the demand side as such that disability translates into dependency establishing the need and consequently the demand for LTC[9].

However, the links between dependency levels and demand/use of LTC are not straightforward. There are many people with some form of disability who can lead completely independent lives without the need for care services. Further, disability also depends on a person's perception of his or her ability to perform activities associated with daily living. On the one hand, survey data can underestimate some forms of disability. People may not report certain socially stigmatized conditions, such as alcohol and drug related conditions, schizophrenia, and mental degeneration. On the other hand, disability data can be too inclusive and measure minor difficulties in functioning that do not require the provision of community care. Some evidence suggests that specific causes of disability may become more prominent with increasing age. These disabilities can have a direct impact on the frailty of longer-living older people. In particular, the number of people with a dementia (Alzheimer's disease) is expected to increase[10].

LTC unit costs, are key determinant of LTC expenditure, and vary according to the type of care provided. Costs tend to be highest for institutional care, followed by home care. Cash benefits for LTC are showing a relatively low unit cost. High costs in institutional care are partly due to the higher treatment needs (due to higher severe disability/dependency levels) of institutionalized patients. This induces higher labor costs. Higher capital costs relative to home care are another

[9] European Commission (2015)

[10] According to OECD (2013), the economic and social impact of chronic brain disorders such as Alzheimer's disease will become the number one public-health problem worldwide, directly affecting 100 million people by 2050

reason. In addition, high unit costs may be related to inefficiencies, due to organizational or institutional inefficiencies, wrong payment incentives for providers and suboptimal levels of care leading to high costs (due to over/-under-treatment). Also, care may be cost-ineffective, e.g. if an adequate level of care is provided at home at a lower cost. To address these issues, many countries are trying to control the costs of LTC by encouraging home care, giving choice for the adequate form of care to the dependent (cash benefits) and regulating the supply of LTC arrangements[11].

The extent to which a country relies on formal care and the extent to which this is provided in institutions or at home are important determinants of public expenditure on LTC. There is an increasing focus on the "opportunity costs" derived from informal care: the impact on labor market and productivity, as well as on carers health status itself. All OECD countries are involved in either the public provision and/or financing of LTC services, although the degree of involvement differs across countries. Some countries rely heavily on the informal provision of LTC and their expenditure on formal care is small. Other countries provide extensive public services to the elderly and devote a significant share of GDP to LTC. Pressure for increased public provision and financing of LTC services may grow substantially in coming decades, especially in countries where the bulk of LTC is currently provided informally[12].

The provision of LTC has significant implications for the labor market. Often, care is associated with low recognition and low salaries, leading to high staff turnover. In some countries, staff shortages in the sector are already high. In the future, there will be fewer people of working age and a decline in the size of low-skilled workforce (which may be relevant for some home-care services), potentially increasing staff shortages. This situation combined with higher pressure on the formal provision of LTC may increase wages in the sector. As the cost of LTC is dominated by labor costs, changes in wage rates of LTC workers are likely to influence future costs of LTC. Migrants make up an increasing proportion of formal-care workers in OECD countries with more

[11] Joshua (2010a)
[12] Costa Font, Norton *et al* (2017)

extensive LTC service provision. Differences in pay and working conditions among countries influence the inflow of mainly female migrant workers.

Cross Cutting Design Issues in Long Term Care:

There is growing consensus about the role of social protection in LTC. Informal care by close family members is the main pillar of most long-term care systems. However, due to demographic ageing, the need for long-term care is expected to increase while the informal care potential is expected to decline. From a budgetary perspective, informal care is often viewed as a cost-saving alternative to subsidized formal care. This view, however, neglects that many family carers are of working age and face the difficulty of reconciling care and paid work, which might entail sizeable indirect fiscal effects related to forgone tax revenues, lower social security contributions and higher transfer payments[13].

From the individual standpoint, that LTC costs can be catastrophic, and a realisation that self-insurance through savings is not realistic for many people. This is because both the risk and the cost of LTC are heavily skewed towards those on lower incomes; and for those on middle incomes putting aside resources for future LTC needs competes for fiscal space alongside expenditures on pension contributions, mortgages, childcare, and education. In the absence of a risk-pooling mechanism, those in need of LTC can find themselves entirely reliant on family members. This means that the need for LTC has repercussions beyond the individual, and can easily affect the earning capacity of working-age children.

Risk-pooling is therefore one of the key options to distribute risk and share payment of LTC costs among a larger group of individuals. This can be achieved through social insurance, tax-based (either universal or means- tested) public systems, or private insurance. Each of these has certain advantages and disadvantages, and working examples of each are to be found across the countries reviewed in this paper.

[13] Geyer, Haan and Korfhage (2017)

***Social Insurance**:*

Social LTC insurance systems have some features that make it more attractive than tax-funded systems. Notable among these are:

Allocation transparency: the allocation of benefits usually follows a defined algorithm, rather than depending on the discretionary power of LTC managers or on available resources. Thus, social insurance arguably provides greater assurance regarding entitlement to benefits. Also, by making LTC a social right linked to past payment of specific social contributions, it does away with potential issues of stigma surrounding take-up of benefits. Since social insurance systems are usually accessed through one unique point of assessment, and since benefits are harmonised, it could be argued that they also have the potential to facilitate access and to limit geographical inequality.

Financial transparency: social insurance is typically financed by social contributions (payroll taxes) that are assigned specifically to the system and not to the general state budget. Not only does this create a reliable and predictable financing stream, but it may also enhance people's willingness to pay additional social contributions if those are tied to a particular risk that they consider it worth being protected against – not a trivial advantage when seeking to ensure the social sustainability of the system (i.e. that the system enjoys public support).

Social LTC insurance also has a number of potential advantages over mandatory private insurance:

- First of all, social contributions used to finance social LTC insurance are income related, making them affordable to all individuals through an implicit redistribution from wealthier to poorer individuals. This same redistribution allows for the notional payment of social contributions during periods of unemployment or inactivity.
- Secondly, with social insurance it is possible to pool risks not only at the societal level, but also between generations, with the pay-as-you-go (PAYG) system, as happens in

the case of old-age pensions. The current working-age generation pays for the benefits of current older beneficiaries, on the understanding that future generations will in turn pay for their benefits when they reach old age. This 'intergenerational contract' allows benefits to be paid from the beginning of the programme

- Thirdly, the social contribution rate can be changed more readily at any given point to reflect and accommodate changes in risks and costs, rendering social insurance more flexible in accounting for uncertainty in LTC needs and costs.

Social insurance systems also have potential disadvantages. Some of these stem not from the concept of social insurance itself, but from the way in which systems are managed. The 'intergenerational contract' inherent in Pay-As-You-Go (PAYGO) creates an implicit burden on future generations that demographic aging only serves to aggravate. The allocation of benefits through a well-defined algorithm may render care packages too rigid and leave little room for them to reflect the particular needs of individuals – although the possibility of receiving the benefit as a cash-for care (CfC) payment could add flexibility to the system, e.g. by allowing users to hire their own personal assistants or pay informal carers, as is the case with the social insurance systems in the Netherlands, Germany.

By linking social contributions to wages, social insurance systems have a limited tax base, which raises issues regarding their equity, as they tend to leave any earnings generated from capital exempt from payments. Social contributions levied on wages increase the tax on wage earnings which can have distortion and competitiveness effects. This also leaves the financing of the system vulnerable to economic fluctuation (e.g., when there are increases in total unemployment in periods of economic downturn and consequent diminished streams of revenue). However, unlike actuarial insurance, because participation in social insurance is compulsory, the link between premium and individual risk can be broken. Social insurance, or social security, is a compulsory public 'insurance' program, generally designed to serve a defined population. Also, whereas the right to benefits is based on an insurance contract with private insurance, social insurance programs are generally based on legislation, and the state can alter contributions, and change conditions for receiving social insurance and the provisions of the program, even

retrospectively. In the OECD, social LTC insurance systems are to be found in Germany, the Netherlands, the USA (*Medicare),* Japan and South Korea.

Tax Based Systems:

Tax-based systems are funded from the state's budget (whether of central, regional or local government), and as such their revenues are drawn from the taxes levied by the state. Herein lies one of the greatest strengths of tax-based systems: they have a broader tax base, and therefore financing is not limited by the share of wages as proportion of Gross Domestic Product (GDP). As capital income also provides a financing source, the system may be regarded as more equitable at the societal level, although this ultimately depends on the relative importance of different types of taxes e.g., indirect taxes on consumption typically involve less redistribution than proportional income taxes). Another advantage of tax-based systems is their flexibility and adaptability in providing benefits, which means that uncertainty regarding the future costs of LTC may be addressed more easily. The potential flipside of this is arguably reduced transparency in the allocation of these same benefits.

A disadvantage of tax-based systems over social insurance systems is the potential for inequality between groups of users with similar needs. Unlike social insurance, in tax- based systems there is no pre-defined algorithm to define eligibility, and this process is often handed over to the discretion of LTC managers or is dependent on available budgets. When it is left to local governments to determine eligibility or availability of services, this can give rise to inequality based on where people live. In the OECD, different tax based systems can be found in Sweden, Denmark, Finland which all provide universal LTC services and are free at the point of delivery. LTC systems in the United Kingdom and Poland are also examples of tax-based systems. The United States (*Medicaid)* also includes a tax-based LTC program which is means tested.

Private LTC Insurance:

Voluntary private insurance for LTC has faced various obstacles to implementation. Chief among these is adverse selection, where 'bad risks' (i.e. people at greater risk of needing LTC) will buy insurance, while 'good risks' will not, and thus drive premium prices higher and ultimately cause

the market to collapse. In the United States, for example, only twelve companies sold over 2500 policies; well below the total number of policies sold in the 1990s. The absence of sales coupled with weak actuarial modelling led the US Congress to annul the Community Living Assistance Services and Support (CLASS) Act in 2013. The Act which supported a private insurance mechanism based on voluntary enrolment had been introduced in 2009 and provides an example of the effects of adverse selection on a voluntary insurance system.

The need for LTC is an uncertainty which makes it unsuitable for actuarial insurance. Given the scope for improvement in health treatments and changes in care, costs over an insured person's lifespan (e.g. if dependent older people live longer with LTC needs), the need for LTC might best be characterized as an uncertainty, rather than a risk: while the potential costs of LTC can be assessed, the time horizons make it impossible to calculate the probability of needing LTC services 30 years hence. Therefore, LTC is an uncertainty, which cannot be insured and renders actuarial insurance impractical[14]. Despite the mountain of evidence pointing to a high probability of needing LTC at some point in the course of a lifetime, younger people may be myopic in their assessment of LTC risks and may opt not to buy insurance. This leads to the absence of personal cover when they reach old age – a problem that ultimately public systems of last resort have to address. Lack of awareness on the part of potential purchasers of private insurance has long been considered one of the main barriers to take-up of private LTC insurance[15]. Moreover, the existence of a public system of last resort may itself dissuade people from buying private insurance, i.e. the public sector may crowd out private insurance. Finally, private insurance usually requires some capital to be accumulated in the form of paid premiums before benefits can be paid out.

[14] Insurance is defined as actuarial if the premium is based on the risk of an event occurring and the size of the resulting loss. Mathematical and statistical methods are applied to assess insurance risk. Actuarial insurance can cope with individual, measurable risk. It cannot set a premium when the risk is either certain, such as a pre-existing medical condition; or uncertain, where the statistical probability of the event occurring for the group as a whole is unknown

[15] Barr (2010)

The problems of adverse selection and myopic behaviour can be addressed by making private LTC insurance mandatory. When LTCI is made mandatory three issues nonetheless remain. First, many people – including those on lower incomes, those with pre-existing conditions and those closer to old age – might not be able to afford the premiums (in private insurance, premiums reflect differences in risk, rather than income) and this would require public subsidies. Subsidies would also be necessary during periods of unemployment or inactivity (e.g. when studying, when on maternity/paternity leave etc.), when people do not have sufficient sources of income. Secondly, the need for capital accumulation (pre-funding) would remain, meaning that the current older generation would not be covered. Thirdly, the issue of uncertainty about risk and associated costs would remain. The latter could lead insurance companies to raise insurance premiums, with negative consequences for affordability. Alternatively, insurance companies may take a conservative approach and provide only limited benefits that most likely would cover only a portion of LTC costs. This is indeed the option followed by private LTC insurance companies in countries like France which provides one of the rare examples in the world where private LTC insurance is of some importance, with an estimated 11 per cent of people privately insured in 2012[16]. Even in France, however, private LTC insurance is confined to a supplementary role, concentrated among older workers and those on higher incomes. Apart from in France, across the OECD voluntary private insurance has only a marginal presence at best.

Scope, Coverage and Eligibility of LTC

Eligibility for LTC benefits and whether access to these benefits is universal (i.e. based on need only) or means tested is heavily influenced by financing methods. By definition, in insurance-based systems the payment of premiums (or social contributions in the case of public systems) entitles beneficiaries to receive benefits in the event that they require LTC. Therefore, these are systems that are usually universal. In tax-based systems there is scope for either universal (Denmark, Sweden, Finland) or means-tested access to benefits - such as the United States (*Medicaid*) and United Kingdom. Still, eligibility thresholds for accessing LTC benefits or the

[16]Doty *et al* (2015)

breadth of LTC systems can vary markedly between countries, even among those universal LTC systems.

Public LTC systems seldom cover the full cost of LTC. This means that the scope of coverage (what needs or services are financed) and the depth of coverage (what share of costs is publicly financed) of LTC systems can vary significantly and are not necessarily linked to whether the system is financed through social insurance or taxes. Regarding the scope of coverage, the costs of board and lodging are not usually covered by LTC systems (except under means-tested social assistance). This is the case with LTC insurance in Germany and Japan where these costs are paid by the user out of his or her own pocket. In the United Kingdom and in the United States the costs of board and lodging are defined according to income and assets of the user.

Some national LTC systems adjust the depth of coverage to the income of users. In France, although eligibility for the APA (*Allocation Personnalisée d'Autonomie*) is based on need alone, the monthly amounts are adjusted according to the income of the user. In many OECD countries, access to subsidised LTC falls short of the assessed hours of care which leaves a substantial part of the costs to be covered by the user's own resources. As is the case with eligibility rules (i.e. breadth of coverage), the depth and scope of coverage are largely unconnected with the way the LTC systems are financed. There is therefore a mixed picture in terms of the share of total expenditure that is financed privately across countries and financing systems. Despite its social LTC insurance, private expenditure on LTC in Germany amounts to one third of total expenditure on LTC – much higher than in tax–financed Denmark where its amounts to 10 per cent. For institutional care, private expenditure constitutes an even larger share of total expenditure across the OECD, and most costs are borne by users.

In practice, most LTC systems combine universal and means-tested features, and in some cases, parallel sub-systems co-exist. Insurance systems typically do not cover all care costs (e.g. board and lodging in institutional care) and are therefore supplemented by a means test social assistance component that acts as a safety net for those who cannot afford the out-of-pocket costs of care. Countries with means-tested benefits have other, parallel, universal benefits

designed to support people with LTC needs, such as the Carers Allowance in England. Other countries, such as Poland, also provide care allowances in parallel with other benefits meant for older people with LTC needs.

There has been a move towards ensuring greater targeting of public resources, even in universal social insurance or tax-based systems. In some cases, this targeting has involved reducing the breadth of LTC systems, for example., by making social insurance-based systems not 'carer blind'. In the case of the Netherlands, eligibility for benefits under social insurance takes account of the amount of informal care that relatives should provide (regardless of whether or not they do provide it) in what is termed 'customary care'[17]. In Sweden, there has been a consistent policy of concentrating public resources on individuals with greater needs. In England, many local government authorities only provide LTC services to those with the most severe needs. In other cases, the greater targeting has involved changes to the depth of coverage, i.e. changes in private contributions to the costs of LTC. For example, in Germany the amount of LTC insurance benefit paid to eligible users is lower if they opt to use the money to pay for an informal carer. In France the amount of the public universal benefit, the *Allocation Personnalisée d'Autonomie* (APA), is adjusted according to the user's income, in what has been termed 'progressive universalism'. The reconfiguration of financial entitlements to LTC, particularly under conditions of fiscal austerity' has become associated[18] with the concept of 'implicit partnerships' which involves an implicit (or 'silent') agreement, encompassing the financial co-participation of public funders and the time and/or financial resources of users and their families.

Generational Economy and Intergenerational Equity:

The economic behaviour of individuals varies in systematic ways as they proceed through life. The transition in population age structure influences the shares of the population likely to be in need of LTC. The transition in population age structure bears directly on the challenge that working age adults face in meeting their economic and social responsibilities. In the context of

[17] The Netherlands has codified the explicit 'customary care principle' that defines the 'normal daily care' that partners, parents, co-resident children or other household members are supposed to offer each other
[18] Costa Font and Zinante (2017)

aging and the rising demand for LTC, OECD countries have sought to look at the assets held by the elderly as sources of financing (e.g. accumulated assets, such as housing stock) and building mechanisms that ensure the adaptability of LTC systems to societal and demographic changes (e.g. pre-funding mechanisms and other forms of intergenerational financing)[19].

Interest in the role of property assets as source of the funding of LTC has grown. As individual wealth is usually greatest around retirement age, with a sizeable proportion of that wealth taking the form of property, assets are being seen by policymakers as a potential source of financing for LTC needs[20], particularly in the case of older people who need to move into institutional care. However, this is an approach that lacks broad consensus among citizens in most OECD countries, since many people find it unfair to have to forsake their homes in order to qualify for public support for LTC needs. For example, the support for state intervention is strong in most European countries. On average 86 per cent support the responsibility of the state to provide care to those in need and to, both financially and in terms of respite time, support informal caregivers[21]. Furthermore, this may be regarded as penalising people who have saved over the course of their lives, and may stand as a barrier to rehabilitation in institutional care settings if users have no home where to return to if rehabilitation is successful. Nonetheless, a number of solutions have been proposed that allow the mobilisation of assets invested in a person's own house, while protecting most of its value and without requiring its sale (e.g. reverse mortgages) – a relevant issue for those in need of home care. Recent developments in England, under the Care Act 2014, formally enshrine this into legislation. This payment can be deferred until after death, and there are other safeguards in place to protect surviving co-resident relatives who remain in the principal residence[22].

[19] Lee and Mason (2011)
[20] In contexts of sluggish economic growth and widening inequalities in income and other social outcomes, policy makers have been seeking to identify comprehensive, coherent and effective policy packages to foster inclusive growth. Growing unequally undermines future economic development, particularly where inequality of opportunity locks in privilege and exclusion, reducing intergenerational social mobility and social cohesion
[21] Costa Font and Zinante (2017)
[22] Mayhew *et. al* (2016)

Funded systems require sufficient funds to be accumulated before they can pay out benefits. An advantage of PAYGO systems for LTC is that payment of benefits is immediately possible from the moment such a system is put in place. This fact notwithstanding, pre-funding through reserve funds can smooth out the effects of demographic ageing by limiting the amount of implicit debt that is passed on to future generations in the context of a PAYGO system. Other possible advantages of having pre- funded elements built into LTC financing systems include smoothing over possible changes to benefits or contributory rates to meet the costs of care over time.

A number of countries that have implemented PAYGO-type social insurance-based systems to finance LTC also have pre-funding mechanisms in place, although the amounts accumulated are equivalent to only a very limited fraction of expenditure. In Germany, the recent LTC insurance reforms introduced an increase in the contribution rate. The resulting funds will be set aside in a buffer fund that will only be spent from 2035 onward, in order to level the effects of the country's demographic transition. Pre-funding options and reserve funds also offer ways to strengthen the intergenerational balance in financing LTC. This is because current generations build up assets for future generations, while using revenue from taxes on consumption ensures that older people also contribute to the financing of LTC needs.

The German LTC insurance model is one example of a system that specifically levies social contributions on older (retired) people, too. Demographic aging will increase the share of older people in the total population, as well as the relative size of the share of income or assets held by older people, making it less defensible to rely on taxes or contributions levied on a diminishing pool of working-age people alone. Another way to strengthen the intergenerational balance is to have differentiated payments according to the number of children, as has been the case in the German LTC insurance system where childless people pay an additional percentage on the contribution rate.

The development of LTC approaches has varied considerably across countries. The pioneers in developing comprehensive LTC systems starting in the late 1960s and early 1970s were the

Netherlands, Sweden, and other Scandinavian nations. In the latter, their programs followed their approach to providing social welfare policies in general: tax-financed, locally administered services. The Netherlands built on existing local programs for service delivery but financed them from an off-shoot of the social insurance system in the health care field. In terms of a general model of policy initiation, the Scandinavian, Dutch, and German cases are straightforward: a social problem emerges and attracts public concern, and a reasonable solution—usually a policy tool that has already been used for analogous problems—is deployed. The LTC policy initiation process in Japan involved looking at experiences in Germany and Scandinavia,[23] while the Republic of Korea's LTC insurance program looked toward the experiences of both Germany and Japan.[24]

Although national patterns of how to fund and deliver LTC differ significantly, they can be grouped into four broad categories[25]. There is no uniform or simple typology that captures the dimensions and diversity of approaches adopted by most countries. However, broadly speaking, the LTC systems described in this note can be characterized as: (a) the social insurance model, (b) the universal model, the (c) means-tested model, and (d) hybrid approaches that blend various design and delivery features of other models. In OECD countries, some public LTC programs cover most or all of the older population, providing benefits to anyone meeting a test of dependency. Others serve only people whose income and assets are below certain levels. In most countries, both local and national governments are involved in financing LTC. In virtually all cases, beneficiaries share responsibility for their LTC by paying premiums or cost sharing through out-of-pocket (OPP) expenditures. Private LTC insurance and equity release schemes are relatively minor mechanisms for service provision in almost all countries, with the exception of France. However, these types of schemes and mechanisms are likely to grow in importance in the future, given the need to maintain financial sustainability and intergenerational equity.

[23] The prior initiation of LTCI in Germany was important for Japan's switch to a social insurance model. The Government's initial move in that direction actually came in 1989 with the appointment of a discussion group to think about old-age care (Japanese Ministry of Health and Welfare, 1989).
[24] Campbell *et al*. (2009)
[25] OECD (2005); MISSOC (2009); Kraus *et al.* (2010)

Social Insurance Model

The Netherlands, Germany, Japan, and the Republic of Korea offer social insurance for LTC**.** Social insurance programs cover all or most of the population and have a dedicated funding source. The Netherlands program, introduced in 1968, is the oldest form of social insurance for LTC in the world. The German program, established in 1995, covers LTC through the same organizations that provide health insurance, but with entirely distinct funding. The contribution rate is 1.7 percent of income (up to a ceiling), divided equally between workers or retirees and employers or pension funds. In 2005, childless employees began to pay a supplementary contribution of 0.25 percent – this supplementary contribution has recently been increased - the differential contribution rate acknowledges that raising children is one of the pillars of the LTC insurance system, since children will be paying contributions in the future. High-income people may opt out of the social insurance system by purchasing equivalent or private LTC insurance. The social insurance system covers over 70 million Germans, and the private LTCI system covers another 9 million high-income workers and civil servants. In Japan, everyone aged 40 and over participates in a social insurance program operated by municipalities. Half the program cost is covered by contributions or premiums, and half is covered by payments from the central, prefectural, and municipal governments. For covered workers, the contribution rate is 0.9 percent, split equally between employers and employees. People aged 65 and over pay an income-related premium.

The Universal Model

The Nordic countries provide universal LTC coverage through public services**.** Everyone is entitled to LTC services through municipal programs funded primarily by local and regional tax revenues. The central government of Finland covers roughly 30 percent of costs, the central government of Sweden covers 15 percent, and the Danish central government makes no fiscal contribution. While coverage is universal in the Nordic countries, benefits or required cost sharing may vary according to the ability of local governments to raise Own Source Revenues (OSR). Differences in the proportion of the population served, the level of benefits and services, and the level of charges have been especially high in Sweden and Denmark.

Means-Tested Systems Model

The United Kingdom (UK)[26] and the United States of America (USA) rely primarily on means-tested programs financed from general taxation. In the UK, the National Health Service (NHS) covers nursing care in the community and in nursing homes. Non-medical LTC is furnished by local government social service departments on a means-tested basis, with the exception of Scotland which offers LTC on a universal basis. In the UK, funding comes primarily from the central government but also partly from local government taxation and user charges.

In the USA the limits for eligibility as well as the scope of the LTC services covered are set at the state level and thus vary considerably. In most states, Medicaid covers costs for residential care. The Medicaid program was not originally designed to concentrate on help for the elderly, but it has evolved into an important pillar for LTC financing. Due to the high cost of nursing home care, two-thirds of the elderly population end up relying on Medicaid. *Medicare* is a national social insurance program, to which contributions are paid either as 'Medicare tax' while working or by continuing to pay premiums after retirement. In the last 20 years, a private market for LTC insurance has emerged in the USA. Private insurance companies—which number more than 100—offer complementary insurance for costs related to LTC. The insurance products are designed for cases in which benefits from Medicare have been exhausted and the insured is not entitled to Medicaid benefits. Insurance is voluntary and has normally been taken out individually

While many other countries have embraced universal, government-managed, LTC insurance the USA has moved in a very different direction. In the USA, funds for health and LTC for the elderly are provided from public as well as private sources. The country took modest steps to expand private LTC insurance through tax incentives, and government-funded marketing campaigns, and tied this coverage more closely to *Medicaid* which is a tax-based program designed for low-income earners covering hospital care as well as home care. However, these efforts met with

[26] Under the system of devolved government in the UK, the countries of England, Scotland, Wales and Northern Ireland have different criteria for the provision of LTC. Compared with the current English system, the Scottish system of 'free personal care' and the Welsh system are both more generous. The term 'UK' will be used only when all four countries are being referred to; otherwise the emphasis is on LTC in England.

little success, and participation in private insurance still remains very low, accounting for around 7 percent of the total. Public funding is based on the Medicaid and Medicare programs, while the private element consists of private insurance as well as out-of-pocket payments.

Efforts to address LTC under the 2010 Affordable Care Act (ACA) made some progress and the *Commission for Long Term Care* (2013) – which was established in the wake of the Community Living Assistance Services and Supports (CLASS) Act[27] being repealed by Congress - made a number of strategic recommendations for improving coordination between health and LTC and workforce development, but deferred from making substantial recommendations on sustainable funding arrangements. Shortly after the 2016 U.S. presidential election, the Senate and House began the formal process of repealing the Affordable Care Act (ACA)[28]. Just as the ACA acted as a major reform of the payment and delivery systems for health and had an impact on some LTC services, repealing the ACA will also have a major impact on health care providers[29], consumers, and companies in between, such insurance companies and providers of LTC services[30] [31].

Hybrid System Approaches and Models

A simple dichotomy between programs that are universal and programs aimed at the poor does not adequately characterize LTC systems. A universal program, for example, can cover everyone but vary benefits according to income. France's personalized independence allowance (APA), also know as the 'autonomy pension', provides cash payments to be used for LTC services for people aged 60 and over. A maximum benefit amount is specified for each of four levels of dependency. The benefit is reduced according to a sliding scale based on income, with the highest-income participants receiving only 10 percent of the maximum benefit for their disability level. The

[27] The CLASS Act was passed in 2009 and was intended to be a self-sustaining national voluntary insurance program funded by purchasers of private LTCI. However, the Department of Health and Human Services took the view that the plan was actuarially unsound and could not be implemented. Congress repealed the CLASS Act in 2013.

[28] Within hours of his inauguration, President Donald Trump signed an executive order instructing all federal agencies "to minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open healthcare market

[29] Kasier Foundation (2017)

[30] Dobson, DaVanzo *et al.* (2016);

[31] Ku *et al.* (2017)

central government and the elected councils in each department jointly fund the benefit, which took effect in 2002. At the same time, in France, the private market for LTC insurance (LTCI) in France has been growing and now covers over 11 per cent of the population.[32] France has the largest LTCI market in the world.[33] Some countries have both a universal social insurance program and a means-tested social assistance program. In Germany, people who cannot meet the cost-sharing requirements for nursing home care are helped by local means-tested programs which are financed by sub-national governments.

In the transition countries of Central and Eastern Europe comprehensive LTC systems are rapidly emerging. Relative to other European states, LTC in these countries is a latecomer to social policy for the management of social risks[34]. However, aging societies, growing care needs, and broader socio-economic developments—often linked to accession to the EU—are increasingly challenging traditional ways of organizing social policies for LTC and creating pressures to find new approaches. In the Asia-Pacific region[35], particularly China[36] [37], countries have also embarked on a wide range of measures and initiatives to address aging and to strengthen and improve the finance and governance of LTC systems

[32] Joshua (2010b).
[33] Doty *et al* (2015)
[34] See: http://documents.worldbank.org/curated/en/2010/11/13246793/world-bank-report-long-term-care-ageing-case-studies-bulgaria-croatia-latvia-poland
[35] World Bank (2015)
[36] Joshua (2011)
[37] World Bank (2013)

Chapter II:

Social Insurance Models: The Netherlands, Germany, Japan, and the Republic of Korea

A The Netherlands

Policy Context

The Netherlands was the first country to introduce a universal mandatory social insurance scheme for covering a broad range of LTC services which are provided in a variety of care settings. The Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten* AWBZ) insurance scheme for LTC was established in 1968 to cover previously uninsurable health costs such as nursing or residential care[38]. Prior to 1968, the financing of LTC facilities was highly fragmented and increasingly insufficient to provide access to care for lower-income groups. The decision to proceed along the route of a universal public health insurance scheme for LTC was linked to the following factors: (i) the existing social health insurance for curative health services (the sickness fund) only covered two-thirds of the population (primarily lower- and middle-income groups)[39] and (ii) the financial risk of LTC was considered largely uninsurable through private insurance, and there was broad political support to expand public financing[40].

The AWBZ has been administered by the health insurance scheme (known *Zorgverzeringswet*), but until recently remained separate from it. The health insurance board set the budget for AWBZ, subject to approval of the Minister of Health, Welfare and Sport. The AWBZ covered the whole population, regardless of age, income, or employment status, and it funds institutional, domiciliary nursing, and personal care. People with physical, cognitive, or developmental disabilities or long-term mental illness are all covered. In 2014, around one in twenty residents in the Netherlands are recipients of the program which covers residential and home care

[38] Germany followed in 1995, and Japan established its system in 2000

[39] Therefore, a straightforward expansion of this scheme to include LTC in the mandatory benefits package was not an option, because higher-income groups would not have been included and would not have contributed to the financing of LTC.

[40] Schut and van den Berg (2010)

services[41]. More services were brought under AWBZ over time, including home help and personal care services. However, there have over the years been active policy discussions about the range of services that should be covered by AWBZ in the wake of cost escalations.

After almost two decades of political discussion and policy reviews urging for a reform of LTC to safeguard its fiscal sustainability, the government managed to build a political majority for an overhaul of LTC. The reforms came into effect in 2015[42] and can be seen as having a hybrid focus, characterized by, on the one hand, austerity measures intended to safeguard the long-term financial sustainability of the Dutch long-term care system, and on the other hand by a normative discussion about public values such as solidarity versus individual responsibility[43].

Financing

Until 2015, LTC was financed by two schemes: *AWBZ* which covered 95 per cent of public expenditures for LTC, and the Social Support Act (*Wet Maatschappelijke Ondersteuning: WMO*). The first step in the reform of LTC took place in 2007 with the introduction of the WMO[44]. The major driver for reforms was to demand greater individual responsibility in LTC. The reforms also increased the role of municipalities in non-residential care. The most conspicuous alteration was that the coverage of housekeeping services shifted from the AWBZ to the newly established WMO. The budget for these services was also substantially cut. It was the financial crisis of 2008 which created a window of opportunity for more radical reform.[45]

[41] van Ginnekan and Kroneman (2015)
[42] Maarse and Jeurissen (2016)
[43] Jorgen (2017)
[44] The WMO replaced previous legislation on the responsibilities of local municipalities for transport and housing adaptations for disabled people. Significantly, it also transferred responsibility for funding domestic help—which constituted about 42 per cent of the AWBZ budget for non-residential nursing and care—from AWBZ to municipalities. Funding for these responsibilities came from central government through national taxation; these resources were not ring-fenced within municipality budgets. The shift of funding responsibility from the social insurance AWBZ to municipalities involved a significant loss of entitlements, and access to domestic help became entirely dependent on discretionary municipal budgets.
[45] Tjadens (2008)

The reforms include the introduction of a new Long-term Care Act (*Wet Langdurige Zorg, WLZ*) which replaces the AWBZ. The WLZ, which came into effect in 2015, provides a new regulatory framework for residential care. Just like the former AWBZ, it is set up as a statutory health insurance scheme. Applicants are subjected to a nationally organized needs assessment procedure according to uniform and strict standards. Residential care is intended for clients who need permanent supervision to avoid escalation or serious damage and clients who need 24 hours care because of physical problems or self-control problems. Under the new law, clients may also apply for a personal budget. A new option is to organize full care at home. The payroll premium is set at 9.5 per cent of taxable income beneath 33.600 euros. The transition of the AWBZ into the WLZ is in accordance with earlier policy recommendations to re-focus the AWBZ on long-term care in a residential setting.

The provision of all non-residential care, formerly covered by the AWBZ, has been devolved to either insurers or municipalities. Under the 2006 Health Insurance Act (*Zorgverzekeringswet, ZVW*), insurers have now been made responsible for contracting community nursing (e.g., diabetes care, administration of medicines, wound care and injections) and 'body-related' personal care (e.g., support in washing, dressing and shaving).

The AWBZ scheme had endured considerable pressure over the past decade. As both coverage and demand for LTC increased, expenditure also rose. In an effort to contain costs, the AWBZ budget was capped and set annually by central government. However, this budget was not adjusted in line with demographically driven increases in demand, resulting in delayed hospital discharges and waiting lists for services.[46] In 1999, legal action led to a ruling that the government was responsible for providing sufficient funds to purchase insured care, and consequently, capped budgets and waiting lists were ruled incompatible with insurance principles. AWBZ therefore became an open-ended scheme, and both costs and premiums rose rapidly and substantially. In 2001, total AWBZ expenditure was €15.9 billion; by 2008 it had reached €22 billion and in 2012 eligibility criteria was drastically restricted for the personal care

[46] Van Gameren (2005)

budgets. However, despite these restrictions in 2014 AWBZ expenditures had risen to €27.8 billion[47].

Prior to the changes introduced in 2015 the LTC system several measures had ben taken to address AWBZ funding issues**.** One strategy to meet AWBZ funding shortfalls was to increase co-payments for middle- and higher-income groups. Eligibility criteria used by the (then) RIO Needs Assessment Boards were also tightened.

Introduction of the new WLZ has been accompanied by measures to reduce fraud which emanated from budget holders managing their own LTC budget. A new government body, the Social Insurance Bank, has been established to manage the budget of behalf of budget holders. Other key features in the reform include: first, for elderly people for whom living at home is no longer possible, residential will be available under the new Long Term Care Act; second, insurers will be made responsible for home nursing (which includes personal care), which is now part of the Health Insurance Act – the objective being to move home nursing care closer to general practitioners and other types of primary care such as district nurses; third, most forms of non-residential care (the LTC part) will be transferred to municipalities under the Social Support Act 2015 – which provides home help services, transport arrangements and home adaptations and adjustments The overall objectives of the reforms are to: a) reduce costs and keep LTC affordable by reaching savings of €3.5 billion annually by 2018. However, introducing the reforms has been far from smooth given that new institutions have been created and new service delivery models introduced.

Over time, there will be an increasingly larger share of older persons who have the possibility to use housing wealth to finance LTC. In the Netherlands, the growth of owner occupation has been supported by state backed guarantees on mortgages and tax subsidies for homeowners[48]. The overall level of owner-occupation has risen steadily decade after decade. This rise in owner-occupation from a relatively low base has been matched by a decline in social renting, partly as

[47] Van Ginneken and Kroneman (2015)
[48] Nederlandse Vereniging van Banken (2014)

a result of the sale of some social housing, followed by housing associations gradually becoming financially independent after subsidy reductions. The development and utilization of equity release schemes to fund LTC in the Netherlands therefore depends heavily on age cohorts and tenancy type[49].

Organization and Assessment of Eligibility

AWBZ beneficiaries previously chose which organization provided their services. AWBZ benefits covered home nursing, personal care, day care, overnight care, respite care, and residential care. Personal budget holders constituted approximately 10 percent of all those receiving AWBZ funding for non-residential care. Assessments of eligibility are conducted by Needs Assessment Boards. Until 1997, assessments of eligibility for AWBZ-funded services were conducted by provider organizations, leading to allegations of 'cream-skimming' behaviors. Subsequently, assessments were centralized through the creation of the Center for Care Assessment (CIZ). As part of developing a more unified approach to eligibility criteria, assessments have moved away from a focus on potential service inputs. Support needs are now broken down into six functional domains: (a) Personal care (e.g., showering, dressing, toileting, shaving, skin care, eating); (b) Nursing care (e.g., wound care, medication, managing symptoms); (c) Supportive guidance (e.g., organizing daily activities, household management); (d) Activating guidance (e.g., counseling and therapy); (e) Treatment (e.g., rehabilitation); (f) Living, services and treatment (e.g., sheltered housing or residential care)[50].

Individual assessments of need are conducted within each functional domains using methods related to a checklist of more than 100 items. This checklist is based on the World Health Organization International Classification of Functioning, Disability and Health (ICF). The extent to which the checklist is completed is at the discretion of the assessors. The aim of the visits is to build a general picture of the applicant in their own surroundings and to establish the extent to which members of the household can contribute to the support. This is intended to give

[49] Reifner et al (2009)
[50] European Commission (2016a)

individuals a much better understanding of the specific domains in which they require help and therefore enable them to exercise choice over who provides that help. Individuals can, for example, seek care from a number of different providers, each of whom delivers one or more of the types of help they need. This opportunity for choice is particularly relevant for personal budget holders.

Reform Pressures

Key drivers for reform of the LTC system have focused on reducing the coverage and scope of LTC scheme; tightening the eligibility thresholds for each of the typical 'care intensity' packages; and reducing payments to providers for each of the care intensity packages or freezing reimbursements to providers despite increases in costs or inflation[51]. Tightening the LTC assessment processes is expected to restrict the growth in LTC spending. However, some continuing demographically-driven growth is still expected. It is not yet clear what the combined impacts of the new municipal-level responsibilities and the care intensity packages will be on care providers and their ability to recruit and retain professional staff. Some instability among providers is anticipated as they are exposed to new market risks and increasing cost and workforce pressures. Evidence suggests that competitive tendering may have contributed to the recruitment of less-skilled labor[52].

Initially, the intention was to implement large expenditure-cuts in LTC, but during the follow-up negotiations the size of these cuts was gradually scaled back. The government assumed that municipalities and insurers will be able to organize LTC more efficiently than the regional care offices under the AWBZ. An expenditure cut was imposed on residential care, as was a decision to close nursing homes for clients with only mild problems. Due to these expenditure cuts, public expenditure on LTC was reduced by 5 per cent.

[51] Woutesse and Smid (2017)
[52] van Staveren (2009)

B. Germany

Policy Context

Germany is currently undergoing drastic demographic changes and is projected to soon be one of the countries in Europe with a substantially shrinking population. According to the Federal Statistical Offices population forecasts, the number of people of working age (20-64 years of age) is expected to fall by 9.6 million to 40.5 million by 2050. At the same time, the number of people aged 64 years and over will rise by 7.6 million to 23.5 million. As a result of this demographic trend, the number of workers available on the employment market will also fall significantly, and will accelerate after 2020[53].

Until the introduction of the LTCI Insurance Act (LTCI) of 1994, Germany did not have a comprehensive public system for financing LTC. Previously, when requiring the use of formal LTC services, dependent people and their families had to pay out-of-pocket. Very limited public support was available through the health insurance scheme, and means-tested social assistance support, funded from taxation, was available for people with insufficient means to meet their care needs. The extensive reliance of older people on social assistance, particularly to fund institutional care, was considered to be stigmatizing and incompatible with German citizenship. However, it was arguably the financial burden of social assistance expenditure on the German municipalities and regions (*Länder*), rather than pressures from disabled or older people, that shaped the insurance reforms[54]. The introduction of LTCI led to a substantial reduction between 1994-2002 in the numbers of people who were dependent on social assistance to fund their care.

Financing

The LTCI Act established Social Insurance and mandatory private LTCI, which together cover almost the whole population. Non-employed family members are covered by the head of

[53] BMG (Bundesministerium für Gesundheit) (2009)
[54] Schneider and Reyes (2006)

household's contributions. Around ten percent of employed people, mainly high income earners and civil servants,[55] belong to private care insurance schemes, which are required to offer equivalent coverage, terms, and benefits to the statutory scheme. Since all insurance benefits are capped, private co-payments remain important. Means-tested social assistance also still plays a vital role, particularly in nursing home care where about one-third of all residents receive social assistance.[56] Until 2008, LTCI was funded by adding a further 1.7 percent of gross monthly payroll costs to existing social insurance contributions. In 2017, the contribution rate amounted to 2.55 per cent of gross salary[57] (up to a maximum of €3938 in 2017)[58] shared between employers and employees; people without children pay an additional 0.25 per cent i.e. 2.8 per cent of gross salary[59]. Whereas other social insurance contributions are split 50:50 between employees and employers, employees pay a larger proportion of LTCI contributions. In 2015, 70.3 million (90 percent) of the population were covered by mandatory statutory long-term care insurance[60] and about 9.5 million (11.5 percent) by mandatory private long-term care insurance[61]. Following the introduction of *Pflege-Bahr* reforms[62], Germany has taken significant steps to establish a coherent financing mix, ensure the fiscal sustainability of LTC expenditure, and provide adequate coverage to the population[63].

The federal states are responsible for ensuring that an efficient and cost-effective LTC infrastructure is provided and that the scale of offered services is adequate, as well as for the quality and efficiency of LTC institutions. It is the task of the authorities (the Federal Government, governments of the states, local authorities) to avoid disparities in support and to ensure a regular supply of LTC in every region in Germany[64]. This includes assuming the investment costs

[55] Huber and Rodrigues (2009)
[56] BMG (2008)
[57] Blumel and Busse (2017)
[58] Link (2017)
[59] From 2005, a Federal Constitutional Court decision on equal treatment of people with and without children required childless people to contribute an additional 0.25 per cent of gross income.
[60] Nadash and Culler (2017)
[61] Busse and Blumel (2014)
[62] named after the Health Minister who introduced the reforms
[63] Busse *et al.* (2017)
[64] Arntz *et al.* (2007).

of all local, state-owned, and non-profit-making care institutions and private maintenance. In addition, the *Länder* are responsible for subsidizing the building and maintenance of nursing homes and meeting other care service infrastructure costs.

Germany has had a system of life annuities (*Leibrente*) for a century, which was regulated by the civil code. These annuities were arranged between private individuals and gradually fell out of use. When they were used, they were mainly between family members, with only a few banks acting as brokers. In general, equity release schemes do not form part of mainstream financial services in Germany and are seldom used to fund LTC[65]. This is partly because restrictive planning laws impede expansion of the private housing market, and partly because the number of homeowners in Germany is comparatively low[66].

Organization and Assessment of Eligibility

LTCI funds are responsible for collecting contributions, determining eligibility, and reimbursing domiciliary and institutional providers for services provided to eligible people. LTCI funds are separate departments within the sickness insurance funds. Regional-level associations of LTCI funds (and municipalities as payers of social assistance) negotiate annually with associations of the organizations that provide professional domiciliary and institutional care services over contracts and prices. Federal law requires that private and charitable organizations are given preference over public providers in these negotiations, in order to stimulate market development and competition.

Eligibility and benefits are determined by the insurance principle that people requiring similar levels of help due to disability should receive equal treatment. People with care needs of all ages—including disabled children—are eligible. In legal terms, the 'need' for LTC (or

[65] In German, equity release products are known as *Immobilienverzehr*, which means literally 'eating your home' ('real estate consumption'). There is no specific legislation governing ERS, whether in the civil code (Bürgerliches Gesetzbuch), or in tax or other law. from reverse mortgages are not a form of income and merely amount to a loan. There are no government subsidies or promotion to encourage reverse mortgage products at the moment.

[66] Reifner, *et al.* (2009)

'dependency') traditionally referred to those who need help with ADLs and on additional IADLs. The benefits of long-term care insurance were, prior to 2013, graded into three categories of care according to type, frequency and duration of the need for care i.e., *dependency*. A new system was introduced in 2016 which retains the focus on ADLs and IADLs, but is linked to five grades of care which take account of physical, mental and psychological impairments and focuses on maintaining *independence*. Eligibility is determined by the Medical Review Board, which conducts an assessment of a person's independence in six different areas[67] – mobility, cognitive and communication abilities, behavior and psychological problems, self supply of care, dealing with requirements due to illness or therapy, organization of everyday life and social contacts – which are assigned different weights to produce an overall assessment. The new approach measures the degree of de/independency for LTC instead of the the time and frequency of support needed.

LTCI benefits are set by law, and eligible beneficiaries may choose between home care, day and night care, and nursing home care. In home care, beneficiaries can opt for a cash payment (at a lower value), in-kind professional services (worth nearly twice as much), or a combination of the two. Based on the new system, the cash value of LTC benefits are linked to the Grade of independence. Each grade is paid at one of five levels, depending on the assessed level of independence. All persons in residential care are assigned between grades 2-5. At each grade,' benefits for people in institutional care are higher than the in-kind service benefits for people at home. Beneficiaries opting for in-kind service benefits can choose between service provider organizations with which their insurance fund has agreed for the purchase of services, and they can also choose the specific service interventions they wish to receive from their chosen provider.

Levels of insurance benefits (and contributions) have fixed ceilings, so they are not open-ended entitlements determined by needs. Moreover, both benefit and contribution levels are set by Federal law, requiring amending legislation for increases in either level. Changes to the eligibility

[67] Two additional areas – activities outside the house, and household maintenance - are also assessed, but are not taken into consideration for scoring purposes.

criteria must be approved by Federal Government. Since January 2013, monetary support is intended to cover home care delivered by family members[68].

Family members serving as caregivers at home can attend training courses free of charge, and short-term care is provided during holidays of caregivers. The caregiver is also covered by statutory accident insurance and statutory retirement insurance, financed by the sickness fund administering the long-term care insurance of the person in need. There are fiscal limits for professional ambulatory services delivered on an in-kind basis. For people choosing institutionalized nursing care, benefits are available for day or night clinics as well as for old-age or special nursing care homes. Higher benefits may be granted in exceptional situations. A newer development is the option of personal budgets for recipients of professional ambulatory long-term care[69]. During the 1990s, pressures on LTCI were relatively small, compared with those on the health and pensions insurance schemes. Pressures began to build starting around 2000 due to a variety of factors, including:

- Continuing high levels of unemployment, particularly in the former East Germany, reduced the level of funds coming into the scheme. Although the unemployment insurance funds and social assistance boards pay the LTCI contributions of their beneficiaries, these were much lower than would have been paid by employed contributors.
- Expectations of population aging have continued. The dependency ratio is expected to shift from 3:1 in 2008 to 1.6:1 in 2050, with a doubling of the number of 'care dependent' people eligible for LTCI from 2.2 to 4.4 million.[70]
- The proportion of LTCI beneficiaries receiving institutional care, and therefore higher benefit, was increasing. In 2012 2.5 million (3.1 percent of the population) were entitled to benefits from social long-term care insurance[71].

[68] Gabanyi (2017)
[69] Statisticsches Bundesamt (2013b)
[70] Beske and Witton (2008)
[71] Statisticsches Bundesamt (2013c)

- There had been a small but gradual increase in the proportion of care insurance recipients opting for all or part of their benefits in the form of the higher-level in-kind service option.

Reform Pressures

Germany has been reviewing and amending its LTC system since the early 2000s**.** Both the Rürup[72] and the Harzt[73] enquiries concluded that there should be no major changes to the structure of LTCI, particularly as any changes that increased the role of social assistance in funding LTC would meet resistance from the *Länder* and municipalities. Nevertheless, both reports recommended reducing the higher levels of in-kind benefits paid to recipients in institutional care to the same level as the in-kind benefits received by people living at home.[74]

Some interim reforms were introduced between 1995 and 2005. From 2004, retired people have been required to pay their long-term insurance contributions in full, rather than these being subsidized by their pension insurance fund. In 2002, responding to criticisms that the insurance eligibility criteria were biased toward physical disability, amending legislation introduced additional benefits to support family carers of people with very intensive 24-hour care and supervision needs arising from dementia. These benefits took the form of additional funding for each beneficiary to be spent on respite care and additional advice and support services for carers of older cognitively impaired people.

The first major structural changes to LTCI passed Federal Parliament in March 2008 and came into force on 1 July 2008[75]. These changes included: (a) raising contribution rates from 1.7 percent to 1.95 percent of gross salary for people with children (of any age) and from 1.95 percent to 2.2 percent of gross salary for people without children; (b) benefits could be drawn after a minimum of two (down from five) contribution years; (c) benefit levels—both the in-kind service option for people living at home and in institutions and the cash allowance—were

[72] http://www.eurofound.europa.eu/eiro/2003/05/feature/de0305104f.htm
[73] http://en.wikipedia.org/wiki/Hartz_concept
[74] Glendinning and Igl (2009)
[75] Rothgang (2010).

increased, with the largest increases in the lower-level in-kind service option benefits for people living at home and (d) increases in levels of other benefits, including the costs respite care per annum, were also increased;

In 2012 the Federal Government of Germany published its demographic strategy[76] which included detailed analysis of aging and LTC. Shortly afterward, the LTC Adjustment Act 2013 (*Erstes Pflegestärkungsgesetz*) was passed and stipulated that as from 2014 the necessity for further adjustment to LTC should be considered every three years[77]. Adjustments were designed were benchmarked against average wage development and inflation and subjected to an overall affordability test with respect to the state of the economy. In 2015 the contribution rate of LTCI was raised by 0.3 percentage points and by a further 0.2 percentage points in 2017[78]. A total of €2.5 billion has been made available to support improvements in LTC.

A part of the additional revenue will feed a precautionary fund intended to stabilize future contribution rates. In addition, families that wish to provide care at home will be given greater support through the creation of community-based long term care centers which will be staffed by case managers who will provide persons in need of care and their relatives with advice, and organize and coordinate care services. On 12th August 2015, the Federal Cabinet passed the Second Bill to Strengthen Long-Term Care. The Act introduced a new definition of long-term care needs to the day-to-day practice setting. The Act entered into force on 1st January 2016. The new assessment procedures, based on maintaining *independence*, and changes in the benefit amounts available to beneficiaries in LTC insurance system entered into force by 1st January 2017[79]. The reforms also introduced incentives to younger people to take out private

[76] Federal Ministry of Interior (2012)
[77] Götze and Rothgang (2014)
[78] German Federal Ministry of Finance (2017)
[79] Starting in 2017, an additional €5 billion will be available annually for LTC. Furthermore, the index-linking of benefits, stipulated by law, was be introduced in 2017. This will mean that an additional €1.2 billion, approximately, was available, in early as 2017, to pay for long-term care insurance benefits. The financial situation of the LTC insurance allows for stable contribution rates, all the way into the year 2022. That is two years longer than previously estimated. In order to finance the introduction of the new long-term care need definition and the associated improvements in benefits and services, the long-term-care insurance contribution rate increased by 0.2 percent to 2.55 or 2.8 percentage points for childless persons, from 1st January 2017

(supplemental) LTC insurance products provided by health insurance companies and some by life insurance companies. Under the new LTC program the federal government provides a monthly subsidy to those buying supplemental LTC policies. Since the reforms were introduced in 2013 and additional 1 million people have taken out private LTC insurance policies.

C. Japan

Policy Context

Japan has the world's fastest aging population and highest life expectancies. In 2017, life expectancies were 80.5 years for men and 86.8 for women[80]. Japan also has the highest proportion of over 65s in the world at around 21 percent of the population, which is predicted to increase to almost 30 percent by 2025 and 40 percent by 2050[81]. In addition, the proportion of the population aged 80-plus is expected to grow more rapidly than in other industrialized countries.[82] Women represent a higher share of those needing care than men because they have higher life expectancy[83]. Because the proportion of frail persons increases sharply with age, especially in their 70s and 80s, nearly 27 percent of them are bed-ridden and need day-to-day care, and 12.8 percent need help in eating, using the toilet, and changing their clothes.

Traditionally, the care needs of the elderly, sick, or disabled in Japan were met within the family, but various factors necessitated the expansion of the public role in care provision**.** Being one of the countries with the highest proportion of elderly people (defined as those who are 65 years and older), the state provided some care services through local governments. However, its extent was limited and covered those with the most severe care needs. A number of social forces made it necessary to expand the public role in providing care. Such forces included changes in demography (aging of the society), family structure (the increasing proportion of one-person

[80] WHO (2017)
[81] Curry *et al* (2013)
[82] Izuhara (2003).
[83] Fukawa, T (2007)

households and households that include one elderly person), the labor force (increasing female labor participation)[84], and the fiscal burden on health insurance for covering long stays in hospitals – the large number of so-called "social admissions" of older people hose problems were not strictly medical.

The Long-Term Care Insurance Act was promulgated in December 1997 and two years later (in 2000), the Long-Term Care Insurance (LTCI) scheme was introduced[85]. The insurance system covers LTC of the elderly, which was previously provided partly through the health insurance system and partly by welfare measures. LTCI integrated the previously separate health insurance schemes and public welfare system. The insurer of the LTCI is the municipality government. There are two tiers of coverage: the primary insured for people aged 65 years or older and the secondary insured for persons aged 40 to 64 years. The primary insured are eligible to receive care whenever they have a need, while the secondary insured are eligible for care only for certain diseases, such as dementia, cerebrovascular diseases and articular rheumatism.

Funding

To finance the LTCI scheme, mandatory monthly contributions are raised from all of the working population. Persons aged 65 and over, classed as Category 1, have their contributions deducted from their pensions, and those aged between 40 and 64, classed as Category 2, pay their contributions through a LTCI supplement to their health insurance which is split 50:50 between employers and employees based on income. Premiums for Category 1 are subject to a means test and can be subsidized by the government. Through these mechanisms, social solidarity is maintained as every citizen and business contributes to LTCI. Premium amounts differ across municipalities. Overall, public funding for LTCI is split 50:50 between taxes[86] and income-related premiums.[87] In addition, all those using LTCI pay a standard co-payment of 10 percent of the cost of their services (excluding care management), regardless of their income level of one-

[84] Kyogoku (2007), Abe (2009)
[85] Hayashi (2015)
[86] Central and prefectural government together contribute 37.5 percent, and 12.5 percent is sourced from local municipalities' own source revenues.
[87] 19 percent from Category 1 contributors and 31 percent by Category 2 contributors.

person households and households that include only elderly persons), the labor force (increase in female labor force participation),[88] and the fiscal burden on health insurance for covering long stays in hospitals—the large number of so-called "social admissions" of older people whose problems were not really medical.

Equity release schemes do not have a significant role in funding LTC in Japan, although some programs have been introduced recently**.** Programs such as the *Chuo Mitsui* reverse mortgage product[89] make funds available only for specific purposes, such as financing LTC support services or home renovations. While most reverse mortgage plans do not require borrowers to make any payments until they die or vacate the home, some require periodic interest-only payments. The Japanese program to fund home renovations, for example, requires interest-only payments until the borrower dies or sells the home, at which time the balance becomes due. The Japanese government will also guarantee continuous and timely rental payments if an older couple agrees to rent their home to a young family that needs additional space.

Organization and Assessment of Eligibility

Eligibility criteria are set nationally but administered locally. Applicants self-refer themselves to regional public health offices and are assessed by municipal officials who administer a 79-item questionnaire focusing primarily on ADLs that cover physical and mental health. The answers are scored using a computer-based algorithm to create five categories which differentiate the type and amount of care needed. The result is reviewed by a local expert committee, alongside a report from the assessor and a doctor's report, and the final level of eligibility is confirmed. In about one-fifth of cases, the computer-calculated level is altered, usually upward.[90] Individuals are then referred to for-profit or not-for profit companies that provide LTC services. Everyone aged 65-plus is eligible, as are people aged 40-plus suffering from age-related disabilities.[91] Neither the availability of informal help nor income is taken into account in the determination. Older people receive 96 percent of total expenditure from the LTCI scheme, while people aged

[88] Kyogoku (2007), Abe (2009)
[89] Toshiro (2013)
[90] *op cit.* Ikegami (2007)
[91] Campbell and Ikegami (2003)

40-64 suffering from age-related disabilities receive only 4 percent. Funding for other disabled people aged 40-65 and those under age 40 is sourced from workers' compensation schemes, disability pensions and universal health insurance.

Benefits are all in the form of services, not cash. LTCI covers institutional care; domiciliary home help, nursing, and bathing services; day care and respite care for people living at home; home equipment and adaptations; and other services such as group homes for people with dementia. Debates prior to the introduction of LTCI focused on the respective benefits and drawbacks of cash or in-kind service benefits and their impact on traditional patterns of family caregiving, particularly the traditional responsibilities of daughters-in-law. Advocates of in-kind service benefits argued that cash payments would inhibit demand for services and therefore the supply of services, prolong oppressive care obligations and poor quality family care, and cost more because demand for cash payments would be higher. Opposing arguments for in-kind service benefits focused on the need to reduce the burden on unpaid family caregivers, particularly daughters-in-law—these arguments prevailed. The level of benefit depends on the level of assessed care need. For non-residential care, the level of benefit at each level is determined by the cost of model care plans/service packages judged appropriate for that level of care need.

Reform Pressures

LTCI costs have escalated significantly. In the first year of the scheme, only half of the estimated number of hospital beds were transferred to LTCI, so the insurance fund had a net surplus—only ¥3.6 trillion instead of an estimated ¥4.3 trillion was spent. Expenditure was expected to increase in subsequent years to ¥5.5 trillion, as demand increased and the supply of services expanded. In fact, spending rose to ¥8.2 trillion by 2011[92] because more people than expected were eligible for LTCI—some 16 percent of the 65-plus population, against an original estimate of 12 percent. Based on new revisions undertaken in 2013, it is estimated that costs of LTCI will rise to the equivalent of €120 billion by 2025[93]. To meet these costs, the government increased sales taxes

92 Shirase (2014)
93 Ministry of Health, Labor and Welfare (2013)

by 3 percent in 2014[94] which were expected to yield ¥5.1 trillion and earmarked ¥200 billon to aged care (LTC and health) - the rest was earmarked for childcare, pensions and other age related expenditures.

The increased use of services has also brought a rise in costs, in turn causing long-term care insurance premiums to increase as well. The primary insurance premium paid by primary insured persons was 2,911 yen (national average) in FY2000–2002, but continued to rise to 3,293 yen in FY2003–2005, 4,090 yen in FY2006–2008, 4,160 yen in FY2009–2011, 4,972 yen in FY2012– 2014 and 5,514 yen in FY2015–2017[95]. Concerns about rising costs and increases in contribution levels have come to predominate policy debates, as demand continues to increase as more people became aware of their entitlements. Initial reforms were launched in 2011[96] which placed greater emphasis was placed on the role of Local Comprehensive Care Centers – which provide a range of services to the elderly population – including comprehensive consultation and support services, multifaceted support services that focus on integrating health, housing and LTC services, care management, preventive LTC services – the expansion of home care services with 24-hour cover, and a more compressive form of licensing LTC providers. In addition, specific measures were introduced in 201497 to improve efficiencies in the LTC system were introduced, including: reducing the duration of hospital admissions; raising consultation fees visiting hospitals, localization of preventive services, and making eligibility requirements stricter.

Reforms to the LTC system planned for 2017-2023[98] focus on the following: (a) promoting initiatives for strengthening insurers' functions towards independence and preventions of serious conditions by strengthening the role of Community General Support Centers and by creating incentives to support community-based care; (b) strengthening the coordination between medical care services and long term care services provided under the Long Term Care

[94] Yen 100 billion was allocated to medical care reforms; Y60 billion to reduce insurance premiums; and Yen 30 billion to sibsidize people with chronic illnesses
95 Inamori (2017)
96 Act for Partial Revision of LTCI 2011 (which passed on 15 June 2011)
97 Takashi (2014)
[98] Ministry of Health and Welfare (2017)

Insurance Act and the Medical Act by combining functions that provide daily health care with end of life care and well as residential care; (c) promoting local initiatives at the municipal level to integrate – through Community Welfare Plans – services aimed at family and LTC support which will enable older people to obtain services from the service providers by 2018; (d) maintaining sustainability of the LTCI system by increasing co-payment rates by to 30 per cent for high income users of LTC.

The number of people providing LTC services reached approximately 1.33 million workers (head count) in FY2010 a sharp increase from 0.55 million (head count) in FY2000[99]. Although the number of workers has grown, LTC providers always suffer shortages of human resources to provide LTC, as the demand for services continuously increase. It is regarded as a big challenge to secure the necessary personnel, and to improve their working environment. In the context of both ageing and labor shortages significant attention is being devoted to the revision of arrangements for family care leave[100] to support employees who have to care for aging family members and the need to reduce withdrawal from the labor market. In 2016 amendments to the Employment Insurance Act and the Act on Child Care and Family Leave were introduced. The policy objective of the amendments was to reduce growing incidence of people of working age leaving paid employment to provide long-term care to their relatives. The measures consisted of (a) the option to split care leave into segments, (b) the creation of a system of exemption from overtime work, (c) the option to take time off for care in half-day units, and (d) an increased rate of care leave benefits. Amendment (d) was implemented in August 1st, 2016, and amendments (a) and (c) took effect on January 1, 2017. In addition, the period for which reduced working

[99] National Institute of Population and Social Security Research (2014)

[100] Care leave benefits were created under the 1998 amendment of the Employment Insurance Act, together with the implementation of the care leave system in 1999, and initially involved payment of 25 per cent of the pre-leave wage after the end of care leave. The system of Care Leave itself dates back to the 1995 Act on Child Care and Family Care Leave

hours are permissible as an option was lengthened to three years under a separate 2017 amendment[101].

D. The Republic of Korea

Policy Context

In July 2008, the Republic of Korea introduced *Noinjanggiyoyangboheum*, or social insurance for LTC. Planning for LTC started in 2001 when 7 percent of the population was aged 65 and older, but in a demographic context where fertility rates were declining. The population in Korea is rapidly aging; the proportion of people aged 65 years and older increased from 7.2 percent in 2000 to 11 percent in 2010. According to official predictions based on the population dynamics of declining fertility (from 6.2 in 1960 to 1.2 in 2014), increasing life expectancy[102] from 75.9 to 82.2 between 2000 and 2014, and mortality, 14.5 percent of Koreans will be over the age of 65 in 2018, increasing to 20.8 per cent by 2026[103]–which means that the speed of population aging is projected to be higher than the most OECD countries[104]. These demographic changes have been accompanied by changes in family patterns, with more than 50 percent of older Koreans either living alone or with their spouse, the highest suicide rate (55 per 100,000) among OECD countries, and the head of one in five households aged over 65. Traditionally, older Koreans had lived with their adult children[105], but this steadily decreased from 38 per cent in 2008 to 29.2 per cent in 2016[106].

Korea's introduction of LTCI was linked to the expansion of social protection and health measures. The social protection measures (including pensions, unemployment insurance, and a

[101] Ikeda (2017)
[102] Although life expectancy at birth has reached 77 years for men and 84 years for women, there is an 11year difference between life expectancy and healthy years. This means that older adults endure chronic illnesses for years
[103] Kang *et al* (2012)
[104] Jeon and Kwon (2017)
[105] Glavin and Ejaz (2017)
[106] Statistics Korea (2016)

minimum income guarantee regardless of age or ability to work) and health measures (including the merger of over 350 insurance societies into a single insurance fund) were initiated by President Kim Dae Jung who became president in early 1998[107]. Following 14 months of analytical work conducted by the Planning Committee for Elderly Long-Term Care (PCELTC) and the Korea Institute for Health and Social Affairs (KIHASA)[108], LTCI with a tax subsidy was seen as a comprehensive solution to addressing cost containment of health insurance and inappropriate use of hospitals to provide social care services. Particular attention was paid to the experiences of Japan and Germany.

The policy attention devoted to LTC was based on the consensus among policy makers that addressing future aging problems were a higher-order priority than addressing current social problems. LTCI also had broad support among the public and the government's political opponents. In 2004, the final plan for the LTCI scheme was submitted to the government, and in 2006, the LTCI program was submitted to the legislature. The law was passed and signed into law in 2007. The number of eligible beneficiaries has consistently increased since the introduction of the LTCI scheme from 146,643 persons in July 2008 to 341,788 persons in December 2012[109] and to just under 500,000 in 2016[110]

Financing

The LTC system has four financing sources which incorporate some aspects of the German and Japanese approaches.[111] The four principal components of the system are based on: First, contributions from all participants to the National Health Insurance system - contributions to LTC insurance are determined as a fixed percentage (currently 6.55 percent)[112] of the health insurance contribution; contributions by the self-employed and farmers are decide by composite scores reflecting the individual's income, property and other assets. In other words,

[107] Kwon and Holliday (2007).
[108] See: https://www.kihasa.re.kr/html/jsp/english/main.jsp
[109] Korean National Health Insurance Corporation (2012)
[110] National Heath Insurance Service (2016)
[111] *Op cit.* Kwon (2008)
[112] Kwon *et al* (2013)

anyone who pays health insurance contributions also pays LTCI contributions. Second, the government supplements LTCI contributions with additional funding from general taxes, which represents 20 percent of anticipated contribution receipts. Third, the state and local government subsidize the full contribution for those eligible for social welfare benefits (called the Basic Livelihood Security Program). Finally, coinsurance is set at 15 percent for costs for home care and 20 percent for institutional care services[113]. The type of long-term care benefits consists of community-based home care and institutional care. Home care includes home-visit care, home-visit bathing, home-visit nursing, day/night care, and short-term respite care. For example, home-visit care includes physical support and household work provided by trained personnel in the beneficiary's home. Institutional care includes services provided to beneficiaries admitted to long-term care facilities for the elderly (excluding geriatric hospitals), with nursing care and assistance to maintain and enhance physical or mental functions

Similarities of the Korean LTC system to the Japanese and German LTC systems can be observed in the following attributes:

*Similarities with Japanese approach***:**

- Benefits are restricted to people aged 65 or older and some younger people with an aging-type disability such as dementia, cerebrovascular disease or Parkinson's disease (although not only to such people aged 40 or older, as in Japan).
- Financing comes from both a new social insurance contribution, collected along with health insurance, and from tax revenues.
- Eligibility and level of need are assessed through statistical analysis of a questionnaire linked to ADLs. The assessments are reviewed by a locally appointed committee.

Similarities with the German approach:

[113] Rhee *et al* (2015)

- Administration is by social insurance agencies, and local governments have no role in the process.
- Recognized LTC needs categorized into levels - Korea recently increased the levels from three to to five in 2014.
- There is provision for a cash benefit as well as services in-kind. However, the cash-benefit option can be used only in exceptional cases.
- There is strong concern about control of expenditure, although this is set out as an object of policy rather than fiscal caps written into law.

LTC insurance provides largely in-kind services and only in exceptional cases, for example when no providers are available in district or region. Benefits depend on the level of functional limitation determined in the assessment process, which is described below. There are ceilings on the benefits for non-institutional care, ranging from USD1,298-USD1,824 per month depending on level of need; and USD1,015-USD1318 for residential care. Monthly limits are calculated according to the care need levels and type of benefits provided. The beneficiary can use more services than covered as long as one pays all the costs for the services beyond the maximum level. The type of payment to providers varies from pay per hour for home care, pay per visit for home nursing and baths, and pay per day for institutional care and day/evening care.

Equity release schemes are in their infancy in the Republic of Korea, although interest has been increasing. In the wake of recent parametric reforms to the pension system—which brought about drastic cuts in benefits—and fiscal pressures brought about by age-related spending, interest in equity release schemes is growing rapidly.[114] It is anticipated that the nascent reverse mortgage system might be able to complement the general pension system by serving as a constant old age income source after retirement without concerns over securing housing finance. The activation of a reverse mortgage system is seen to hold potential as an additional old age income source, based on the fact that over 80 percent of total assets possessed by people aged 60 and older are in real estate, and 74.3 percent of the elderly have their own houses.

[114]ADBI (2009)

Organization and Assessment of Eligibility

The uniform premium and benefit package of Korean LTCI are a heritage of its centralized, single-payer health insurance system. The National Health Insurance Corporation (NHIC) administers LTCI alongside health insurance. Path dependency also affects the financing mix: LTCI in Korea is not a pure social insurance scheme, but financing from contributions has a greater role than tax subsidies. As in the case of health insurance, the Ministry of Health Welfare and the Family (MHWF) plays a key role in the policy for LTCI and tightly monitors the insurer.

Following the introduction of LTCI, the number of (private) providers in the LTC sector has increased rapidly from 2,600 to 5000 institutions and 11,900 to 12,900 home based care agencies between 2009 and 2016. The number of care workers and nurse aides has also increased dramatically. For example, the number of care workers increased from 176,500 to 301,700 and the number of nursing assistants increased from 4,200 to 9,700 between 2009 and 2016[115]. LTCI provides coverage for LTC for the elderly (aged 65 or above) and age-related LTC of those younger than 65 years old. It is a political compromise because everybody is expected to pay contributions and everybody is eligible when he/she has LTC needs due to age-related health problems, and the system is designed in a manner that the population under 65 years of age is much less likely to access LTCI benefits. This is because the system does not provide coverage for disability-related LTC. The priority is on the social care aspects of aging and related problems, rather than aiming to solve problems related to the medical aspects of aging. The population coverage of LTCI increased from 2.9 per cent to 7.2 per cent of older people between 2008 and 2016[116].

In contrast to health insurance, individuals need to obtain prior approval for LTC services through an assessment of functional limitation that takes account of physical, cognitive, behaviors, nursing care and rehabilitative characteristics. Visiting teams from branch offices of the NHIC: National Health Insurance assess the functional status for eligibility[117], using 56 evaluation items.

[115] *op cit.* National Health Insurance Service (2016)
[116] *ibid*
[117] An assessment committee in the regional offices of NHIC consists of 15 members, including a social worker and a medical doctor.

Prior to 2014, 3 levels of functional status/limitations based on the ability to perform ADLs - which were categorized as Level 1 (most severe and who are wholly dependent on other people), Level II (severe, and who have significant need for the help of others) and Level III (moderate, who have some need for the help of others) - which lead to different amounts of benefit levels. In 2014 two more levels of functional status were added to address the population with dementia (who are are designated level five)[118]. The number of older people with dementia was estimated to be 540,000 in 2012, with a prevalence of 9.2 percent, and projected to double every 20 years, increasing to 1.27 million (10 percent) in 2030 and 2.71 million (15.1 percent) by 2050[119]. The rapid aging of the population in Korea is expected to have a major impact on future dementia prevalence, given that age is a major risk factor for dementia. The trend in the increase in dementia cases is expected to outpace the increase in numbers of the older population, foreshadowing an epidemic of dementia

Reform Pressures

The introduction of LTCI and tax-financed LTC is a major change in the Republic of Korea's social protection system. LTCI is anticipated to have a big impact on the health care system because the elderly account for a large share of health expenditure and for social admissions to hospitals[120]. The proportion of institutional care, as percentage of total LCTI expenditure, increased from 43.3 per cent to 51 per cent whereas expenditure for home care decreased from 56.7 per cent to 48.7 percent between 2009 and 2015[121]. This trend suggests that coordination between health insurance and LTCI will become a key challenge in the context of the need to develop a continuum of care and in striking a balance between prevention, rehabilitation, and re-ablement LTC services, particularly for addressing physical and mental health-related disabilities[122]. Benefit coverage of LTCI will need to be coordinated with that of health insurance, particularly in the context of determining out-of-pocket payments across

[118] Lee (2014)
[119] Ministry of Health and Welfare (2012)
[120] Kwak (2017)
[121] *op cit.* National Health Insurance Service (2016)
[122] Choi (2015)

health and social care services. Relative generosity of the payment to LTC hospitals (paid by health insurance) and to LTC social care institutions (paid by LTCI) will also affect provider incentives if the risk of clients with high needs being denied services is to be avoided.

One of the major organizational barriers in linking services between LTC and healthcare is the indistinct role between geriatric hospitals and LTC facilities (nursing homes)[123]. In principle, health insurance is designed to provide medical services benefits, whereas long-term care insurance provides for care services that go beyond acute medical needs to include social services and personal support. However, it has proven difficult for the system to distinguish between the two needs in older people because they often exhibit needs that require both health and long-term care simultaneously. As older people's needs for both health and long-term care increase, excessive or even redundant use and provision of services may arise due to the current disconnection between the two systems. Moreover, the disabled elderly may not be able to identify and express their needs explicitly such that selection of and linkage with the appropriate combination of health and long-term care services may not be feasible. It is, therefore, important to construct an integrated delivery system that provides coordination between long-term and healthcare services. Over the past decade, there has been a steep rise in the number of geriatric hospitals, also known as long-term care hospitals. These provide inpatient chronic care and rehabilitative services for geriatric patients who have conditions such as stroke and dementia. Geriatric hospitals are managed through the national health insurance system, while long-term care facilities operate under the LTCI. The unclear role between the two institutions is manifested in their similar patient composition, with dementia and stroke being the most prevalent conditions.

Local government in LTC has been primarily restricted to financing the long-term needs of the poor (through the public assistance program) and the regulation and certification of LTC providers. Going forward, LTC policy is expected to provide greater support to local governments in order to help facilitate effective coordination between LTC and other social welfare and social

[123] Sunwoo (2017)

assistance services. Moreover, given the high variability across LTC institutions and services providers, quality of care is likely to become critical issue, as will differentiation in payment systems for different types of LTC services. Workforce planning is also a concern, given the diminishing size of the working-age population.

The Republic of Korea has seen one of the highest levels of increase – among all OECD countries - in public expenditure in health and LTC. Between 2005-2013 expenditures on health and LTC increased by 36 percent; and the annual growth rate in LTC in real terms was 36 percent for residential care and 57.2 percent for home care[124]. The Republic of Korea's total LTC expenditure is predicted to continuously increase from around 2.6 percent of GDP in 2020 and reach 4.5 per cent of GDP in 2050[125].

The performance of the LTCI shows that the at-home care system needs to be strengthened in order to ensure the long-term financial sustainability of the LTCI and reduce the regional inequality in access to available service resources. Options for containing costs include changing the paradigm of LTC - which currently focuses on maximizing functional abilities – to one that focuses on prevention-oriented LTC and a reorientation toward supporting independence. For example, by not only supporting the provision of intensive care for serious illnesses but also supporting the prevention of diseases and the management of minor illnesses. To this end, community-based care services – akin to those in Germany and Japan – need to be given consideration.

[124] OECD (2015b)
[125] Kim (2015)

Chapter III: The Universal Model: Denmark, Finland and Sweden

Policy Context

The Nordic countries of Denmark, Finland, and Sweden share a common history and political traditions, leading to very similar systems for social care and LTC. All three countries pursue the general goal of providing LTC services free of charge to everyone in need, independent of financial circumstances[126]. Up until the first half of the last century, LTC in all Scandinavian countries was provided almost exclusively by families. Public involvement in LTC evolved from being aimed at the poor elderly to a more universal approach after the 1940s – initially in Sweden, Denmark and Finland, and later in Norway.[127] Population aging[128] across all three countries is also similar with the population aged 65 plus projected to increase in Denmark from 18 percent of the total population in 2014 to 25 percent by 2050, in Sweden from 19 percent in 2014 to 24 percent 2050, and in Finland from 19 percent in 2014 to 26 per cent in 2050. Over the same time period projected life expectancy for the population aged over 65 will increase. in Denmark life expectancy will increase from 17.5 years in 2013 to 21.3 years in 2050 and for women from 20.2 years to 24.3 years; in Sweden life expectancy for men will increase from 18.6 years to 21.9 years and for women from 21.1 years to 24.7 years; in Finland life expectancy for men will increase from 17.8 years to 21.5 years, and for women from 21.4 years to 24.9 years

Financing

In Denmark, Sweden, and Finland municipalities are responsible for financing and providing LTC. The costs of providing LTC are financed out of general income taxation; most of it from local income taxes, whereas national governments are responsible for overall control and for establishing the broad legislative and financial framework health and social care, including LTC services for the elderly. The national government also transfers some earmarked grants aimed

[126] Given the similarities between the LTC systems in these three countries, Denmark is used to provide an in-depth description of the organisational and arrangements of LTC under a universal system of care.
[127] Antonnen and Sipilä (1996).
[128] European Commission (2015)

at LTC for the elderly. To compensate for regional differences, there is an equalization grant that aims to redistribute revenues among local governments.[129] Expenditure on LTC in 2015[130] is among the highest among advanced economies: Denmark allocated 4.8 per cent of GDP; Sweden 3.6 per cent of GDP[131], and Finland 1.8 per cent of GDP.

Organization and Eligibility

Denmark

Denmark adopted an explicit policy of community and home-based care for the elderly in the early 1980s. This policy was accompanied by the development of extensive services to support disabled and older people outside of institutional settings. Thus, no new residential facilities have been established since 1987. In Denmark, LTC falls under social care and is the responsibility of 98 local municipalities[132] with regard to both provision and financing. Health services, on the other hand, are financed and managed at the regional level. The rules on long-term care are part of the Consolidation Act on Social Services (CASS).

Local authorities provide care for the elderly based on the general principle of free and equal access to the assistance offered. They finance the costs of LTC through local taxes and block grants from the state. Any person who is lawfully resident in Denmark is entitled to assistance under the Consolidation Act on Social Services. They are eligible to receive personal care and help with practical duties, irrespective of age, income or wealth. There are no minimum requirements in impairments to receive personal and practical help. In general, assessments have to be multidimensional and have to take into account all aspects of the individual's well-being, i.e. functional ability, welfare, life content, home conditions and possibilities of self-determination, but also include a review of medication, rehabilitative support, visitation and referral to specialist or other health care professionals. Functional impairments are assessed using the Barthel index.

[129] Karlsson et al (2004)
[130] European Commission (2015), OECD (2015a).
[131] With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing, from 3.6 percent in 2013, to 5.1 percent in 2060.
[132] Prior to reforms initiated in 2007 there were 275 municipalities and 16 counties. The counties were transformed and consolidated into 5 regions.

After an individual assessment services are provided, even if the services required are for less than 2 hours per week[133]. Since 1996, everyone aged 75 and older is entitled to at least two preventive visits annually from a case manager employed by the municipality in order to evaluate individual needs, and assist with planning for independent living.

Preventive home visits to older people have been introduced. The introduction of such visits did not command specific guidelines on how to carry out the visits. Thus, there are significant variations between municipalities in how the law is implemented. Home care services are the most common services. Homecare services are targeted at seniors who live at home but who are unable to manage everyday life without help. Citizens are both entitled to practical assistance (e.g. cleaning and laundering) and personal assistance (e.g. bathing or shaving). In 2013 over 160,000 persons received permanent home help in their own home, while 88,197 were in various types of residential care institutions[134].

Since 2002, people are entitled to choose a private or public provider of practical assistance and, since 2003, also providers of personal care. Personal budgets were introduced for a limited trial period in a small number of municipalities. The user is allocated the cash equivalent of the services s/he is assessed as needing. Responsibilities for purchasing services, ensuring quality care and administering the budget rested with the user. The budget could be used to purchase municipal or privately provided services and could also be used to pay relatives for providing care. However, even where the personal budget option existed, take-up was low and users tended to be mentally able. There are no plans to extend this pilot scheme.

LTC work is characterized by permanent contracts, and it is generally part-time (30 hours a week). There is a high turnover and 30 percent change job every year[135]. Elderly care is demanding both

[133] Denmark has a broad definition of "need for assistance" and leads to a high percentage of people receiving less than 2 hours' permanent help per week. In 2012 around 50 per cent of the elderly received up to 2 hours help, around 11 per cent between 2 hours and less than 4 hours help, and another 11 per cent between 4 hours and 8 hours of help.
[134] Kvist (2014)
[135] Schultz (2014)

physically and emotionally. The level of sick absenteeism is about three times as high as it is for employees on average, and care workers have a 61 per cent higher risk of requiring early retirement. As the work tasks are determined, care workers feel to have a low degree of influence over work tasks. Low wages and gender wage differences have led to strikes[136]. In 2012, there were 150,600 full time persons working in care and nursing which encompass home care, institutional care, rehabilitation, residents for adults, 24 hour institutions for children and youth with special needs and various daytime offers. 131,400 employees work with care, nursing and pedagogical activities and the rest with cleaning, cooking and administration. By far the largest share of persons working in the long-term care sector are social and health assistants who work 30 hours a week. They amount to 67,600 persons out of a total of 131,400 full-time persons in LTC.

LTC Reforms have been slow to emerge: In the context of the financial crises and with the challenges posed by an ageing population two Commissions have, in recent years, been established to review LTC. The first commission, *The Elderly Commission*, started its work in January 2011 and published its main report with 43 recommendations in February 2012. The second Commission, *The Home Care Commission,* was established in June 2012 by Parliament. The second Commission published its main report and 29 recommendations in June 2012. The outcomes from these Commissions has resulted in stricter monitoring by central government of of municipal finances, and generally more prudent management of resources by municipalities. Taken together these reforms have contributed to: de facto retrenchment in home help with fewer people receiving fewer hours of home help; the continued expansion of home based solutions, including elderly housing, preventive home visits and earlier training and rehabilitation. In addition, rehabilitation and engaging citizens in meeting their own needs and making them more autonomous in general is reflected in both health and long-term care policy changes. More recent policy reform efforts[137] are focusing on:

[136] Hohnen (2011)
[137] European Commission (2016e)

- "Future Home care" which aims to strengthen municipal rehabilitation efforts and the services they provide to frail, elderly people.
- Transparency reform – with a greater focus on quality and results. The aim is to create greater and more systematic knowledge about quality and best practice, improving accountability as well as achieving better management of the health care and long-term care system based on improvements in the overall health of the population, a high level of patient involvement and lower expenditure per capita. The accessible health data should provide a platform for transparency and dissemination of best practice as well as management and priorities in the health care sector on the basis of key goals and results.
- Stronger health care agreements – which include new mandatory key action areas and specific objectives. Furthermore, across the boundaries of health and LTC, the care agreements aim to ensure focus on inequality and the active involvement of people in need of health and LTC services and support for their relatives. The overall aim of the care agreements is to ensure coherence and coordination of efforts across hospitals, general practice and municipalities so that citizens receive support that is consistent and of high quality at the lowest effective cost.

Equity Release

Denmark has a number of unique features which are reflected in the fact that specialist mortgage banks have 90 per cent of the mortgage market in, and most mortgage loans are with a fixed interest and carry no prepayment penalties, a feature that is virtually unique in the EU and largely due to loans being funded via callable bonds (meaning that if borrowers pre-pay their loans the credit institutions can repay bond investors)[138]. Through the long-standing tradition as financial market players specialized in the granting of long-term loans against mortgages on real property, the mortgage banks have achieved a central position in the Danish economy. The significant dual role of the mortgage bonds - as an effective funding instrument on the one hand, and a secure investment on the other - has given the bonds a central positioning the Danish capital market.

[138] *Ibid.*

Although loan products exist where disbursement takes place in installments, these are so insignificant that no distinctive equity release scheme exists. In fact, financial products in Denmark are so flexible that they can also be used for equity release purposes without having to be designed to it specifically. In practice, all homeowners may raise loans against mortgages on real property only based on creditworthiness and the loan-to-value in question. Softer requirements are imposed on consumers the lower the ratio and has led older people to mortgage their homes for the purpose of equity release by way of an ordinary mortgage regardless of purpose.

Reform Pressures

The Nordic systems for financing LTC are remarkably similar, and the institutional set-up is almost identical in all three countries. Differences between the three countries are notable only the emphasis of different types of services, or in details concerning the design of schemes for user charges. However, LTC is a domain of social policy where two fundamental principles of the social democratic model appear to collide – reconciliation of universalism with the political tradition of strong local self government autonomy. Thus, the models practiced for financing LTC are based on a compromise between these two general principles – municipalities have some degree of autonomy in designing local policies, but national governments intervene to assure that the conditions are comparable throughout the countries. At the same time the approaches have in-built sub-optimal outcomes – from an efficiency point of view – since in none of the countries do municipalities have the main responsibility for health care which has resulted in local and regional authorities attempting to 'dump' costly needs on each other.

Across all three countries, policy reforms on LTC are bound up with systems of multi-level governance. Reforms have focused on:

- The balance between centralized and decentralized functions across different types of LTC services in order to maintain aggregate fiscal discipline and improve allocative efficiency and technical efficiency
- The introduction of consumer-style choice into what have hitherto been traditional Nordic welfare model(s) of extensive, publicly-funded and publicly-provided services
- The introduction of market mechanisms of user choice to stimulate the development of new service providers, particularly providers who are able to provide personal care as well as domestic help
- The reform of sub-national government which have responsibilities for providing most of public services, like healthcare, long-term care, education, social and cultural services. Consequently, they account for the majority of general government employment and they largely determine the overall public sector employment trends. Wage costs account for about a half of municipal expenditures.
- Currently, most progress has been made in forming larger municipal entities. The smaller municipalities are obliged either to merge with other municipalities or alternatively to form municipal partnership areas (joint municipal boards). However, as the largest municipalities account for larger segments of population and expenditure, attentions not only focused on mergers per se, but on service reforms in the biggest municipalities that determine the overall outcome of optimizing LTC services.
- Reform of taxation and block grants given that local tax rises have been commonly used to finance municipal expenditure pressures for LTC, and local governments have the legal right to set the municipal income tax rate without any limitations and mortgage taxes within certain nationally defined boundaries. Almost half of local government revenues come from municipal income tax.

Chapter IV: Means Tested Systems - United Kingdom and the United States of America

A. United Kingdom

Policy Context

The aging process in the United Kingdom is not as severe as in many other OECD countries. This does not, however, imply that old-age dependency in the UK[139] is not gradually increasing, but that the aging processes of the population is progressing at a slower rate. According to official projections,[140] the number of people aged over 85 years, will more than double by 2033 and reach 3.2 million inhabitants, and the number of people aged over 100 will quadruple. Life expectancy at 65 years is also increasing[141]: in life expectancy at birth for men is 79.5 years and for women it is 83.1 years[142]. By 2050 life expectancy at 65 is forecast to be 21.9 years for men and 18.9 years for women. Evidence suggests that although life expectancy is increasing,[143] disability free life expectancy is not increasing at the same rate, meaning more people are living into older age with multiple long-term conditions, frailty, dementia and social care needs[144]. People are spending a longer time living with conditions that seriously reduce their quality of life, such as arthritis, the effects of a stroke, or dementia. Current trends in obesity and other lifestyle-related diseases are also expected to increase the future demand for LTC[145]

Since the 1980s, there has been a shift from LTC services that are free at the point of delivery to services that are means-tested, as long-stay hospital provision declined and residential care and nursing home provision increased. There has been a long history of policies that aim to improve co-ordination between health and social care services. Recent policy developments –

[139] Under the system of devolved government England, Scotland, Wales and Northern Ireland have different systems for the provision of LTC in the UK. This chapter will therefore refer to the 'UK' when referring to all the countries, and to 'England' when referring to the latter.
[140] Office of National Statistics (2009).
[141] European Commission (2015)
[142] Public Health England (2017)
[143] Humphries *et al*. (2010).
[144] Mortimer and Green (2016)
[145] ILC (2016)

particularly in England, have sought to promote collaboration across the boundary between health and LTC (also referred to as 'adult social care' in the UK), mainly at the local level, with the introduction of primary care trusts, pooled budgets and joint appointments. The *Health and Social Care Act 2012* provides for widespread reform of the health system in England, and the *Care Act 2014,* which came into force in 2015. The government planned to introduce major reforms in April 2016 to both LTC in England and pensions across the UK. However, in 2015 a decision was made to postpone to 2020 implementation of reforms to the LTC system[146].

The *Care Act 2014* contains crucial reforms in law for the care and support of individuals in England. The Act is person-centered, and local authorities (LAs) instead of promoting certain types of care, now have a legal responsibility to promote individual wellbeing when exercising a care and support function; are required to ensure that people should not fit into available social care, and that social care must be tailored for the individual. The Care Act establishes a set of national eligibility criteria which sets the minimum threshold of needs for local government support. The Care Act also establishes *Deferred Payment Agreements* (DPAs) whereby a person, subject to having eligible needs and a means test of non-housing assets, can delay paying for their residential care for a period of time, which can be the entire length of their stay, with local authorities covering the cost[147]. DPAs are designed to prevent the worry of having to sell homes promptly at a time of potential distress. In addition, the Act prevents individuals from losing their support for care if they move between LA areas; an individual can move between LAs and their LTC will continue at its current level until the new local government has assessed them. All of these changes will have implications for the future funding of LTC.

Funding

Health and social care both have separate budgets. Under the system in England a distinction is made between the health and social components of LTC, with the former providing universal

[146] Hancock et al (2016)
[147] See: http://www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6522542/ARTICLE

access to health services which are provided 'free' at the point of delivery and the latter providing a means-tested 'safety net' mechanism for people on low incomes and with few assets. The health services (under the Department of Health) are funded by central taxation and national insurance contributions (NICs) while the primary providers of LTC are LAs with the Department of Health setting policy. LTC is financed from both central government block grants and own source revenues (OSR) which is raised through local taxes and user charges.

The formula for funding local government is designed in such a way that an area wanting to increase its spending on LTC can do so at its discretion. LAs have to finance any increase in LTC expenditures from local taxes and charges—a system known as 'gearing', which is intended to keep costs down. Individual contributions for LTC costs are significant and can take the form either of co-payments or the private purchase of services in the market. Older people can apply for public care services at the local level and, after a needs assessment conducted by the local authority social services department, a package of services or a CfC allowance (also know as 'Individual Budgets' which allow care recipients to commission and purchase their own care) is defined and allocated to the user. However, variations among different local authorities are widespread.

LTC services arranged by local authorities attract user charges depending on the user's financial means (except for nursing costs in nursing homes and, in Scotland, nursing and personal care). Older people may also arrange and pay privately for their own residential or home care without involving a local authority. Total adult social care expenditure on older people in 2014-15 England amounts to over GBP 39.5 billion[148] - this includes some GBP 10.0 billion expenditure on short and LTC services provided to people aged 65 years and over by 152 local governments[149], GBP 14.7 billion on the Disability Living Allowances (DLA)[150]; GBP 5.6 billion on Attendance

[148] Brown and Hood (2015), National Audit Office (2014).
[149] Health and Social Care Information Centre (2015)
[150] The DLA has been phased-out and replaced with Personal Independent Payment (PIP) to cover long-term ill health or disability and is is designed to cover extra costs associated with these conditions. The PIP is divided into two components a mobility component and a daily living component. Eligibility is based on assessed needs

Allowance (AA)[151], and GBP 2.4 billion on Carers Allowance (CA)[152]. Some aspects of spending on LTC allowances are targeted at other population groups, but the bulk of spending is on older people. Expenditure by LAs on all adult social care services including those aged 18-64 years and those aged 65 years and over amounted to GBP17 billion - which represents a 1 percent decrease in cash terms and 3 percent in real terms compared with 2013-2014[153]. In 2013-2014 LAs raised over GBP 2 billion from users of LTC in co-payments and user fees. Aside from the formal LTC system, it is estimated that there are 5.4 million unpaid informal carers who provide LTC with a value of GBP 55 billion.[154]

LTC insurance has a poor track record, suffers low take up, and equity release schemes have been slow to take off. Only a very small number of people - 23,000 - had private long-term care insurance in 2013[155], an increase of only 1000 above the level holding such policies in in 2007[156]. The advent of DPA's, under the Care Act of 2014, is likely to further dampen the demand for LTCI and reduce the utilization of equity release from housing owned by older people to pay for LTC.

Organization and Eligibility

In England the LTC system involves numerous institutions, which make integration very challenging. But the systems are changing. The system involves mostly social care services (or their cash equivalent), run by LAs and overseen by the Department of Health. Health care services (also run by the Department of Health), while cash payments (such as Carers Allowances for people who provide care; Attendance Allowances for people who receive care, and Personal Independent Payments for people who have long term ill-health or disabilities) by the Department of Work and Pensions, and housing, which is also a Local Authority

[151] The AA is divided into two categories depending on needs: a day-time only cash allowance; and night and day cash allowance.
[152] CA provides a weekly cash benefit for the provision of 35 hour of care by a relative – if the person earns less than a fixed threshold. The CA is designed as proxy measure to compensate for opportunity costs of lost income rather than as wage for the provision of informal care.
[153] ADASS (2015)
[154] NAO (2014)
[155] Association of British Insurers (2014)
[156] Association of British Insurers (2010).

responsibility falls under the Department of Communities and Local Government. In the wake of recent policy and legislative changes integration between the different areas of responsibility has become of paramount importance in the wake of large numbers of older people being admitted, as emergencies, to hospital which cost the NHS GBP 12.5 billion in 2012-2013. In 2013, the *Better Care Fund* was established with a budget of GBP 5.3 billion to increase the integration between health and LTC. In 2015/2016 the *Better Care Fund* budget had increased to GBP 5.9 billion, but is projected to fall to GBP 5.12 billion in 2017/2018 and increase slightly to GBP 5.6 billion in 2017/2018[157]

LAs operate a system of public funding that provides state-funded LTC services to those with assets below a threshold level. LA provided services are often subject to charges. Under the Care Act of 2104, the intention is to maintain the existing position which is that LAs may not contribute towards the cost of care and support in a care home where the adult has more than GBP 23,250 in capital. The value of a house is included in the means-testing asset assessment if the older person is moving into a residential care home [and no partner or qualifying person remains living there], but not for home care.

The means-testing system relates charges to ability to pay. For those receiving state support in residential care homes, the local authority takes all income [including pension and benefits] apart from a minimal weekly personal allowance. An older person receiving LTC in their own home is usually asked to pay charges so long as this does not reduce their net income below a certain level, which is linked with the pension credit system. Thus the amount of LTC support any individual person actually uses in the care system depends on assessed according to national eligibility criteria[158]. The national eligibility criteria do not focus or examine on what needs an individual has, but whether they are unable to meet certain outcomes and, if so, whether this has a significant impact on their wellbeing. This ensures where a person has eligible needs their care plan is developed, with their input, to meet the outcomes they want to achieve. Local authorities then set a needs-eligibility threshold; people with needs assessed at below this

[157] Department of Health (2017)
[158] See National Eligibility Criteria - http://www.legislation.gov.uk/ukdsi/2014/9780111124185

threshold do not receive support. Under the Care Act 2014, a life time cap was introduced. This means that no one will have to pay any more for their eligible LTC care once they spent their own resources up to maximum limit. The cap applies to the cost of care that people receive in their own home or if they are living in residential care. The introduction of these reforms have now been postponed till 2020. If these reforms had been implemented in 2016, as originally planned prior to postponement, the cap would have been GBP 72,000 and the upper capital limit would have been GBP 118,000 for residential care, and GBP 27,000 for home care[159]

A Financial Advice Market Review launched in 2015 to assess the way companies provide and market financial advice. In parallel with the reform of LTC under the Care Act of 2015, and recent pension reforms, the government launched a review to explore ways in which government, industry and regulators can take individual and collective steps to stimulate the development of a market to deliver affordable and accessible financial advice and guidance to everyone – including the growing number of older people with low incomes and savings. The Review, which submitted its report in 2016[160], explored the supply and demand sides of the market for financial advice and guidance on a range of products (including pensions, LTC insurance, and housing wealth), the barriers to providing financial services and the potential remedies

Reform Pressures

Prior to the Care Act 2014 consecutive governments attempted to reorganize LTC in order to introduce greater user control over the composition, timing and flexibility, and responsiveness of services and to cut costs. The assumption was that market-driven LTC services funded by local authorities (and increasingly also by individuals funding their own LTC entirely from their own private resources) but provided by a range of charitable and for-profit organizations would bring about greater flexibility, responsiveness and better 'value for money.' Also, during the 1980s and

[159] Wittenberg (2016)
[160] HM Treasury (2016)

1990s, the rhetoric of user involvement in service design and delivery encapsulated by the term 'co-production' enjoyed increasing popularity among policy makers.

In the early 2000s a policy of "personalization" across the whole of public services, placed an emphasis on choice and control. In the area of LTC this was reflected in the expansion of direct payments to more user groups and Individual budgets (IBs). Another important development was the Health and Social Care Bill 2008,[161], which brought together existing health and social care regulators into one regulatory body, the Care Quality Commission (CQC)[162], with tough new powers to ensure safe and high quality services. As a result of the merger, the CQC redeveloped its approach to inspection and performance review. The CQC also brought the performance framework together for health and LTC into the outcomes and accountability framework and developed joint health and LTC indicators[163]. To complement the work of the CQC, the government also established the Social Care Institute for Excellence (SCIE)[164] – which promotes good practice and service improvements across the LTC system

The Care Act 2014 recognised that the previous system did little to reward prudent financial management and forward planning. It therefore sought to mitigate people's fear that with no limit on LTC costs, every pound people saved could potentially be used to pay for care costs. The previous system therefore created uncertainty for all, and fear and distress for the worst affected, who also tended to be the most vulnerable and frail. Those who have saved throughout their lives, under the previous system could lose almost everything, including their house. The 2014 Care Act has been introduced under challenging fiscal conditions and it remains to be seen – when there have been 5 years of funding reductions totaling £4.6 billion and representing 31 percent of real terms net budgets – how the ambitions and provisions are implemented. In 2020 there are plans to introduce substantial reforms into the system. The key change is the introduction of a lifetime cap on an individual's ability to pay towards their care costs. To benefit

[161] Department of Health (2008b).
[162] See: http://www.cqc.org.uk
[163] CQC (2015)
[164] See: http://www.scie.org.uk

from a life time cap, a person will have to be assessed by a LA as having eligible care needs. The LA will then calculate those needs and keep track of the cumulate amount of those costs through a person's 'Care Account'. Until their Care Account reaches the cap, the LA will apply a means test to determine how much the person must pay towards the costs of their assessed needs. Once the cap is reached, the state will meet the costs of their eligible care needs without a means test

B. United States of America

Policy Context

The growth rate in the retired and elderly population in the USA will outpace general population growth within the next 50 years. LTC needs are closely linked to age, and demand for LTC services and support[165] will increase dramatically in the years to come. There will also be fewer working adults to support the aged, especially those aged 85 and over whose needs for long-term care increase dramatically. The older population – classified as person 65 years and older – numbered 47.8 million in 2015 (the latest year from which data is available) – this represented 14.9 percent of the population[166]. By 2050, there will be about about 94 million persons, more than twice their number in 2013, and by 2040 people aged over 65 are expected to grow to 21.7 percent of the population[167]. At the the same time, family sizes will be smaller than they are today, and fewer older people will be married in 2040. This decreases the total resources available to older

[165] In the USA LTC is commonly referred to as "Long Term Services and Supports" (LTSS). The US Congress *Long Term Commission* (2013:1) defines LTSS "as assistance with activities of daily living (ADLs, including bathing, dressing, eating, transferring, walking) and instrumental activities of daily living (IADLs, including meal preparation, money management, house cleaning, medication management, transportation) to people who cannot perform these activities on their own due to a physical, cognitive, developmental, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more. LTSS include such things as human assistance, supervision, cueing and stand by assistance, assistive technologies, workplace supports, and care and service coordination for people who live in their own homes, community residential settings, or institutional settings". LTSS are described "as a distinct set of services from health care services, although they may include health-related services" (p.1). For the sake consistency across this Background Note, the term LTC will be used.

[166] US Census (2017)

[167] Colby and Ortman (2015)

people who need LTC which will cause a greater reliance on paid LTC in the future, and will further affect the economic and social security of older people and their families.

In the USA, personal responsibility for LTC has traditionally been emphasized and is reflected in the modest safety net provided by Medicare and Medicaid for those in greatest need of LTC[168]. *Medicare*[169] is a health insurance program for people over the age of 65 and certain disabled individuals. Medicare covers a limited amount of LTC, including nursing home care after a hospital stay of at least three days. *Medicaid* is a joint federal-state[170] means-tested and needs based program - rather than a social insurance program - that covers impoverished individuals' health care and LTC costs. Because of high LTC costs, however, nearly 65 percent of all nursing home residents are Medicaid recipients. There is a substantial number of people – estimated at over 9 million – who have dual eligibility to both Medicare and Medicaid. Most of these people are with disabilities and Medicare acts as the primary payer for a range of services for people with dual eligibility. Medicaid provides cost-sharing assistance and may pay for services not covered or limited under Medicare[171].

A Home- and Community-Based Services (HCBS) program was introduced in 1995 to re-dress Medicaid's bias towards residential provision. In some states, Medicaid may pay for in-home services, assisted living/residential care, or nursing home care for individuals that are eligible. To qualify for Medicaid, individuals must verify that they no longer have any savings or other assets to pay for services. Federal policy requires states to examine financial histories for the previous five years in order to assure that individuals have not transferred assets out of their name to avoid using them for health and LTC costs. Under the Affordable Care Act (ACA)[172] introduced

[168] Nordman (2016)

[169] Medicare is partially financed by payroll taxes imposed by the Federal Insurance Contributions Act (FICA) and the Self-Employment Contributions Act of 1954. The Medicare tax in 2015 is equal 2.9 per cent (split between 1.45 per cent by employees and 1.45 per cent by employers).

[170] A few states have their own names for Medicaid. Examples are "Medi-Cal" in California, "MassHealth" in Massachusetts, "Oregon Health Plan" in Oregon, and "TennCare" in Tennessee.

[171] Jacobsen *et al* (2012)

[172] The ACA remains highly controversial, and around 32 State legislatures have introduced some form of legislation to challenge or interfere with the law's implementation.

in 2010 (which expanded the Medicaid program significantly as part of a broader plan to cover millions of uninsured Americans) the focus was on developing and expanding home care and community based alternatives to institutional care[173]. The ACA, also incorporated the Nursing Home Transparency and Improvement Act, the Elder Justice Act[174], and the Patient Safety and Abuse Prevention Act.

In 2013 Congress established the *Long Term Care Commission* which was tasked with developing a plan and legislative recommendations for the establishment, implementation, and financing of the LTC system. The Commission reported in September 2013[175] and outlined several service delivery and workforce recommendations – such as establishing integrated care teams, the use of assistive technologies, enhanced data sharing across care settings and between providers, training for family care givers. But it failed to make recommendations on how to strike a sustainable balance between public and private financing.

While many states have made advances with expanding HCBS[176], the program is still biased towards nursing home care[177], since coverage for nursing homes is mandatory and other HCBS program components are optional**.** To provide an additional spur to community-based LTC services, the federal government provided additional support to transition people from nursing homes to the community, through nursing home diversion programs and *Money Follows the Person* (MFP) grants[178] – which were introduced in 2006 – designed to support state efforts to rebalance their Medicaid LTC programs by providing more services in the community and fewer services in institutional settings. The MFP targets individuals who have been residing in institutions for at least six months to two years and includes an enhanced federal matching rate (75-90 per cent) for a twelve-month period for all LTC costs for each person who successfully

[173] Ng *et al* (2015)
[174] Regulations under this Act, issued in 2015, have sought to expand the coverage of home based LTC services to preserve the dignity and independence of older citizens.
[175] Long Term Care Commission (2013)
[176] In 2012, a total of 3.2 million individuals were in receipt of Medicaid HCBS services and in 2014 582,000 individuals were on a waiting list for services with the average waiting time exceeding 2 years.
[177] Scheppach (2009).
[178] O'MalleyWatts (2009).

transitions to the community. By 2015 44 states were operating MFP programs[179]. Under the ACA several payment and delivery system reforms were launched to alter patterns of care and spending for people on Medicare[180].

Financing

Long-term services and supports are financed from both private and public sources, with the majority covered by publicly financed health insurance programs. With few affordable options in the private insurance market and limitations of coverage under Medicare, those with insufficient resources rely on Medicaid. According to the Centers for Medicare and Medicaid Services (CMS) National Health Expenditure Accounts data, total national spending on LTC was USD310 billion in 2013[181]. Medicaid covered 51 percent of total expenditures followed by other public programs (21 percent), out-of-pocket spending (19 percent), and private insurance (8 percent).

HCBS programs account for a majority of Medicaid LTC expenditures. Total federal and state LTC spending was USD146 billion, including $75 billion for HCBS and USD 71 billion for residential services[182]. However, it is important to note that well over half of all LTC is informal, unpaid assistance provided by spouses or other relatives.[183] - the value of family caregiving exceeds the total value of all paid LTC. Family caregiving was estimated to be worth $450 billion in 2009[184]. While the existing Medicaid-based system offers relatively comprehensive coverage for the poor, it is problematic for middle income households. To become eligible, people must effectively impoverish themselves. In most states, an individual must "spend down" financial assets to less than USD 2000 for an individual and USD 3000 for a couple, to qualify, and must fall within severe income limits[185].

[179] O'Malley Watts *et al* (2015)
[180] Bohl *et al* (2014)
[181] US Department of Health and Human Services (2016)
[182] Eiken *et al* (2015)
[183] *Ibid.*
[184] Long Term Care Commission (2013)
[185] States can use a special income rule, to set the income standard for nursing facilities or for home and

LTC costs often exceed what individuals and families can afford given other personal and household expenses. Institutional settings such as nursing facilities and residential care facilities are the most expensive. In 2015, a nursing facility can cost USD 50,000 to USD 280,000 per annum[186] while an assisted living facility is USD 30,000 to USD 94,000 per annum. Generally, HCBS are less expensive than institution-based LTC, but may still represent a major financial burden for individuals and their families – for example, a paid, in-home care service for twenty-four hours a day, seven days a week can cost over USD150,000 per year[187].

Elderly people seeking to hedge against their risk of needing costly LTC services may purchase private insurance. Private long-term care insurance is typically inaccessible to all with current or future care needs often due to high premium prices. Although private long-term care (LTC) insurance, which began as nursing facility insurance, has been available for about 30 years, the market for this insurance product is relatively small. In 2011, between 7 to 9 million Americans had private LTC insurance coverage and the average annual premium for an individual policy totaled USD 2,283. In 2012, only twelve companies sold over 2500 policies; the total number of policies sold dipped below the level of sales in the 1990s[188].

In 2009 the House and the Senate passed versions of a provision called the Community Living Assistance Services and Supports (CLASS) Act[189]. This was intended to be a national, voluntary private insurance program for purchasing LTC coverage, financed by individual premium contributions. However, concerns about actuarial soundness, solvency and adequacy of the LTC cash benefit that would be paid led to the repeal the CLASS Act under the American Taxpayer Relief Act of 2013[190]. On the demand side, a number of factors have prevented the reverse mortgage market from growing bigger in the US. Equity release schemes— such as reverse

community based care.

[186] See: https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_040115_gnw.pdf

[187] Frolik (2016)

[188] Cleve, (2103)

[189] Colello and Mulvey (2013)

[190] When the CLASS Act was repealed the US Congress set up the *Long Term Care Commission*

mortgages—to pay for LTC have been available in the US since 1989 when The Congress established the Home Equity Conversion Mortgage (HECM) program.[191] This program, was phased out in 2015: out of tens of millions of eligible homeowners, less than 1 million loans originated through the HECM program[192].

Organization and Eligibility

The Centre for Medicare and Medicaid Services (CMS) administers Medicare and Medicaid along with the Department of Labor and the Treasury. The Social Security Administration (SAA) is responsible for determining Medicare eligibility and processing premium payments for the Medicare program. The Chief Actuary of CMS – which is a division of the Department of Health and Human Services (DHHS) - is responsible for providing accounting information and cost-projections to the Medicare Board of Trustees in order to assist them in assessing the financial health of the program. Since the beginning of the Medicare program, CMS has contracted private companies to operate as intermediaries between the government and medical providers. These contractors are commonly already in the insurance, social services or health care area. Contracted processes include claims and payment processing, call center services, clinician enrollment, and fraud investigation.

Workforce constraints significantly hamper the expansion of LTC. Direct care workers include nursing aides and orderlies, home health aides, and personal care and home care aides. Nursing aides and orderlies work primarily in nursing homes and assisted living facilities, and perform both paramedical tasks and assistance with ADLs. The professional workforce specifically trained to meet the LTC needs of the older adult population will not be adequate to meet the future needs for LTC For example, there were only 7,500 board-certified geriatricians in the United States in 2015, and there is only about one geriatric psychiatrist for every 23,000 older adults. By 2030, this will fall to one for every 43,000 older adults. In addition, less than 4 percent of social workers specialize in aging, despite the fact that 75 percent report working with older adults. Nurses, who

[191] Michelangeli (2008).
[192] See: http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/sfh/hecm/hecmhome

provide a significant amount of care for older adults, have high rates of turnover in nursing homes. Due to the aging of the population and the rebalancing towards home and community-based services, demand for direct care workers is set to increase by 48 percent over the next decade, adding 1.6 million positions[193].

Medicaid policy has traditionally steered people with LTC needs into an institutional setting, while most beneficiaries would prefer to remain living in their own homes or community while receiving services. The HCBS program, which makes staying at home a possibility for many individuals, provides assistance with LTC needs which are typically measured by the number of ADLs and IADLs that a person cannot perform on their own. The ADLs include bathing, dressing, transferring from bed or chair, eating, using the toilet and continence, all of which are activities that are critical to day-to-day living. IADLs such as shopping and answering the telephone are central to living independently. In 2015, an estimated 10 million people over 65 lived in the community with an ADL or IADL disability. A further 6.5 million people over 65 are estimated to reside in nursing homes.[194] The ACA provided states that spent less than half of their Medicaid LTC budgets on community-based care with a financial incentive to rebalance, i.e., change the ratio of institutional care to home and community bases services (HCBS). Wide variation in spending patterns and in financial and need eligibility standards exist across the states. Both functional assessments and financial eligibility determinations are required prior to the receipt of LTC services which are supported by Medicaid – however comparatively few states have coordinated screening and assessment tools[195].

Policy Reforms

The United States has attempted to relieve pressure on its means-tested Medicaid program by enhancing the interface with Medicare and improving while the majority of advanced and

[193] Long Term Care Commission (2013)
[194] *ibid*
[195] For example, in the state of California Nursing home care is administered by the Department of Health Services (DHS). Home care and personal care services are administered through the Department of Aging (DOA) and the Department of Social Services (DSS), respectively.

emerging countries have created public LTCI programs. Measures that have been explored includes expanded state and federal tax incentives and a federally funded marketing campaign to encourage consumers to purchase private coverage While these initiatives may have encouraged some consumers to purchase private policies, none have materially changed the nature of this coverage. There have also been attempts to introduce managed care models, which offer the potential for improving care coordination.

The US system of LTC is complex and fragmented. The network of providers to deliver LTC support is complex, multi- faceted, specialized, isolated from other service providers, and confusing to the average consumer. Few providers in this network evaluate a person's over-all situation in order to arrange for the right combination of services based on actual needs. Instead, access to services is often organized in relationship to their funding streams, governed by a mix of federal, state, and local rules and procedures. Separate agencies may have unique eligibility rules, intake and assessment processes. When the need for LTC arises in the wake of a medical event—a hospitalization for an accident or illness, or a transition from a post-acute stay to long-term care—the planning and organization of the care for an individual is often handled separately from the health care planning, and there are few incentives for health care providers to integrate LTC with medical care planning or service delivery. Patients may be discharged to a nursing home or their own home for post-acute care. When individuals need LTSS, frequently they and their families must find and arrange for LTSS on their own.

The LTC Commission was established to look at sustainable long term care funding, but its mandate was too limited. This Commission was severely limited by the timeframe and resources allotted to it by Congress. While there was broad consensus among members of the Commission that LTC in the country as it currently operates is ill-equipped to meet current or future needs, it was the beyond the realistic scope of the Commission to propose a meaningful and comprehensive solution within the Commission's mandate and framework. As a result, the LTC Commission did not propose any fundamental reforms to financing of LTC, and instead

proposed that a new standing Commission or similar national-level governmental body should be established to address issues of the financing and delivery of long-term care services.

Shortly after the 2016 U.S. presidential election, the Senate and House began the formal process of repealing the Affordable Care Act (ACA)[196]. Just as the ACA acted as a major reform of the payment and delivery systems for health and had an impact on some LTC services, repealing the ACA will also have a major impact on health care providers[197], consumers, and companies in between, such insurance companies and providers of LTC services

[196] Within hours of his inauguration, President Donald Trump signed an executive order instructing all federal agencies "to minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open healthcare market

[197] Kasier Foundation (2017)

Chapter V: Hybrid System and Approach: France

A. France

Policy Context

If current demographic tendencies continue, by 2050 about one out of three French inhabitants will be over 60 years old. Over the next few decades, the share of the French population aged 65 and older will increase steadily, to reach about 25 percent in 2030 and nearly 30 percent in 2050[198]. Moreover, by 2050 for every 10 inhabitants in the 20-59 age group there will be 7 persons over the age of 60. The sheer demographic weight of people aged 85 and older will rise even faster, increasing from about 1 million people in the mid 2000s to about 2.5 million in 2030. Life expectancy in France for men aged 65 years was 18.9 years in 2013 and will rise to 22,2 years in 2050; for women life expectancy at 65 years in 2016 was 22,9 years and will rise to 25.9 years by 2050.[199]

The definition of specific LTC policy—or, to use French terminology, a policy for the '*dependent elderly'*—emerged in 1994 and has evolved progressively ever since. Prior to this time there was no specific policy for dependency[200] and LTC in France. In France, LTC for the elderly and disabled belongs to a specific sector of the social system that combines elements of medical and social care, and which is referred to as the "health and social care sector" or "third sector".[201] The health and social care sector is split into two subsectors that encompass care for the elderly as well as for disabled people. Care may be provided at home or in residences. In addition, intermediate care services provide temporary care to dependent patients and respite services for their caregivers cuts across many different sectors split between between health insurance, domiciliary care and residential social care, state support through tax deductions for families who

[198] Beland and Durandal (2012)
[199] European Commission (2015)
[200] Although disabled people were eligible for the *Allocation compensatrice pour tierce personne* (ACTP) – which translates into the 'third person compensatory benefit.'
[201] Chevreul *et al* (2015)

employ a carer[202] and CfC benefits for frail elderly people, a large-scale private insurance sector (see Financing below), and a significant informal carer network within families.

The first attempt to address the risk of dependency and the link with LTC was through pilot schemes at the local level. In 1997 a temporary national scheme was approved with the introduction of the *Préstation Spécifique Dépendance* (PSD) which after severe criticism was replaced in 2002 by the *Allocation Personnalisée d'Autonomie* (APA).[203] A heat wave in 2003 which caused about 15, 000 deaths - the majority of whom were elderly and living alone – was a turning point in national policy-making, and resulted in LTC becoming a state priority. In 2004 the *Caisse Nationale de Solidarité pour l'Autonomie* (CNSA) was established and given the mandate to finance the risk of dependency, and to plan and coordinate LTC at the national level.

Finance

Under the French system, LTC costs related to health/nursing care services which are provided at home or in institutions are paid for by social health insurance. On the other hand, social care related to the risk of dependency (i.e., costs outside the scope of health insurance) is covered by two separate schemes: (i) for dependent elderly - the *Allocation Personnalisée d'Autonomie*[204](APA) – which is intended to cover part of the cost of a "help plan" based on assessed need and income, and (ii) *Prestation de compensation du handicap*[205] (PCH) - for disabled people under the age of 60 which was introduced in 2006. In addition to the APA and the PCH, France has a large LTC insurance market – comprised of 25 companies products[206]. Market growth is also encouraged by the choice of the 75 products offered by French insurers,

[202] Tax deductions were introduced to reduce the cost of home-care services and to incentivize employment in LTC.
[203] *Personalized compensation benefit*.
[204] *Personalised Autonomy Benefit*
[205] *Disability Compensation Benefit*
[206] Canarelli (2015)

for example, cash benefit products provide greater choice of both care service and service provider[207]. In 2016 about 15 percent of the population aged 40 years had private LTCI.[208]

By 2050 the number of LTCI policy holders is expected to double to around 10 million. The French LTCI system, unlike the USA, is based on a fixed-sum payment, which allows policy-holders to choose their organization of care and services as they wish. In France, indemnity policies are the dominant model. Typically, they provide eligible recipients with a fixed level of monthly benefits for life, once the insuree meets criteria set in the policy regarding the level of dependency and waiting period. The bare-bones private coverage provided by the private LTCI schemes are marketed as a supplement to a limited public benefit provide by the APA and PCH[209]. About 20 percent of indemnity policies solely cover risks associated with severe or very severe levels of dependency, while about 80 percent also cover the risk associated with moderate levels of dependency. LTC is priced in units using prospective mortality which considers the probability of being alive at each year in the future. Variations are considered between full and partial dependency prevalence rates, between ages, and between genders[210]. Four main types of contract are available:

- Contingency cover (*contrat de prévoyance*), where the policy holder pays a regular premium in order to receive a predefined benefit in the event of dependency. If the risk does not occur, the global amount of cumulated premium is lost;
- Life insurance policy, which offers the possibility of receiving the death or retirement pay-out in advance in the event of dependency;
- Life insurance with dependency cover (*contracts d'épargne dependence assurance-vie*), where the policy-holder can cumulate savings in their policy and can choose to convert

[207] Dale *et al* (2013)
[208] Dupourgue (2016)
[209] Doty *et al* (2015)
[210] Boivin-Champeaux and Berquin (2015)

them to a monthly benefit in the event of dependency. Under this option, the policy-holders do not lose their savings;

- Additional health cover (*conrat complémentaire santé*), which is an option in private health insurance policies.

Although private LTC insurance markets have emerged in France, demand for these products is still comparatively low. Studies[211] suggest citizens have difficulty understanding the low-probability / high-loss events and do not necessarily perceive old age disability or dependencies as problems that they have to confront, or are unable to understand the financial products and services. The development of LTCI in France is linked to the real cost of dependency and the catastrophic costs of covering dependency generated needs. The main obstacles to expansion of the private LTC market in France[212] include:

- Lack of information to potential users;
- Adverse selection with a tendency for high risk individuals to take out LTCI;
- The extent of public cover and its potential to crowd-out private LTCI.

Home equity release programs have ben around for a long time in France. A form of equity release has been available in France for 200 years[213] but under the French *prêt viager hypothécaire*[214] system, which was introduced following a legal ruling in 2006, there are now three ways to purchase a property: (i) the buyer pays the vendor a lump sum plus a monthly annuity; (ii) the buyer pays the vendor a lump sum (called a *bouquet*), but no annuity; and (iii) the buyer pays the vendor a monthly annuity only, but no lump sum. These equity release scheme has a clear goal of facilitating access to credit for older people and can only be granted to a physical person, and has to be a loan on a property that has to be used exclusively for

[211] Lusardi and Michell (2007), Courbage and Roudaut (2008).
[212] Ibid.
[213] Reifner *et al* (2009).
[214] The term means, literally translated, 'old-age mortgage loan', which conveys the concept of 'lifetime mortgage'. The words *prêt hypothécaire rechargeable* translate as 'rechargeable loans' which convey the reverse character of this type of mortgage, compared with that of an ordinary mortgage which, especially in France, must be repaid in instalments. 'Rechargable' offers an image of the mortgage as a credit line (overdraft,
credit card credit) where the borrower takes out a loan, repays it and repeats the process as required.

residential purposes. The property need not be the main residence of the borrower; it can be a second home or a rental property. The average amount of funds disbursed through these schemes is about €90 000, and is strictly reserved for non-commercial use and it is never sold in combination with other investment type products.

Since the legal ruling in 2006, around 4,000 contracts are issued per annum.[215] Around 95 percent of *viager* properties have tenants – in other words, the vendor lives on the premises until he or she either dies or leaves (for instance to enter residential LTC). About 30 percent of such tenanted properties become vacant before the death of the vendor, which means the buyer can then live in the property or rent it out to create income. The contract is void if the vendor dies within 20 days after the exchange of contracts or if it is found that the buyer knew that the vendor had an incurable disease when they bought the property. It is also void if the selling price is found to be too low – i.e., if the price has been fiddled in some way to avoid inheritance tax. In terms of public financing for LTC, the overall cost for the dependent elderly in 2015 was around €40 billion[216] of which 70 per cent is publicly funded and the rest is borne by the health insurance system, and the départements[217] cover 20 percent. The CNSA manages revenue collected through general taxation,[218] a fraction [0.1 percent from the *Contribution sociale généralisée* [CSG] ,[219] as well as the *Contribution Solidarité Autonomie* [CSA].[220]

Organization and Eligibility

The *Préstation Spécifique Dépendance* (PSD), which was introduced in 1997, was designed not only as a means to deal with the growing costs of ageing and dependency, but was also envisaged as a mechanism for creating a new job market in LTC provision. It was a means-tested benefit

[215] *op cit.* Reifner (2009).
[216] Chevreul and Bringham (2015)
[217] The départments of France are administrative divisions. The 100 French départments are grouped into 22 metropolitan and four overseas regions, all of which have identical legal status as integral parts of France. The departments are subdivided into 342 arrondissements, which in turn, are divided into cantons. Each canton consists of a small number of communes.
[218] 15 percent of total LTC expenditures.
[219] The General Social Contribution (CSG) is a tax used to finance social security expenditure.
[220] The Solidarity Contribution for Autonomy (CSA) is unique tax in which employers pay a contribution of 0.3 per cent of the payroll tax on the *National Day for Solidarity* – which is a day of unpaid work.

delivered by the *Conseils Géneraux,*[221] covering only the most dependent people [which corresponded to the first three scales of the national *Autonomie Gerontologique groups iso-ressources* for measuring dependency (AGGIR scale).[222] Beneficiaries were able to use the PSD to fund LTC services both at home and in institutions, and they were allowed to pay their relatives for services but not their spouses and partners. However, the PSD was deemed a failure because (i) the number of potential beneficiaries was very limited as the benefit was dependent on income and the threshold for dependency was deemed too high; (ii) it did not encourage the creation of new jobs in LTC;[223] and (iii) there were large inequalities in the allocation of PSD benefits between the regions in France.

The APA was introduced to replace the PSD with the aim of containing costs and increasing the number of recipients. Unlike the PSD scheme, the APA is separate from the social security system and was initially introduced as a universal benefit which anyone over the age of 60 could apply regardless of income. However, a system of co-payments was gradually introduced which varied according to the care user's means - although under a threshold of around €700 per month people do not pay user fees. The means test is based on taxable income and some assets, but does not include the value of the home if a close relative also lives there. In residential care (which is provided in collective housing without medical care, retirement homes which offer some medical care, and long term care units located in residential homes or hospitals) individuals pay for their own accommodation costs and personal expenses, and those with low incomes receive a subsidy towards this. Moreover, the APA CfC benefit is also allocated to people belonging in the fourth dependency AGGIR scale, covering therefore also mid-range dependencies. The largest components of the APA are funded by the départements [through

[221] General Councils.

[222] The AGGIR scale assesses dependency on a ranked-scale of GIR 1 to GIR 6 is similar to the ADL and IADL framework - with GIR 1 indicating high levels of dependency and GIR 5-6 indicating slight or no dependency. The AGGIR scale is the one most commonly used in France. This scale covers so-called instrumental dimensions, that correspond to relatively complex activities with the dominating cognitive component (cooking, medication use, finances, etc.) as well as dimensions with the dominating physical component (so-called fundamental dimensions that are related to such activities as walking, dressing, toileting, etc.). However, at present, only the fundamental activities are taken into account while assessing the dependency of the elderly within the scale AGGIR

[223] Le Bihan and Martin (2007).

local taxes], while the CNSA distributes the revenue received through the CSA and the CSG in attempt to provide equalization transfers weighted in favor of departements (who finance two thirds of the costs) with the largest deficits. In this sense, the APA is more efficient is combating inequalities between regions.

The APA CfC is designed as an indirect wage subsidy, which is provided to LTC users in order to pay for their care services. Although the recipients can use the APA benefit to pay their relatives the system is oriented towards professional LTC by using case management and even organizing care services through non-profit organizations. In practice older persons claim the benefit from the *Conseils Géneraux* who is charged with assessing individual needs and proposing an appropriate care package. Moreover, the local authorities monitor and evaluate the implementation of the personalized care plan.

Policy Reforms

The development of the public and private sector LTC schemes have emerged independently of each other. Since 2005, four major reviews have been published to review LTC policy and its future.[224] The main policy issues addressed in 4 of these 5 reviews focused on:

- How to finance APA in a fiscal environment where *départements* were struggling to allocate their scarce resources to fund the risk of dependency and the provision of LTC;
- How to decrease the burden of user charges that exceeded the average revenue of elderly persons due to the costs if catering and lodging fees in nursing homes;
- The extent to which the German model of social insurance for LTC could be adapted/adopted in the French policy environment given variations in the tax rates in the two countries and the challenge posed by the level of government subsidy required in Germany;

[224] Cour des Comptes (2005), CAS (2006) Gisserot and Grass (2007)

- The insurability of the risk of dependency – particularly if increases in life expectancy are accompanied with higher levels of disability – and rising costs;
- The extent to which the private and public systems define and apply 'dependency' to assessing physical, mental and social risks.

Recommendations from reviews of the LTC system conducted in 2008, 2009 and 2011 were eventually abandoned. Following the 5th review of LTC[225] government announced plans to create a 'fifth risk' – i.e., dependency or loss of autonomy – which is defined as a new field of the social security system. It was designed to complement existing health insurance pillars – pensions, health, family, and work injuries[226] and many attributes in common with the German LTC system. Among the positions adopted during these reviews were[227]: a rejection of the proposal to create a fifth branch of social security to cover LTC; the principle of mixed public-private financing", combining a high base level of solidarity with (non-compulsory) private LTCI involved in a complementary manner; widespread coverage of the population by private LTCI through the reorientation of life insurance policies or plans towards a dependence guarantee along with the integration of a dependence guarantee in the supplementary health coverage contracts; the possibility to reclaim part of the dependency benefits on the inheritance of the more wealthy elderly to finance part of the APA program. There was thus a clear re-orientation away from the idea of setting-up a fifth social insurance pillar to cover LTC. The global financial crises that hit in 2008, and its concomitant deleterious effects on public finances, played a significant role in steering policy away from the fifth pillar approach.

In 2013 new contribution measures were introduced and in 2014 a new LTC specific law was adopted. In 2013, the government introduced a new Additional Solidarity Contribution for Autonomy (CASA). This took the form of an extra 0.15 percent tax that is levied on the income of people in receipt of pensions. This fund is not earmarked specifically for LTC, but has been channeled (on an exceptional basis) to the Old Age Solidarity Fund. In 2014 a new LTC specific

[225] Known as the *Vasselle Report* (2008)
[226] Available at: http://premier-ministre.gouv.fr/inofmation/questions_responses_484/est-cinquiemerisque
[227] Chevreul and Brigham (2015)

law was enacted: *Adaptation de la societe au viellissement*[228] which makes provision for higher monthly ceilings for LTC benefits – but still retains the link with income, and makes provision for respite care for caregivers. In addition, a Higher Council on Family and Life Cycles was established and the role of the CSNA was strengthened to improve revenue collection.

[228] "Adaptation of society to its aging population"

Chapter VI: Conclusions

Three conclusions can be drawn from how OECD countries are addressing the growing need to provide LTC to their rapidly aging populations. The first is that in spite of the substantial differences in how they currently fund and provide LTC, they are converging on quite similar strategies for how such assistance should be organized and provided going forward. The convergence can be seen in the shifts toward enabling people to age in place rather than providing LTC in residential settings, toward allowing people to have more choice in care providers, and toward distributing funds from central government to sub-national levels in an effort to reduce disparities in the delivery of services to people with similar needs.

The second conclusion is that every country is working to dramatically slow the growth in LTC expenditures because without these measures the programs that provide assistance to the elderly are not sustainable. So far, most of the efforts to slow LTC spending have involved freezing the services covered, restricting care to those deemed in greatest need, and not raising reimbursement rates to care providers (which reduces the number of providers of LTC services). These actions have caused costs of care to be shifted to individuals and their relatives as well as to other programs that provide income and housing assistance to elderly who cannot afford the cost-sharing required of people receiving LTC services.

The third conclusion is that the sustainability of financing LTC services and other assistance for the elderly is an urgent matter among OECD countries. The finance crisis has caused historically high numbers of younger age cohorts to be unemployed or underemployed and therefore unable to pay higher taxes to support the elderly while saving monies for their own retirement years. It is strikingly clear that most countries are unprepared for the coming costs of assisting the rising numbers of elderly in their populations and that the current economic crisis is making it far more difficult to create financing mechanisms that will enable such programs to be sustainable beyond the current decade.

Rapid population aging in low and middle income countries (LMICs) will inevitably generate an increased demand for long-term care (LTC) services. Research and practical experience from high income countries – and the very diverse patterns of LTC in terms of funding mechanism, the balance of formal and informal services, the degree of state participation, and the overall level of provision – hold important lessons.

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Annex 1: Glossary of Key Terms used in Long Term Care

Activities of daily living (ADL): a term used to describe self-care activities that a person must perform every day, such as eating, dressing, bathing, transferring between the bed and a chair, using the toilet, controlling bladder and bowel.

Actuarial Insurance: Insurance is defined as actuarial if the premium is based on the risk of an event occurring and the size of the resulting loss. Mathematical and statistical methods are applied to assess insurance risk. Actuarial insurance can cope with individual, measurable risk. It cannot set a premium when the risk is either certain, such as a pre-existing medical condition; or uncertain, where the statistical probability of the event occurring for the group as a whole is unknown

Assessment: The overall process for identifying and recording - the health and social care risks and needs of an individual and evaluating their impact on daily living and quality of life, so that appropriate action can be planned.

Assistive technology (AT): can be defined as any piece of equipment that helps people to perform activities of daily living. This broad definition incorporates a large number of devices, ranging from 'low-tech' mobility devices such as zimmer frames to 'high-tech' speech synthesizers or stair-climbing wheelchairs. It also, with the advent of wireless and satellite communications, incorporates: **Telecare**: involves the use of electric sensors and aids (such as emergency cords, speakers linked to a call center, epilepsy sensors, medication dispensers) that make the home environment safer, enabling people to live at home, and independently for longer. **Telehealth**: refers to the use of electronic sensors or equipment to monitor people's health in their own homes (e.g., blood pressure, weight, oxygen levels); and, **Telemedicine:** refers to the use of sensors and electronic devices for communication to aid diagnosis and management of health and social care

Attendance allowance: cash benefits provided to people in need of care, subject to an evaluation of dependency or care needs [distinguishing them from pensions and other social assistance or in-kind supplements], which may be used to pay for home care services, institutional care, or to pay or hire informal carers, depending on the benefit setting.

Care allowance: cash benefit awarded to those providing care to the dependent older person.

Carer: the person providing care to the dependent older person- also called *caregiver.*

Care package: services designed to meet an individual's assessed needs as part of the care plan arising from their assessment. Consists of one or more services, which may be residential and/or community-based. A cost is often attached if provided, and hence needs to be approved by the budget holder; may also require contributions from the individual.

Care plan: personalized care plan details the high level, integrated health and social care requirements after a holistic assessment has taken place. Based on the summary of the risks and needs from the assessment, it should include details of the services to be provided, the assessed individual and their carer(s) participation, the objectives, a review date and consent from the assessed person to share the plan with the care team.

Care recipient: the dependent older person in need of or receiving care.

Care user: see under *care recipient.*

Case management: when an individual has numerous long term conditions and complex needs, their care becomes more difficult for them to manage. Case Management is where a named coordinator actively manages and joins up care by offering, amongst others, continuity of care, coordination and a personalized care plan for vulnerable people most at risk.

Cash-for-Care (CfC): cash benefit schemes aim to cover expenses to purchase formal care at home or in an institution or to support informal care, allowing household's choice over care decisions.

Cognitive impairment*:* refers to a deterioration or loss of intellectual capacity that results from in impairments related to short-and long-term memory, orientation to people, place and time, deductive or abstract reasoning and ability to perform activities of daily living

Community care: network of health and social care designed to enable an individual to remain independent and living in his or her own home. See also under *home care*.

Dementia: the loss of memory, reason, judgment, and language to such an extent that it interferes with a person's ability to perform activities of daily living. It is not a disease itself, but a group of symptoms that often accompanies a disease or condition. Alzheimer's disease is the most common type of dementia. Other types include vascular dementia, dementia with Lewy bodies and frontotemporal dementia.

Dependency: condition when older people's overall level of functioning is substantially reduced, such that they are likely to require help from a third party, or substantial help from aids and adaptation, in order to fulfill the normal activities of daily life. Dependency is often used as a synonym for emerging social risks that LTC responds to.

Dependency ratio: demographic indicators that relate the young and old age population [those generally inactive] to the population of working age.

Domiciliary Care: is used interchangeably with the term "Home care" to mean any type of health and/or social care given to a person in their own home. Both phrases are used interchangeably regardless of whether the person requires skilled care or not. More recently, distinctions are

drawn between "home health care" meaning skilled nursing care and "home care" meaning non-medical social care.

Equity Release Schemes: transform fixed assets in owner occupied dwellings into liquid assets for private pensions or for the provision of Long Term Care. They thus enable a homeowner to access the wealth accumulated in the form of his or her home, while being able to continue to live in it. ERS enable an illiquid asset becomes a source of liquidity, mainly for consumption purposes.

Estate recovery: procedures allowing recovery of long-term care expenses from the estate (assets, savings and investments) of the care user before or after his or her death as a means to finance long-term care expenses. Sometimes linked to *reverse* mortgages when applied to housing assets

Formal care: long-term care services supplied in some kind of contractual relationship (e.g., by the employees of an organization or of the care recipient) in either the public or private sector, including care provided in institutions like nursing homes, as well as care provided to persons living at home by either professionally trained care assistants, such as nurses, or untrained care assistants.

Governance: the procedures associated with the decision-making, performance and control of organizations, with providing structures to give overall direction to the organization and to satisfy reasonable expectations of accountability to those outside it.

Home care: care provided to care recipients living in their own houses or apartments, including day care, respite care and direct support to individuals who provide care, such as care allowances and care leaves.

Informal care: care provided by informal caregivers such as spouses/partners, other members of the household and other relatives, friends, neighbors and others, usually but not necessarily with an already existing social relationship with the care recipient; usually provided in the home and typically unpaid.

Iatrogenesis*:* refers to inadvertent adverse effects or complications caused by or resulting from medical treatment or advice. In addition to harmful consequences of actions by physicians, iatrogenesis can also refer to actions by other healthcare and social care professionals, such as psychologists, therapists, social workers, pharmacists, nurses, dentists, etc.

Institutional care: long-term care services supplied or available 24 hours a day in institutions that also serves as a place of residency for those receiving care, with common areas of living for residents, even if they enjoy separate rooms. It does not include temporary or short-term stays, such as respite care.

Instrumental Activities of Daily Living (IADL): activities that enable a person to live independently in a house or apartment, such as preparing meals, performing housework, taking drugs, going on errands, managing finances, using a telephone.

Long-Term Care (LTC): the organization and delivery of a broad range of services and assistance to people who are limited in their ability to function independently on a daily basis over an extended period of time. The services may be provided in a variety of settings including institutional, residential1 or home care.

Social Insurance: Government-sponsored programs with all of the following characteristics: The program, including benefits and financing method, is prescribed by statute; the program provides for explicit accountability of benefit payments and income, usually in the form of a trust fund; the program is financed by contributions (e.g., taxes or premiums) from or on behalf of participants, which in some programs are supplemented by government income from other sources. Investment income on program assets may also be used to finance the program. The program is universally (or almost universally) compulsory for a defined population, or the contribution is set at such a subsidized level that the vast majority of the population eligible to participate actually participate.

Sub-national level: The *sub-national level* serves to differentiate from the national level of governance and encompasses regions, municipalities, provinces and other authorities of public administration at a non-state level. In the design of LTC the sub-national level is of critical importance given differentials in ageing, dependency ratios, etc.

Nursing care: provision of care that includes assessment, treatment or care which can only be provided by or under the supervision by a qualified nurse and extends to control of medication, dressing, injections, feeding requiring nursing skills, pressure sores, specialist incontinence management, complex prosthesis management and appliances, cognitive and behavioral support and management of complex psychological or aggressive states; but does not include any prescribed activity for the provision of equipment by health authorities.

Nursing home: Care home that provides nursing care.

Palliative Care: Palliative care is the active holistic care of people with advanced progressive illness. It includes the management of pain and other symptoms and provision of psychological, social and spiritual support. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of illness and provided in conjunction with other medical and social interventions. Palliative care seeks neither to hasten death nor to postpone it. The provision of euthanasia and assisted suicide is not part of the responsibility of palliative care

Personal care: Provision of LTC that does not fall under the term nursing care and although its actual meaning depends from the appropriate care context it often includes care relating to personal hygiene and toileting, assistance with feeding, eating and drinking, management of

urinary and bowel functions, promotion of continence and management of incontinence, assistance with mobility and transfers, promotion of independence and social functioning, anxiety and behavior management, social care needs assessment and ensuring personal safety, encouragement and assistance with cognitive functions, and administration and monitoring of medication.

Re-ablement: refers to services which help someone to accommodate their illness or loss of activities by daily living by learning or re-learning skills necessary for daily living.

Rehabilitation: focuses on services for helping someone to get better

Residential home: residential care home that does not provide nursing care.

Respite Care: refers to the provision of planned short-term and time-limited breaks for families and other unpaid care givers in order to support and maintain the primary care giving relationship. Respite also provides a positive experience for the person receiving care. The term "short break" is used in some countries to describe respite care, and provision is designed to mitigate the effects on physical or mental health problems that arise from care giving

Social Care: Often used as a synonym to long-term care in literature, but refers to promotional, preventative and protective measures that can be taken to provide personal social services to adults, children and other groups such as people with disabilities, offenders and people with drug dependencies. In the specific context of LTC for the elderly, *social care* refers to services providing assistance with self-care and instrumental activities of daily life, including personal functioning, domestic maintenance and social activities given on a continuing basis to individuals with chronic impairments and/or increased levels of dependency.

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Abstract

Population aging is a global issue that is either affecting or will soon affect virtually every country around the world. With large numbers of older people experiencing significant losses of intrinsic capacity, leading a dignified and meaningful life is often only possible with the care and support of others. Long-term care (LTC) has therefore become one of the most rapidly developing policy areas in OECD countries, where significant institutional change and innovation have taken place over the last two decades. Governance and finance arrangements for the delivery of LTC differ between countries. LTC in the Netherlands, Germany, Japan, The Republic of Korea, the Scandinavian countries (Sweden, Denmark and Finland), England, the United States, France were selected to cover differences between systems. However, across the different systems debates about intergenerational and state responsibilities are increasing evident. The paper delivers an up-to date assessment of design parameters and captures the measures being taken to build financial sustainability into LTC policy and program reforms. Rapid population aging in low and middle income countries (LMICs) will inevitably generate an increased demand for long-term care (LTC) services. Research and practical experience from high income countries – and the very diverse patterns of LTC in terms of funding mechanism, the balance of formal and informal services, the degree of state participation, and the overall level of provision – hold important lessons.

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