Overview of Financing and Managing Long-Term Care Services inSix OECD Countries

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1. Introduction

The aging of the population seems to have increased the demand for formal long-term care (LTC) services in high income OECD countries. This situation is exacerbated by women's increased labor force participation and by cultural change, as more women question their traditional role as the primary family caregivers, in particular in Japan, for their husbands' parents (Ogura and Sumi, in this issue). Formal LTC services for the elderly had been provided primarily through social welfare systems, sometimes targeted at the poor elderly or those without families, although the United States has a private market for formal LTC services and private LTC insurance as well. In some countries, in the past, elderly persons or their families were reluctant to rely on public support even when eligible for it possibly because of the low quality of such services or the social stigma attached to them. Consequently, in such countries, the burden of caregiving fell on the informal sector, primarily on female family members. Today, however, many high income OECD countries are challenged by diminishing supply of informal care for several reasons. They include firstly, due to demographic changes the elderly have fewer children, who may volunteer to take care of them. Secondly, due to increased life expectancy elderly wives are often too frail to provide the necessary care by themselves and for their husbands who have slightly shorter life expectancies and earlier care needs. Thirdly, due to increased labor marketparticipation of women, less of them are available for full-time caregiving. In these circumstances, a social insurance approach has been developed for LTC services in countries such as Austria, Germany, Japan, and the Netherlands. In contrast, Sweden and England choose to stick to the social service model to cover long-term care. The experiences of these six countries illustrate the questions of financial sustainability and reform that affect the future of LTC services.

2. The Basic Indices in Six Countries

Table 1 shows the basic indices related to the LTC services in six countries. While population aging is common to all six countries, Japan will experience the most serious aging rate (defined as the proportion of the age 65 or over in the total population) of about 40 percent in 2050 because of its very low fertility rate and its relatively long life expectancy. General government liabilities as well as tax revenue as percentage of GDP are key factors in determining a government's ability to support LTC services. The burden of government liabilities is lowest

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in Sweden, less than 50 percent of GDP, and with more than 200 percent, the highest in Japan. In the other European Community countriesthe burden of government liabilities ismuch smaller. The order is reversed for the annual tax revenue, with Sweden collecting 46 percent of GDP in taxes and Japan 27 percent. The employment rate for the age group 55-64 is a key indicatorregarding the dependency rate of the elderly. Sweden has the highest employment rate for this age group and Austria the lowest. Public spending on family benefits, particularly child payments and allowances,may significantly influence fertility rate, and hence the availability of informal care in the future.Japan has experiencedvery low fertility for more than two decades, but its public spending on family has been increasing very slowly, and Japan still is by far the lowest of the six countries at 1.3 percent of GDP. In contrast, the United Kingdom spends the most at almost 3.6 percent, with the other four countries spending about twice as much as Japan does, relative to their GDP.

Table 1. Basic Indices in Six Countries

	Year	Austria	Germany	Japan	Netherlands	Sweden	UK
Total population (millions)	2010	8.4	81.9	127.5	16.5	9.4	61.3
	2050	9.0	74.4	95.2	16.8	10.5	77.0
Elderly population (%)[#]	2011	17.7	20.7	23.3	15.6	19.3	16.2
	2050	30.0	30.9	38.8	26.4	24.6	23.6
Life expectancy at birth (both sexes)	2010	80.7	80.5	83.0	80.8	81.5	80.6
Total fertility rate[&]	2009	1.39	1.36	1.37	1.79	1.94	1.94
General government liability (%GDP)	2012	83.0	88.5	214.1	81.0	48.0	104.2
Tax revenue (% GDP)	2010	42.0	36.3	26.9	38.2	45.8	35.0
Empl. rate for ages 55-64 (%)	2010	42.4	57.7	65.2	54.1	70.6	56.7
Public spending on family (% GDP)[*]	2007	2.64	2.71	1.30	2.84	3.35	3.58
Contribution rate (% of wages)[§]	2011	33.4	39.9	21.0	31.4	24.8	25.1
Elderly LTC expenditure (% GDP)[†]	2005	1.3	1.0	0.9	1.7	3.3	1.1
	2050	2.5-3.3	2.2-2.9	2.4-3.1	2.9-3.7	3.4-4.3	2.1-3.0
Total health expenditure (% GDP)[‡]	2010	11.0	11.6	9.5	12.0	9.6	9.6

Source: OECD (2006, 2011, 2012).
[#]Share of aged 65 or over in the total population
[&]From OECD (2011)
[*]Including child payments and allowances, parental leave benefits, childcare support and tax benefits.
[§]Income tax and social security contributions (including LTCI taxes) for single individual without children at income level of the average worker, as a percentage of gross earnings from wages.
[†]From OECD (2006).
[‡]From OECD (2012).

LTC expenditure for the elderly was much lower compared with health care expenditure in all countries: around 1 percent of GDP in 2005 for four countries but higher in the Netherlands (1.7 percent) and in Sweden (3.3 percent). We also note that in the Dutch system, a more comprehensive definition of long-term care is used, including care for the mentally and physically handicapped and care for chronic psychiatric patients, which leads to an expenditure level of about 4 percent of GDP. As LTC expenditure for the elderly is strongly correlated with the aging of the population, a very large increase is expected between now and year 2050 for all countries except Sweden which was already spending 3.3 percent of GDP in 2005 (Table 1). Given the already substantial financial burdens on the working generations (Contribution Rate (% of wages) in Table 1), financing LTC services in the coming years is consequently a grave concern in all six countries. The relationship between the health care and LTC is also a great concern, as health care costs keep on increasing, for two reasons. First,

some hospital beds still are used for LTC, for example such as "social hospitalization" in Japan. Secondly, however, even in these countries, LTC services are expected to contribute to the performance of the acute health sector by preventing the need for inpatient admission and by speeding up the rate of hospital discharge.

3. Basic Features of Long-Term Care for the Elderly in Six Countries

In Austria, the LTC system rests on two pillars, namely, family support and public provisions for long-term care. Public provisions are complementary, however, and families still play the major role, as almost 70-80 percent of older persons in need of LTC rely on spouses and children (Schneider and Trukeschitz, in this issue). LTC dependency still presents a serious risk of poverty to older persons in Austria, and a major share of spending on social assistance consists of payments for older persons in residential care. Therefore, debate on adjusting benefits to inflation on a yearly basis is ongoing, and efforts are also underway to prevent or delay institutionalization (Schneider and Trukeschitz, in this issue).

The AWBZ in the Netherlands is a national insurance scheme for LTC. Most expenses within the AWBZ are for (frail) elderly, with or without cognitive limitations or physical or functional limitations. Every person who claims to be eligible for AWBZ funding needs to be assessed. An applicant who receives an indication for LTC may also receive a personal budget instead of care in kind. A combination of care in kind and a personal budget is also possible (Schut and Van den Berg, in this issue)..

The German LTC system provides a universal, non-means-tested benefit, financed by contributions. The insurance partially covers LTC needs, and the benefit scheme allows some flexibility including cash allowances and support for institutional care. Many claimants apply for cash allowances that enable them to arrange care at home with the help of informal care givers.Home care may be strengthened by cash allowances that reward informal care. As almost 80 percent of all benefits to recipients are in the form of cash allowances, informal home care is currently the predominant way of providing care in Germany (Heinicke and Thomsen, in this issue).

The Japanese system was influenced strongly by the German system, and hence there are many similarities between the two. However, there are several important differences (Fukawa 2001) : (a) the main beneficiaries in the Japanese system are those aged 65 and over; (b) cash options are not available in the Japanese system; and (c) benefits in the German system are intended to be universal, whereas regional differences are positively admitted in Japan. The incomes and family situations of the elderly are not considered in determining the level of care need in both Germany and Japan. Benefit amounts vary only by the level of care needed (Tsutui and Muramatsu 2005).

In contrast with Continental practices, the Nordic tradition has been to support clients primarily in kind. Many old people receive services but very few family caregivers are remunerated in cash (Sundström, in this issue). Another important feature of Nordic societies is the far-reaching overlap of what is done informally, mostly in the family, with what is done by public bodies. Swedish authorities attempt to ration services through eligibility criteria, restrictive needs assessment, or raised fees. This policy has led to a postponement of institutional care: older people use Home Help instead, and those who previously used Home Help use less costly "other" services such as transportation. Faster turnover of clients in Home Help and institutional care has at the same time meant that more people than ever will eventually use these services. Public services in Sweden are used to the same extent by citizens of all social classes when in need, and less use by the upper classes is due mainly to their better health (Sundström, in this issue).

The 150 local councils in England have responsibilities for social services and commission social care services, which involve assessment and care planning alongside the procurement of services. Access to social care is managed through a process of assessment, and a social worker or care manager will assess the needs of the person (and of any caregivers or other family members) and develop a care plan to meet those needs. Local authorities are not the only purchasers of social care services for older people, and the NHS is sometimes a substantial purchaser of nursing home provision (Fernández, in this issue).

4. Key Issues in Financing and Managing Long-Term Careof the Elderly in Six Countries

As the entire elderly population has access to LTC services in all six countries, selectivity—targeting resources to the neediest—versus universality is not an issue. In this section, we take up the six issues that emerge from the six papers as key to each country's discussion of long-term care:

- National equity versus local autonomy;
- Public support versus family service;
- Source of financing;
- Quality of care;
- Coordination of health care and long term care;and
- Reform options.

4.1 NationalEquity versus Local Autonomy

As public spending on LTC is growing fast, provinces in Austria have begun to realize that they will not be able to assume the sole responsibility for securing adequate LTC infrastructure.

Areas with higher coverage rates of public services have more older people who benefit from both family care and public services, but in Sweden, in the less-covered regions, older people have to choose between family andstate.

In Japan, there is considerable variation between municipalities in the services available and contribution amounts, and these kinds of regional difference may become a big issues in the future . Wide variation in the availability and use of services across the country are also reported in England.

4.2 Public Support (National or Local) versus Family Service

Increasing attention is being paid to the support of informal care in Austria, where the number of frail older people is growing and at the same time the population of family caregivers is shrinking.

Informal care is also important in Germany, where the majority of caregivers were are family members, female, and 65 or older. Sixty percent of all caregivers were not working, but one-third were working more than 15 hours a week. The average hours per week spent on care amounted to more than 36 hours. About 50 percent of all informal caregiversreceive monetary remunerations.People with a "pre-modern" lifestyle more often have a solid network available for informal help, but such networks are less common for people with a modern lifestyle—that is, greater individualization and urbanization and fewer children. Given the demographic trends of increasing life expectancy and female participation rates combined with lower birth rates, it is doubtful that the same level of care can be maintained by informal caregiving in the long run. As in Austria and elsewhere, the number of people in need of care will rise at the same time that the number of possible caregivers shrinks.

In Japan, informal care is still important, although LTC insurance benefits have become indispensable for the frail elderly. The introduction of LTC insurance was coupled with the liberalization of for-profit firms into the home care service market. Institutional care services, however, were, and still are, reserved for public and social welfare entities. As a result, many de facto institutional care services are provided under the name of home care services in Japan. The expansion of the benefits to home care has relieved the burden of family caregivers substantially (Ogura and Sumi, in this issue), but because the capacity of institutional care has been outpaced by demand, most families must wait for months or years for admission. Within a married couple, the wife typically takes care of her husband with the help of insurance benefits; after he dies, she may live with one of her children and be cared by her children with the help of insurance benefits.

4.3 Source of Financing: Contribution, Tax Subsidies, and Users' Charges

Twenty-seven percent of expenditure on long-term care in England was funded by the National Health Service (NHS), 38 percent by local authorities' social services departments, and 35 percent by service users or their families. Substantial additional resources for health care were announced in the NHS Plan, to secure better partnerships between health and social services, encourage needs-led decision making, promote the independence of older people, and emphasize prevention and rehabilitation. The care planning process will take account of the resources available to the local authority and will also assess the financial means of the service users want to determine what, if any, contribution they will be required to make to the costs of their care. This process means that the amount of public support for dependent persons varies significantly depending on their wealth and geographical location. Several options are being discussed in England to increase resources for LTC services, including increases in individuals' contribution, subsidization of private insurance products, and deferred payments until death to use housing assets.

In Sweden, however, given the prospect of growing numbers of older people in need of care, raising taxes is not regarded as feasible; further rationing and diversification are more likely options.

In Japan, the LTC insurance program is financed through a combination of contributions, government subsidies, and user charges. Service users pay 10 percent of the costs of the services, subject to a monthly ceiling, and the rest is split between contributions and subsidies equally. Anyone age 40 or older must contribute, either as a surcharge to the medical insurance contribution (for those under age 65), or withholding from public pension benefits (age 65 or older). Each municipality sets the contribution amount to cover 20 percent of the cost of benefits. The contribution is reduced for low-income elderly and increased for higher-income elderly, and on average an elderly person contributes around 4,000 yen per month.

4.4 Quality of Care

There is general concern about the quality of care provided by the private sector and agreement on the need for quality-control measures. The legislation governing LTC services typically includes a clause to protect the elderly by ensuring quality of care in home, community-based, and institutional settings. Quality control often consists of certification system of care providers, periodic inspections, and penalties for violating the regulations.

Recent legislation in Austria, Germany, and Japan has improved access to care benefits for persons suffering from mental conditions, and there is a need to develop new approaches to caring for this group of frail elderly with dementia.

4.5 Coordination of Health Care and Long-Term Care

Inappropriate use of acute inpatient beds by many older people was reported in England because of a shortage of suitable alternative services and accommodation. It was argued that social care could contribute to the performance of the acute health sector by preventing the need for inpatient admission and by speeding up the rate of hospital discharge.

Hospital beds have frequently been used instead of long-term care facilities in Japan also, because access to the latter was limited while medically oriented services were readily available to the elderly. It is widely recognized that the elderly have often been overmedicated and subjected toed unnecessary laboratory tests in hospital settings. They have sometimes stayed in hospitals much longer than medically appropriate. Such cases of induced hospital staysfor social rather than medical reasons are called social hospitalization. The situation has been improved since the implementation of the LTC program.

4.6 Reform Options

When LTC insurance was first introduced, various approaches were considered, among them a tax-based option, a public insurance approach, and a private insurance approach. In the countries where a majority supported the idea of public long-term care insurance, various options are again being considered because of the financial difficulties facing the existing systems.

The following points have been raised as problems in the Germany system (Reichert 1998): (a) eligibility standards for long-term care need are biased to physical conditions; (b) there are regional differences in care need assessment; (c) the take-up rate of the cash option is high and the quality of services provided by the family is unclear; (d) the insurance benefit is capped and does not cover the risk fully; (e) the coordination between health insurance and long-term care insurance is not good; (f) and the quality of services and working conditions in the care facilities are deteriorating.

The aging of the population will increase the number of persons in care dependency and will reduce the number of potential informal caregivers. Both developments challenge the sustainability of the German LTC system, and a number of reform options have been suggested, ranging from a slight adjustment of the current system to the radical reform of abolishing the pay-as-you-go system in favor of one with funding principle. A first reform of the LTC system was conducted in 2008 and included a nominal adjustment of benefits to maintain constant real value. Further reforms will be necessary in the near future.

A contentious issue in Japan is whether or not to provide cash benefit in cases where family members are providing care for the elderly. Some local authorities in Sweden are experimenting with voucher systems that allow users, still needs-assessed by the municipality, to choose among providers, and similar arrangements have been mandated since 2009 for all municipalities.

The implications of introducing the personal care budgets to increase consumer direction and choice are important in the Dutch system. Whether the proposed reform will lead to sustainable financing and a more consumer-directed provision of long-term care services crucially depends on the way entitlements are defined, improvements in the accuracy of needs assessment, and the feasibility of determining appropriate client-based budgets (Schut and Vanden Berg, in this issue).

5. Conclusions

LTC services need greater resources, but reforms of care system and supply side renovation are prerequisite for a higher level of support. In view of the very difficult financial situations in the discussed countries, an increase in individual contribution might be inevitable, possiblyin the form of higher user charges or a slimmer catalog of benefits. Asuser charges are likely to involve equity consideration, income related user chargers could be considered.

Financing LTC services remains a key issue, and all six countries are reviewing new options including a broader financing basis for social benefits and a greater reliance on private arrangements. In considering new approaches, finding the balance between public program and private arrangements, and between solidarity and self-help, is critical. Whatever course is taken, the costs of an aging society will not disappear.

References

Fernández, J.-L.In this issue. "Social Care Services in England: Policy Evolution, Current Debates, and Market Structure."
Fukawa T. 2001. "Japanese Welfare State Reforms in the 1990s and Beyond : How Japan Is Similar to and Different from

Germany. "*Deutsches Institut fuer Wirtschaftsforschung Vierteljahrsheft* 4: 571-85.

Heinicke, Katrin, and Stephan L. Thomsen.In this issue. "Social Long-Term Care Insurance in Germany: Origin, Situation, Threats, and Perspectives."

OECD. 1998. "Long Term Care Services to Older People, a Perspectiveon Future Needs: The Impact of an Improving Health of Older Persons." Ageing Working Papers no.4.2. OECD.

OECD. 2006. "Projecting OECD Health and Long-Term Care Expenditures." ECO/WKP (2006) 5. Economics Department Working Paper no.477. OECD. www.oecd.org/dataoecd/57/7/36085940.pdf.

OECD. 2011. "**Society at a Glance 2011 - OECD Social Indicators**" Public use database. OECD. http://www.oecd.org/els/socialpoliciesanddata/societyataglance2011-oecdsocialindicators.htm

OECD. 2012. "Health Data 2012: OECD. StatExtracts." Public use database. OECD. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

Ogura, S. and M.Sumi. In this issue. "What Has Long-Term Care Insurance Brought to Japan-A Critical Survey of the Japanese Economic Literature."

Reichert, M. 1998. "Financing Long-Term Care in Germany: Does the German Model Really Work?" Paper given at the annual meeting of the Gerontological Society of America.

Schneider, Ulrike, and Birgit Trukeschitz. In this issue. "Changing Long-Term Care Needs in Aging Societies: Austria's Policy Responses."

Schut, Frederik T., and Bernard van den Berg. In this issue."Sustainability of Comprehensive Universal Long-Term Care Insurance in the Netherlands."

Sundström, Gerdt. In this issue. "Aging and Old-Age Care in Sweden: Administrative, Demographic, Political, and Financial Aspects."

Tsutui, T., and N. Muramatsu. 2005. "Care-Needs Certification in the Long-Term Care Insurance System of Japan." *Journal of the American Geriatrics Society* 53(3): 522-27.