Contents

Overview of Financing and Managing Long-Term Care Services in Six OECD Countries
........................................................................................................... Tetsuo Fukawa  Seiritsu Ogura  Bernard van den Berg  1

Changing Long-Term Care Needs in Aging Societies: Austria’s Policy Responses
........................................................................................................... Ulrike Schneider  Birgit Trukeschitz  9

Social Care Services in England: Policy Evolution, Current Debates, and Market Structure
........................................................................................................... Jose-Luis Fernández  29

Social Long-Term Care Insurance in Germany: Origin, Situation, Threats, and Perspectives.
........................................................................................................... Katrin Heinicke  Stephan L. Thomsen  51

What Has Long-Term Care Insurance Brought to Japan—A Critical Survey of the
Japanese Economic Literature........................................................................ Seiritsu Ogura  Masayoshi Sumi  74

Sustainability of Comprehensive Universal Long-Term Care Insurance in the Netherlands
........................................................................................................... Frederik T. Schut  Bernard van den Berg  91

Aging and Old-Age Care in Sweden: Administrative, Demographic, Political,
and Financial Aspects.................................................................................... Gerdt Sundström  109

Instructions to Authors/Manuscript Submission and Specifications .......................... 136
Overview of Financing and Managing Long-Term Care Services in Six OECD Countries

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 market participation 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

*1 Director, Institution for Future Welfare
*2 Professor at Hosei University, Tokyo, Japan (e-mail: sogura@hosei.ac.jp).
*3 Reader at the Centre for Health Economics, University of York.
in Sweden, less than 50 percent of GDP, and with more than 200 percent, the highest in Japan. In the other European Community countries the burden of government liabilities is much 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 indicator regarding 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 experienced very 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

<table>
<thead>
<tr>
<th>Year</th>
<th>Austria</th>
<th>Germany</th>
<th>Japan</th>
<th>Netherlands</th>
<th>Sweden</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>8.4</td>
<td>81.9</td>
<td>127.5</td>
<td>16.5</td>
<td>9.4</td>
<td>61.3</td>
</tr>
<tr>
<td>2050</td>
<td>9.0</td>
<td>74.4</td>
<td>95.2</td>
<td>16.8</td>
<td>10.5</td>
<td>77.0</td>
</tr>
<tr>
<td>2011</td>
<td>17.7</td>
<td>20.7</td>
<td>23.3</td>
<td>15.6</td>
<td>19.3</td>
<td>16.2</td>
</tr>
<tr>
<td>2050</td>
<td>30.0</td>
<td>30.9</td>
<td>38.8</td>
<td>26.4</td>
<td>24.6</td>
<td>23.6</td>
</tr>
<tr>
<td>2010</td>
<td>80.7</td>
<td>80.5</td>
<td>83.0</td>
<td>80.8</td>
<td>81.5</td>
<td>80.6</td>
</tr>
<tr>
<td>2009</td>
<td>1.39</td>
<td>1.36</td>
<td>1.37</td>
<td>1.79</td>
<td>1.94</td>
<td>1.94</td>
</tr>
<tr>
<td>2012</td>
<td>83.0</td>
<td>88.5</td>
<td>214.1</td>
<td>81.0</td>
<td>48.0</td>
<td>104.2</td>
</tr>
<tr>
<td>2010</td>
<td>42.0</td>
<td>36.3</td>
<td>26.9</td>
<td>38.2</td>
<td>45.8</td>
<td>35.0</td>
</tr>
<tr>
<td>2010</td>
<td>42.4</td>
<td>57.7</td>
<td>65.2</td>
<td>54.1</td>
<td>70.6</td>
<td>56.7</td>
</tr>
<tr>
<td>2007</td>
<td>2.64</td>
<td>2.71</td>
<td>1.30</td>
<td>2.84</td>
<td>3.35</td>
<td>3.58</td>
</tr>
<tr>
<td>2011</td>
<td>33.4</td>
<td>39.9</td>
<td>21.0</td>
<td>31.4</td>
<td>24.8</td>
<td>25.1</td>
</tr>
<tr>
<td>2005</td>
<td>1.3</td>
<td>1.0</td>
<td>0.9</td>
<td>1.7</td>
<td>3.3</td>
<td>1.1</td>
</tr>
<tr>
<td>2050</td>
<td>2.5-3.3</td>
<td>2.2-2.9</td>
<td>2.4-3.1</td>
<td>2.9-3.7</td>
<td>3.4-4.3</td>
<td>2.1-3.0</td>
</tr>
<tr>
<td>2010</td>
<td>11.0</td>
<td>11.6</td>
<td>9.5</td>
<td>12.0</td>
<td>9.6</td>
<td>9.6</td>
</tr>
</tbody>
</table>


*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 Care of 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 National Equity 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 and state.

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 issue 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 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 caregivers receive 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 to unnecessary laboratory tests in hospital settings. They have sometimes stayed in hospitals much longer than medically appropriate. Such cases of induced hospital stays for 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, possibly in the form of higher user charges or a slimmer catalog of benefits. As user 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

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 Perspective on Future Needs: The Impact of an Improving Health of Older Persons." Ageing Working Papers no.4.2. OECD.


Schneider, Ulrike, and Birgit Trukschitz. 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."


Changing Long-Term Care Needs in Aging Societies: Austria's Policy Responses

Ulrike Schneider*1
Birgit Trukeschitz*2

Abstract

In 2007, 17 percent of the Austrian population was age 65 or old, and the older population will increase markedly over the decades to come. Today, life expectancy at age 50 is 29 years for men, and almost 34 years for women, half of which will be troubled by health problems and functional limitations. As a result, the number of Austrians receiving LTC will increase by at least 41 percent between 2008 and 2030, and, spending on long-term care would claim 1.96 percent of the country's GDP in 2030, which compares to 1.3 percent in 2008. This paper provides an overview of Austria's tax-based LTC system, including its principles of subsidiarity and solidarity, and details of the system, including universal cash benefits for care clients, complex policies regarding funding of social care services, and policies supporting family caregivers.

[Key words] Esping-Andersen, Continental European subsidiarity model, family first, universal cash benefit, domiciliary care services, institutional social care

1. Introduction

Austria is a country of 8.3 million people in Central Europe. Only five cities count more than 100,000 inhabitants. Although one in five Austrians lives in Vienna (1.6 million people), more than half live in smaller towns and villages with fewer than 10,000 residents. Accordingly, the population density ranges from 4,000 residents per square kilometer in Vienna to just 55 in the province of Carinthia (the average being 99). By comparison, Japan's population density measures more than 340 persons per square kilometer.1

In 2007, 17 percent of the population was age 65 or older, and the older population will increase markedly over the decades to come: according to projections by the United Nations Population Division (2002), the median age in Austria will increase from 38 in 2002 to 54 in 2050, drawing level to Japan by that time. As in other industrial countries, the marked and continuous increase in life expectancy is a driving force of population aging. Today, an Austrian male is expected to live a further 29 years at age 50. Women's life expectancy at age 50 is even higher, approaching 34 years. However, half the remaining years (14.6 for men; 18 for women) will be troubled by health problems and functional limitations (see Jagger et al. 2008).

These developments raise questions about the sustainability of the country's pensions, health, and long-term care (LTC) systems. Recent debate has focused on long-term care, given the steady increase in the numbers of older persons drawing LTC benefits over the past years and bleak projections for the future. The fact that in

* 1 Head of the Institute for Social Policy and the Research Institute for Economics of Aging at the Vienna University of Economics and Business.
* 2 Senior research fellow at the Research Institute for Economics of Aging at the Vienna University of Economics and Business.
Table 1. Projected Increase in Elderly Population in Need of Long-Term Care, Austria, 2006-30

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower-Bound Scenario (1)</td>
<td>Upper-Bound Scenario (2)</td>
<td>Lower-Bound Scenario (1)</td>
<td>Upper-Bound Scenario (2)</td>
</tr>
<tr>
<td>2006</td>
<td>334,162</td>
<td>334,162</td>
<td>58,958</td>
<td>58,958</td>
</tr>
<tr>
<td>2010</td>
<td>381,319</td>
<td>381,319</td>
<td>14.1</td>
<td>14.1</td>
</tr>
<tr>
<td>2015</td>
<td>401,569</td>
<td>419,355</td>
<td>20.2</td>
<td>25.5</td>
</tr>
<tr>
<td>2020</td>
<td>410,825</td>
<td>449,435</td>
<td>22.9</td>
<td>34.5</td>
</tr>
<tr>
<td>2025</td>
<td>435,226</td>
<td>493,752</td>
<td>30.2</td>
<td>47.8</td>
</tr>
<tr>
<td>2030</td>
<td>472,179</td>
<td>551,886</td>
<td>41.3</td>
<td>65.2</td>
</tr>
</tbody>
</table>


2008, 5 percent of the Austrian population received an LTC cash allowance can be taken as reliable indicator of substantial limitations in coping with activities of daily living. About 90 percent of those who were entitled to the federal care allowance were age 60 or older (see BMSK 2008, 6).

The latest projections, shown in Table 1, are that the number of Austrians receiving the federal LTC allowance will increase by at least 41 percent between 2008 and 2030 (see Mühlberger, Knittler, and Guger 2008b, 33). As a result, the cost of providing long-term care (including cash allowances and spending on care infrastructures) is estimated to expand by 66 percent to 207 percent. In a middle scenario, spending on long-term care would claim 1.96 percent of the country's GDP, which compares to 1.3 percent in 2008 (see Mühlberger et al. 2008b, 34).

Against that backdrop, this paper provides an overview of Austria's policy response to population aging in the area of long-term care. Section 2 will briefly reflect on basic characteristics of LTC policies in comparison with other countries' approaches to the issue of eldercare and also in comparison with the design of health care policy. Section 3 details different pillars of Austria's LTC system, including cash benefits for care clients, public support for the development and provision of social care services, and policies supporting family caregivers. In addition it will briefly discuss recent policy changes intended to solve the problem of illicit care, provided by an ever growing number of migrant care workers. The paper closes with a brief summary of Austria's policy efforts, emerging ideas about how to secure sustainable funding for long-term care, and comment on other hot spots of the current Austrian debate over long-term care.

2. Basic Characteristics of the Austrian LTC System in a Comparative Perspective

A brief conceptual discussion will provide a useful backdrop for understanding characteristics of Austria's provision of long-term care to the elderly. We will first sketch out typologies (or "regimes") of LTC systems in Europe and explain Austria's place in this grouping of countries (Sec. 2.1). For this purpose, we draw on the literature on social care models, which inspire cross-national comparisons of the outcomes of different policy regimes. Section 2.2 will highlight major principles underlying the provisions for frail older persons in Austria. The aim is to show how these guiding principles relate to system design and the course of action in the country's health care and pension systems and thus to begin to explain major differences in social policy design even within Austria.
2.1 Austria's System in relation to Models for Long-Term Care in Other Countries

The literature on welfare state models has burgeoned in the past 20 years. Following Esping-Andersen's *Three Worlds of Welfare Capitalism* (1990), a number of authors (see, e.g., Evers and Wintersberger 1990; Evers and Svetlik 1993) refined the notion that countries differ with regard to the roles assigned to families, nonprofit organizations, the market, and the state in generating social security and equity. Given that each of these spheres of society is driven by a different logic, varying patterns of responsibilities will bring about dissimilar mixes of welfare services and diverse ways for funding these services across countries. More specifically, the "welfare-mix approach" holds that solutions provided by families and nonprofit organizations primarily reflect affiliation or membership, norms, traditions, and moral obligations. The state and its institutions also emphasize commonality of purpose and solidarity, while at the same time catering to justice and universal access to services. By contrast, market-based transactions feature individualism and choice and hence differences in the preferences for and access to social security.

Early empirical efforts were made to identify and map types of welfare states based on the varying roles of the state, the market, and the family and on major policy outcomes such as stratification and decommodification (Esping-Andersen 1990). Esping-Andersen himself suggested three types of welfare regimes and used data across a variety of cash-based welfare benefits to assign single countries to a specific type of regime (Esping-Andersen 1990; criticism by Scruggs and Allan 2006). A more recent strand of literature accounts for service benefits in addition to cash benefits (Bambray 2005, 2007; Jensen 2008) with some authors singling out specific areas such as social care services to the elderly. These contributions not only complete and correct the otherwise distorted picture of benefit systems but also are more suitable for an analysis of the provision of health and long-term care to frail older persons, where such services play the main role. In what follows, we will therefore sketch out a typology and grouping of countries, as developed in the literature on social care models (Anttonen and Sipilä 1996; Bettio and Plantenga 2004; Timonen 2005; Jensen 2008). According to this approach, at least four types of social care model can be discerned in Europe.

In the Mediterranean Model, the family assumes the main responsibility in caring for frail elderly people and access to social services is very limited. The state provides services mainly in hardship cases. Design, implementation, and funding of public support becomes the responsibility of state or local actors, and there is thus a fragmentation of public services. Access to benefits as well as levels and types of support may vary across jurisdictions. The market for social care services is quite small and serves to higher-income families. Otherwise, social care is provided through a "gray market" that matches migrant care workers and private households at low hourly rates. Italy figures as a prominent example of this type of LTC regime (see, e.g., Bettio and Plantenga 2004; Bettio, Simonazzi, and Villa 2006).

The Anglo-Saxon Model, by comparison, is characterized by means-tested public benefits for persons in need of long-term care. Although public support is still modest, there is less (if any) variation in the level of and access to cash benefits. Service benefits may still vary across jurisdictions or communities. The flow of public benefits to low-income households strengthens the market for social care services, yet families remain a major source of care. The Continental European Subsidiarity Model still insists on family responsibility for caring to the elderly. However, the state has ventured on supporting families in a variety of ways, prominent among them public funding for nonprofit organizations that provide LTC services and also such services as "meals on wheels" to households of frail older people. In addition, the state provides such caregiver benefits as, for example, counseling, pension contributions on behalf of family caregivers in specific cases, generous leave arrangements, and respite care but usually no noteworthy attendance allowances. Benefits to care dependents (care allowances) are very limited. Additional public support is available on a means-tested basis only. The empirical literature on social care unanimously assigns Austria and Germany to this model.

Finally, the Scandinavian Model features a very developed system of LTC services. Access to care services is a civil liberty and hence universal. The federal government sets standards and procedures to secure quality
of services. At the same time, the local government assumes major responsibilities in service delivery. While this model emphasizes the role of the state in catering to the needs of frail older persons, it also exhibits support to family members of care clients. Sweden is the typical reference country for this model and exhibits high rates of service use among the frail older population.

In summary, countries respond differently to care needs of older persons. Most important, the roles of the family and the state in providing care and access to public services differ widely across Europe. If we think of the Mediterranean Model, also called the "all-in the family model," as one extreme and the Scandinavian Model with its well-developed public provisions as another, Austria is situated somewhere in between these two poles. About 80 percent of persons 60 or older rely on family care in case of long-term illness or dependency (see Klimont, Kytir, and Leitner 2007), evidence of a strong reliance on the family system (as in Mediterranean countries). At the same time, the country established a universal, tax-funded LTC cash allowance in 1993 (see Sec. 3.1). This benefit is not means-tested (as in the Anglo-Saxon Model) but neither is it generous enough to open vast access to formal services (as in the Scandinavian Model).

Before delving into the details of the Austrian LTC system in Section 3, in the following section we will discuss two of its guiding principles and briefly contrast them with the general rules shaping the provision of health care benefits.

2.2 Guiding Principles of Austria's LTC System compared to Health Care

Austria's welfare system in general and its LTC system in particular are shaped by the two normative principles of "subsidiarity" and "solidarity." These principles are partly at odds with each other, a fact that, in the case of long-term care, entails a system design that combines universal and selective (means-tested) benefits.

The principle of subsidiarity posits that the responsibility to deal with a problem should lie with the person or organization at the lowest level that is capable of resolving it. As a consequence, passing on a problem from the individual to the family, from the family to the local informal community, from the private sphere to the local public sphere, and—finally—from the local or provincial authorities to the federal government always requires that it cannot (or can no longer) be solved at a lower sphere of action. At the same time, society and the state representing it need to maintain and foster the capacities of individuals and lower levels of government to help themselves (see Badelt and Österle 2001, 20-21).

In the context of eldercare, subsidiarity implies "family first." A person in need of long-term care is responsible for herself or himself in the first place and is expected to make use of his or her own resources or those of the immediate family before requesting help from others. A similar line of reasoning applies to public provision for the population in need of long-term care, where major provincial and local governments share responsibilities with the federal government.

The principle of solidarity maintains that individuals are responsible not just for themselves but also for one another. Any form of social policy is a way of organizing support to other members of society. The very existence of a well-defined LTC policy in Austria acknowledges the solidarity principle. Those who suffer from significant limitations in their activities of daily living are entitled to claim a needs-tested cash benefit, irrespective of income. Furthermore, there is a public responsibility for LTC infrastructures: they are not left to be developed by for-profit firms.

Taken together, the Austrian LTC system reflects both guiding principles. The first tier of support for LTC clients is a tax-funded cash benefit (see Sec. 3.1 for details). This care allowance is not means-tested, in accordance with the solidarity principle.

However, this first tier offers only limited protection against the financial cost of eldercare. By default, the level of the care allowance falls far short of the amount required to cover the full cost of professional care services. The government report on social protection affirms that the care allowance "should be regarded as a lump sum contribution towards care costs" (Federal Ministry of Social Affairs and Consumer Protection 2007, 66). According to a report by the Austrian Court of Audit (Bundesrechnungshof 2007), the allowance usually
covers between 6.6 and 57.7 percent of the cost of an hour of professional care, depending on the type of care needed and on the benefit category.

As a consequence, long-term dependency—especially in old age—still constitutes a poverty risk. In fact, a major share of spending on means-tested social assistance by the Austrian provincial authorities (Laender)—54 percent in 2006—flows to nursing homes and skilled nursing facilities. So even with a federal and universal program in place, older persons in need of long-term care must commonly spend down their assets after the onset of a limiting condition, and the provincial authorities still pay a solid amount in means-tested cash-benefits to LTC clients. These benefits form the second tier of protection. The risk of poverty is buffered by family resources in general and informal care in particular. According to a recent survey on health issues, 9 percent of Austrian men and 19 percent of Austrian women ages 60 and over indicated that they use social care and other types of paid help in the case of long-term dependency on care, whereas 76 percent rely on their families (Klimont et al. 2007, 27-28). However, access to informal support is not always available and may reach its limits at higher levels of care need.

Because of its strong reliance on the principle of subsidiarity, the provision of long-term care in Austria is in stark contrast to the provision of health care services. The social health insurance system covers 98.7 percent of the population and is very visibly pervaded by the solidarity principle. Most important, benefits for all covered services are open-ended: patients are to receive all medically necessary services. Copayments as an element of subsidiarity are in place for medication, assistive devices, and hospital stays. Cost sharing, however, is limited. As a consequence, acute illness in old age does not usually entail catastrophic cost to patients and their families. By contrast, long-term dependency implies significant amounts of cost sharing whenever formal professional services are used.2

Summing-up, long-term policy in Austria reflects two major principles of social policy design, namely, solidarity and subsidiarity. Solidarity manifests itself in a universal cash-benefit system that is needs-based and not income-tested. Subsidiarity in the given context stresses self-responsibility and the role of families in providing care to frail older relatives.

Public support is considered complementary to these efforts. The tradition of subsidiarity also explains the role of nonprofit organizations as the mainstay of service provision and provincial authorities’ responsibilities in LTC policy. If long-term care is compared with health care, the principle of solidarity appears to rank higher in health policy, whereas benefits in case of dependency in old age are less generous and offer less protection against the risk of impoverishment.

The following section will offer more detail about the types of benefits offered to LTC clients and their relatives in Austria. It will describe universal cash benefit system as well as the design, funding and delivery of service benefits at the provincial level.

3. Austria’s Policy Response to the Challenges of Long-Term Care

Although the 1993 legislation on long-term care was a major step toward reducing the fragmentation and differentiation in support offered across the country (see Sec. 2), even today Austria’s response to the challenges of old-age dependency cannot be considered all of a piece. Responsibilities for long-term care are shared between the federal government and the nine provincial governments. In 1993, an agreement was reached on the division of responsibilities across the different levels of government: care allowances were to be governed by one federal law and nine provincial laws, while at the same time program design was to be harmonized with regard to needs assessments and benefits levels. The federal law on LTC cash allowances (Bundespflegegeld-Gesetz) refers to care recipients who receive pension benefits or related benefits based on federal statutory provisions. Care allowances paid under one of the nine provincial laws address LTC clients who are not (yet) eligible for pension benefits, such as younger handicapped people, persons covered by social insurance as co-insured family members, or recipients of social assistance payments. (see OECD 2005, 81;
Österle and Hammer 2006; Da Roit, Le Bihan, and Österle 2007, 657; Federal Ministry of Social Affairs and Consumer Protection 2007, 66). Services infrastructure development (for social care services, day care, residential care) remained a provincial responsibility. In this area, the provinces make use their undivided competencies without putting much emphasis on coordinating or benchmarking their individual efforts. As a result, funding and delivery of social care services still vary considerably across the nine provinces (see, e.g., Trukeschitz and Buchinger 2007b).

In Section 3.1, we will first focus on the tax-based universal care allowance. Since the vast majority of elderly LTC clients are covered by the federal cash benefit (Bundespflegegeld), it will form the core of the discussion. We will add corresponding information on the provincial LTC cash allowances where this appears appropriate. In Section 3.2, we will turn to the funding and delivery of long-term care services by the Austrian provinces, identify core elements of funding rules that are shared by several provinces, and look at alternative emerging funding types.

In addition, this section highlights two policy areas that have been addressed by both the federal government and provincial authorities: (i) policies in support of informal carers (Sec. 3.3), which are not coordinated among the federal and provincial authorities, and (ii) policies to legalize and regulate the "gray" market for domestic support for long-term care clients in need of 24-hour standby care (Sec. 3.4).

3.1 Tax-Based Universal Cash Benefit to Care Clients

On 1 July 1993, federal legislation on a tax-based care allowance came into effect. As agreed with provincial governments, corresponding laws were enacted by each of the nine provinces, such that a universal system of long-term care entitlements was established for the first time in Austria. This legislation created a legal entitlement to a cash benefit for all Austrian residents in need of long-term care, irrespective of age, income, type of disabling condition (mental, physical, psychical or sensory), and regardless of the specific cause of the limiting condition.

Eligibility for the care allowance strictly depends on care need. It is granted in Austria to persons not in an institutional care setting who are in need of continuous care, who (i) require more than 50 hours of care per month on average and (ii) are expected to depend on care for at least six months (Federal Ministry of Social Affairs and Consumer Protection 2007, 66). Care need is assessed on a seven-point scale that takes account of the fact that different kinds of functional limitations require differing types and intensities of care. More specifically, the grading scale is based on the number of hours of care needed per month and on the type of care (OECD 2005, 81). For an applicant to be placed into scale grades 5, 6, or 7 additional criteria apply, underlining the severity of the care needed.

In order to assure that all assessments follow a well-defined and standardized procedure, the federal and provincial LTC allowance acts were complemented by assessment regulations. The ordinance concerning the federal Care Allowance Act has been amended only recently (with changes effective 1 January 2009) to address the specific needs of children with severe disabilities and persons with mental disabilities, especially those suffering from dementia in the assessment.4

Level of Benefit

As displayed in Table 2, cash benefits in 2009 range from €154 per month for scale grade 1 to €1,656 per month depending on the level of care. As of 1 January 2009 the level of benefits was increased by 4, 5, and 6 percent for care clients in the lower, middle, and higher benefit categories, respectively. This increase in the benefit level is modest (especially for the lower LTC cash allowance levels), compared to the inflation rate of about 3.4 percent in 2008 alone.5

The level of the care allowance has not been adjusted for inflation on a regular basis, which is an issue of recurrent discussion. Adjustments of benefits are discretionary and require an act of parliament. Over the past
Table 2. LTC Cash Allowance: Need Categories and Benefit Levels, 2008 and 2009

<table>
<thead>
<tr>
<th>Levels</th>
<th>Hours of Care (per Month)</th>
<th>LTC Cash Allowance (per Month) 2008</th>
<th>LTC Cash Allowance (per Month) 2009</th>
<th>Adjustment as of 1 January 2009 Increase (%) 2009/2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>50</td>
<td>148.30 EUR 191.30 USD</td>
<td>154.20 EUR 198.90 USD</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>75</td>
<td>273.40 EUR 352.70 USD</td>
<td>284.30 EUR 366.70 USD</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>120</td>
<td>421.80 EUR 544.10 USD</td>
<td>442.90 EUR 571.30 USD</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>160</td>
<td>632.70 EUR 816.20 USD</td>
<td>664.30 EUR 856.90 USD</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>180†</td>
<td>859.30 EUR 1,108.50 USD</td>
<td>902.30 EUR 1,164.00 USD</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>180†</td>
<td>1,171.70 EUR 1,511.50 USD</td>
<td>1,242.00 EUR 1,602.20 USD</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>180†</td>
<td>1,562.10 EUR 2,015.10 USD</td>
<td>1,655.80 EUR 2,136.00 USD</td>
<td>6</td>
</tr>
</tbody>
</table>

† Additional requirements for eligibility: level 5: exceptional care need (e.g., requiring at least five units of care one of which is provided at night); level 6: unpredictable/ erratic care needs day and night or need for permanent supervision to avoid endangerment of self or others; level 7: impossibility of hemic movements of extremities (arms and legs) or necessity for life-supporting equipment.

15 years, the benefit levels have been adjusted only three times: 1994, 1995, and 2005 (see Mühlberger et al. 2008b, 9). As a result, the purchasing power of the care allowance has eroded visibly (see Fig. 1). Österle and Hammer (2006) note that the purchasing power of the care allowance has diminished by 16 percent between 1993 and 2004. The Austrian Court of Audit recently found that the LTC care allowance would cover at most 57 percent of the cost of professional care. Care clients with the lowest care needs (grade 1) also face the lowest rate of coverage (just about 7 percent of the potential cost of social care) (see Bundesrechnungshof 2007; see also Sec. 3.1).

**Use of Benefit**

The cash transfer is untied, that is, recipients have full autonomy over how to use it. It is paid to the person in need of long-term care but can be passed on to other persons (e.g., family caregivers). If a care recipient lives in a nursing home or skilled nursing facility, the transfer is paid to the residential care home, except for pocket money. Concern has been expressed that the cash benefit may be used for general consumption rather than improving the situation of a care client in catering to his or her specific needs. Yet authorities have not followed up on the use of the benefit, and scientific studies on this matter are very scarce.

According to findings from an early study by Badelt et al. (1997), formal employment relationships between care dependents and a family caregiver are an exception and most payments are symbolic. As reported by a quarter of the informal carers in their study sample, part of the LTC cash allowance was used to cover (some of) the additional expenses of informal caregiving, or flowed to them as a regular transfers or gifts. However, about 30 percent of informal caregivers, mostly partners coexisting with the care client, in fact stated that the LTC cash allowance merged into the general budget for housekeeping. In the past, the allowance has also been used to pay for (illicit) migrant care (see Österle and Hammer 2006).

In 2001 and again in 2003, home visits of a random sample of clients receiving an LTC cash allowance were conducted by professional care workers offering advice on the care arrangement to care clients and their families. Reports from about 2,000 visits show that the quality of home care was very good or good in three out
of four cases. For another 20 percent of care clients in this study, care workers found minor deficiencies in the care arrangement. The remaining 3 percent of care recipients were found to be neglected (see Nemeth and Pochobradsky 2004, 20). Following the assessments of these counseling projects, the government decided to make counseling visits to the homes of care clients a permanent component of its quality assurance strategy in 2005. However, these visits are not compulsory for recipients of an LTC cash allowance (as is the case in Germany).

**Administration of Payments**

A total of 25 Austrian authorities deal with applications for care allowances. The lion's share of payments (about 80 percent) is made by the supporting organizations of the pension insurance and accident insurance that are both reimbursed by the federal government. The Austrian Court of Audit repeatedly criticized inefficiencies in handling applications, differences in assessment procedures as well as the duration of the duration of the proceedings (see Bundesrechnungshof, 2008a, 2008b). As an example, the administrative expense as a percentage of all payments of the LTC cash allowance reached 8.2 percent in the authority administrating pensions for civil servants (*Bundespensionsamt*) (see Bundesrechnungshof 2008a, 11, 33-34).

**3.2 Public Funding for LTC Infrastructures and Service Delivery**

In Austria, responsibilities of public authorities for long-term care have been established on the federal and the provincial level. In general, public responsibility for the provision social care services rests with at the local
level. An agreement based on Article 15a of the Austrian Constitution between the federal government and the nine provincial authorities lays out the characteristics of service provision: social care services must be established area-wide and provision must continually be expanded. The agreement outlines minimum quality standards and states that social services must be organizationally interlinked. Beyond social services, provincial authorities are responsible for providing advice and information to people in need of long-term care. To ensure that social care services are implemented according to the agreement, surveys of needs and development plans must be elaborated by the provincial authorities.

Whether provincial authorities provide social services themselves (public provision) or commission private (nonprofit or for-profit) organizations (private provision) is a matter of local policy. In domiciliary care, most provinces chose to accredit private social service agencies, mainly nonprofit organizations. Care clients demanding services from an accredited private social service provider may apply for means-tested individual subsidies from provincial authorities.

Just one province (Tyrol) organizes social care services mainly by areas of collaborating communities (Sozial- und Gesundheitssprengel). Unlike domiciliary care, institutional social care in Austria is provided mainly by the public sector. In 2001, more than 56 percent of all employees in care homes worked in homes run by local authorities (see Schneider and Trukeschitz 2005, 26). Again, private-sector providers entering the market must be accredited by provincial authorities to be eligible for subsidies (for investments in building care homes) and public refunds, in case their residents have insufficient means.

It is not only in the comparison of institutional forms of social care providers that differences in the provision of social services come to the fore. Although national standards regarding the aims and principles of care for old and handicapped people have long been legally settled (see, e.g., Rudda and Marschitz 2006, 448), differences in the provision of social care arise and persist at the local level by reason of locally defined responsibilities. The supply of social services varies in quality and quantity at the local level, and care services are still underdeveloped in certain regions. Regional disparities occur not only in the labeling of services, but also in the comprehensiveness, variety, and quality of social care provision (see Federal Ministry of Social Security 2005).

Models of Public Funding of Social Care Services in Austria

Local disparities can be found in modes of public and private funding of social care services in Austria. All nine provincial authorities have made use of the leeway created by the Austrian Constitution and adopted their own social care and funding systems. In general, care clients pay for using LTC services (domiciliary, seminstitutional, and institutional services). Exceptions mainly apply for advice and information, which are free of charge.

The universal LTC cash allowance (see Sec. 3.1) strengthens the purchasing power of people in need of long-term care but does not cover total costs of social care services. Moreover, some provincial authorities set the "price" of social care services provided by accredited providers in their territory. Some provincial authorities subsidize the hourly price of care work; others grant a subsidy to the social service provider, as will be discussed below.

In spite of universal care allowance and price setting, individual financial resources may be still insufficient to cover the total cost of social care services. When institutional social care is needed, even savings are soon eaten up (Schneider et al. 2006, 1). If income is too low to cover costs the social assistance system steps in as a lender of last resort: In case of need for domiciliary care services, local authorities calculate the financial contribution the person is able to pay and top up the difference to the costs of care services. Where care home recipients have insufficient funds, the income and assets of the person in need of long-term care are administered by the provincial authority; only a small amount of money ("pocket money") remains for their own use.

Recipients of social assistance, in general, and people in need of long-term care whose financial resources no longer cover care costs (especially care homes residents), are obliged to refund benefits received from the local
authorities if their financial situations improve. Provincial authorities even have the right to claim refunds from family members, although some provincial authorities have recently waived that right.

An interesting funding arrangement is established in the westernmost province of Austria, Vorarlberg. For health-related home care, private payments do not refer to service units. Those in need of long-term care who join one of the home care associations receive health-related home care for free. Membership is about €25 per year, and donations are welcome if patients are in need of time-consuming care (see Trukeschitz and Buchinger 2007b, 154). Moreover, family members donate a fair amount of money to the home care association when a relative dies. Because the fees are low, this model does not require social assistance to step in.

Despite differences in calculating individual fees and claiming refunds from family members, the modes of public support for clients with insufficient resources vary from provincial authority to provincial authority. For domiciliary care, public funding is either a subsidy to the social service agency (to cover overhead costs) or a substitute payment per hour of care worker activity in case of insufficient private means. The latter can be regarded as the dominant funding arrangement for home care in Austria. Interestingly, hourly payments for domiciliary care are calculated in two different ways, as shown in Table 3. Some provincial authorities prefer regulating the amount of public payment per hour of care work ("fixed payments per hour"). Others define types of costs that social service agencies can claim against the provincial authority ("cost-related payments per hour of care work") (for further information see Trukeschitz and Buchinger 2007b, 146).

Public authorities that set the amount of public payment per hour of care work may do so in three different ways (see Trukeschitz and Buchinger 2007a, 16):

Type 1: The provincial authority regulates the price of one hour of care work and sets the public payment per hour;

Type 2: The provincial authority sets the public allowance paid per hour of care work only; and

Type 3: The provincial authority regulates the price of one hour of care work and pays the difference between the hourly rate and the individual contribution.

Concerning institutional care, provincial authorities provide subsidies to accredited providers to cover part of the cost of building private care homes. Provincial authorities also support people in need of long-term care for stay in an accredited care home if the client’s income and assets are not sufficient.

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Hour-Related Public Payments</th>
<th>Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burgenland</td>
<td>Type 1</td>
<td>Yes</td>
</tr>
<tr>
<td>Lower Austria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carinthia</td>
<td>Type 2</td>
<td>Yes</td>
</tr>
<tr>
<td>Upper Austria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salzburg</td>
<td>Type 3</td>
<td></td>
</tr>
<tr>
<td>Styria</td>
<td>Type 2</td>
<td></td>
</tr>
<tr>
<td>Tyrol</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Vorarlberg</td>
<td>Type 2’</td>
<td>Yes’</td>
</tr>
<tr>
<td>Vienna</td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

Source: Trukeschitz and Buchinger (2007b, 150).

Note: "Yes" in parentheses indicates that there is a subsidy but it is not very important.

*For home care only.

'For health-related home care only.
Public funding varies also according to the different modes of calculating daily rates for care homes (see Table 4). Again, authorities may decide on a certain daily rate or calculate daily rates using specific types of operating costs. In either case, daily rates refer to residential costs; rates for personal care are additional. Daily rates are subject to private payments of care home inhabitants and can be subsidized by provincial authorities if the income of care home residents is insufficient (Trukeschitz and Buchinger 2007b, 150).

Daily rates specified by the provincial authorities apply to all accredited providers within the province and within the same category of service provision. In contrast, cost-related daily rates may vary between accredited care and nursing homes in the same province.

**Levels of Public Funding for Social Care Services in Austria**

In total, €3,257.38 million were spent on long-term care by the public sector in 2006 in Austria (see Mülberger et al. 2008b, 11). As financial resources from specific local authorities (health funds and Bezirkshauptmannschaften) are not included, this sum should be interpreted as the minimum public expenditure.

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Fixed Payments</th>
<th>Cost-Related Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burgenland</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Lower Austria</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Carinthia</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Upper Austria</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Salzburg</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Styria</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Tyrol</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Vorarlberg</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Vienna</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>


**Table 4. Provincial Models for Determination of Daily Rates for Institutional Care, Austria, 2007**

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Hour-Related Public Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burgenland</td>
<td>Yes</td>
</tr>
<tr>
<td>Lower Austria</td>
<td>Yes</td>
</tr>
<tr>
<td>Carinthia</td>
<td>Yes</td>
</tr>
<tr>
<td>Upper Austria</td>
<td>No</td>
</tr>
<tr>
<td>Salzburg</td>
<td>Yes</td>
</tr>
<tr>
<td>Styria</td>
<td>Yes</td>
</tr>
<tr>
<td>Tyrol</td>
<td>Yes</td>
</tr>
<tr>
<td>Vorarlberg</td>
<td>Yes</td>
</tr>
<tr>
<td>Vienna</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Table 5. Expenditures on Long-Term Care, Austria, 2006 (Millions)**

<table>
<thead>
<tr>
<th></th>
<th>LTC Cash Allowances</th>
<th>Social Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Federal LTC Cash Allowance</td>
<td>Provincial Cash Allowance</td>
</tr>
<tr>
<td>EUR</td>
<td>3,257.38</td>
<td>1,621.40</td>
</tr>
<tr>
<td>USD</td>
<td>4,202.02</td>
<td>2,091.61</td>
</tr>
<tr>
<td>JPY</td>
<td>393,458.93</td>
<td>195,848.91</td>
</tr>
<tr>
<td></td>
<td>49.78</td>
<td>9.32</td>
</tr>
<tr>
<td>Total (%)</td>
<td>100.00</td>
<td>59.1</td>
</tr>
</tbody>
</table>

Source: Mülberger et al. (2008b, 11); own calculations.

Note: Vienna stock exchange: exchange rates USD, JPY, 10 December 2008: 1 EUR = 1.29 USD; 1 USD = 0.77 EUR; 1 EUR= 120.79 JPY; 1 JPY = 0.01 EUR.
Figure 2. Share of expenditures on social care services on total public expenditures (Austria, 2006). Source: Mühlberger et al. (2008b, 11), own calculations.

Figure 3. Expenditures of provincial authorities on social care by type of service (Austria, 2006). Source: Mühlberger et al. (2008b, 11), own calculations.
Table 6. Changes in Expenditures on Long-Term Care, Austria, 1994-2006

<table>
<thead>
<tr>
<th>Changes (%) 1994-2006</th>
<th>LTC Cash Allowances</th>
<th>Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Federal LTC Cash Allowance</td>
</tr>
<tr>
<td></td>
<td>54.4</td>
<td>20.9</td>
</tr>
</tbody>
</table>

Source: Mühlberger et al. (2008b, 11); own calculations.

Table 5 displays the expenditures on long-term care in Austria. Provincial authorities contribute more than 50 percent of all public expenditures on long-term care (provincial—LTC cash allowance and expenditures on social care). Forty-one percent of the total expenditure was for provision of social care services by the nine provincial authorities (see Fig. 2).

As Figure 3 shows, three-fourths of all provincial expenditures went to institutional care. Because of different provincial accounting systems, allocation of LTC expenditures to the different types of social services (home care, semi-institutional care, and institutional care) is not always precise. In particular, the share of expenditures on semi-institutional care might be underestimated.

From 1994 to 2006 public expenditures on long-term care increased by 54.4 percent. As Table 6 indicates, increase in LTC cash allowances developed below average. Huge increases appear in expenditures on social care services, mirroring the expansion of service supply and a rise in social service take-up.

3.3 Public Support to Informal Caregivers

Informal, unpaid caregiving is the mainstay of long-term care in Austria. Experts estimated an economic value of informal care amounting up to €2–€3 billion (see Schneider and Oesterle 2003, 236; Mühlberger et al. 2008b, 14). As caregiving for frail or sick relatives and friends is also a burdensome task with implicit opportunity costs, public support for informal carers is necessary not only to compensate for the accompanying risks but also to enable relatives or friends to engage in caregiving.

The following paragraphs describe benefits for informal carer that are available nationwide (for an overview see Table 7; for further details see Bundesministerium für Soziales und Konsumentenschutz 2008, 15).

Coverage of Informal Carers under Social Insurance Law. Family members who care for their frail relatives have health insurance coverage without contributions. Unemployed informal carers who care for relatives receiving LTC allowance of level 3 are eligible to insure themselves under the pension insurance schemes at reduced rates. Since July 2007, relatives caring for LTC allowance recipients of level 5 or higher have not have to pay any contributions for full coverage in the pension insurance system for a period of 48 months.

Family Hospice Leave System. The benefit of this regulation for informal carer, introduced in July 2002 and amended in March 2006, is a right to reduce working hours or to take leave for a period of time to care for a dying relative, for a maximum of six months. Informal carers are still covered by social insurance but have to cope with the loss of income. Unlike maternity leave, no financial support is granted. Only in hardship cases can an informal carer on family hospice leave get an allowance from the Familienhospizkarenz-Härteausgleich.

Financial Support for Respite Care. Beginning in January 2004, family members who provide informal care to a partner or close relative (LTC allowance level 4 or higher) but are temporarily unable to continue caring (from one to a maximum of four weeks; because of illness or holidays) receive an allowance to pay for respite care. This allowance is granted if the net monthly income per month (without transfers) of the relative receiving an LTC allowance does not exceed €2,000 (for LTC allowance levels 4 and 5) or €2,500 (for LTC allowance levels 6 and 7). The income threshold is adjusted in case of dependent family members. Financial support for respite care is capped depending on the need of long-term care (as indicated by the LTC allowance level).
Table 7. Public Support for Informal Carers

<table>
<thead>
<tr>
<th>Benefits for Informal Carer</th>
<th>Type of Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal level</td>
<td></td>
</tr>
<tr>
<td>Coverage under social insurance law</td>
<td>Yes</td>
</tr>
<tr>
<td>Family hospice leave system</td>
<td>Yes</td>
</tr>
<tr>
<td>Respite care</td>
<td>Yes</td>
</tr>
<tr>
<td>Information (care hotline; platform for informal carer)</td>
<td></td>
</tr>
<tr>
<td>Provincial level</td>
<td></td>
</tr>
<tr>
<td>Support of care-related advice</td>
<td>Yes</td>
</tr>
<tr>
<td>Seminars on care</td>
<td>Yes</td>
</tr>
<tr>
<td>Informal events and regular meetings</td>
<td>Yes</td>
</tr>
<tr>
<td>Respite care</td>
<td>Yes</td>
</tr>
<tr>
<td>Support stay in a health resort</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Information Services. As information is crucial for arranging care for relatives, two information services have been established. The Pflegetelefon is a hotline providing information on LTC issues. In addition an internet platform for informal carers offers information and exchange of knowledge.

In addition to federal support for informal carers, provincial authorities engage in activities to facilitate and enable informal.

1. To enhance and assure the quality of LTC service provision, some provincial authorities support care-related advice and counseling by a registered nurse. This support is organized as a lump-sum allowance, a voucher, or a benefit in kind.
2. Information events and regular meetings of informal carers (Stammtisch) are planned to give informal carers opportunities to exchange knowledge and share experiences.
3. Some provincial authorities modify eligibility criteria for respite care in favor of informal carers (lower level of LTC cash allowance required or additional support contingent on income).
4. At least one provincial authority provides support for a one-week stay in a health resort. Copayments for the informal carer are very low (€50).

3.4 A New Approach to Dealing with the Influx of Foreign "Gray Labor" in Long-Term Care

Social care services such as home care and meals on wheels contribute to improved living conditions for people in need of long-term care and prevent or delay transitions into nursing homes. Another aspect of social care services is that they facilitate informal care. As private copayments for professional home care services are common in Austria (see also Sec. 3.2), using social care can put pressure on family budgets, especially in severe cases of LTC dependency. As a consequence, a sizable number of LTC clients or their relatives turn to agencies that recruit care attendants from abroad, sidestepping Austrian labor laws and tax authorities.

Moreover, a chronic shortage of both licensed mobile nurses and stationary nursing places has led to an insufficient supply of care in quantitative and qualitative terms (see, e.g., Schmid and Procházková 2006, 462), which in turn has prompted immigration of legal and illicit foreign care workers. A recent empirical study reports that about 10.5 percent of care workers in Austrian nursing homes and skilled nursing facilities have not been trained in Austria. Slightly fewer than two-thirds of care workers in this group had been trained in another European Union member state, all others in third countries. The eastward expansion of the European Union
potentially facilitates free cross-border mobility of labor because EU citizens do not need to apply for a working permit in the single European market. However, Austria took advantage of an interim arrangement with regard to countries joining the European Union in the years 2007 to 2007 and sustained the restriction to its labor market for workers from these new EU member states (see e.g., Adam, 2004).

Against this background, Austria has experienced a significant influx of foreign "gray labor" from Central and Eastern Europe and the development of what is called a gray market of foreign care workers over the past decade. "Gray labor" refers to illicit personal care workers or homemakers working in private households. These foreign workers do not hold work permits in Austria, do not pay income taxes in Austria, and are not covered by social insurance. Experts estimate that approximately 40,000 illegal care workers support people in need of long-term care and their families (see Rudda and Marschitz 2006, 445). Labor market conditions (especially wages and employment opportunities) are less attractive to these workers in their home countries than in Austria. They commonly chose to commute between their home country and Austria every week or two, staying with a care client for a full week or fortnight. Concern has been raised in policy discussions about the qualification of this group of workers, the quality of care they deliver, and also their employment and living conditions and social protection.

Legal acts regulating the employment of foreign workers and long-term care as well as social care related issues were amended by the federal state in 2006, 2007, and 2008. In July 2007 the Act on Home Care (Hausbetreuungsgesetz) entered into effect, as did an amendment to the industrial code. Care workers from Austria or other EU member states must now be formally employed with the person in need of long-term care, a care client's relative, or a nonprofit social care agency. Alternatively, foreign care workers may be self-employed if they are assisting clients in housework and other instrumental and social activities of daily living (Federal Ministry of Social Affairs and Consumer Protection 2007, 68). Since 10 April 2008, they have been authorized also to help their clients with personal hygiene and intake of food. Even a few medical treatments (e.g., administering medication according to physicians' instructions) have recently been added to the list of legally recognized tasks for this group of personal care workers.

The recent legislation also specifies working conditions and remuneration (see Federal Ministry of Social Affairs and Consumer Protection 2007, 68). Care workers provide 24-hour home care as a member of a client's household for at least 48 hours per week but must not work more than 128 hours for two consecutive weeks. After 14 days, care work must be interrupted for leisure purposes for the same period of time.

Thus if 24-hour care is needed, two care workers must be engaged. Care workers who are not self-employed must be paid at least €1,093.53 per month (gross income for 238 hours, including standby duty) according to the national minimum wage in this occupational area. If two nurses (as mentioned above) are required, the cost of 24-hour standby care may amount to €3,000 to €4,000 (including payroll taxes) (see Adam, 2007a, 2007b). From 7 January to 15 July 2008, the number of self-employed care workers registered for up to 24-hour home care increased from 578 to 9,786. To obtain the total number of workers providing paid 24-hour care, the number of 24-hour care workers with an employment contract must be added. Unfortunately, these data are not available.

In addition to these regulations, financial support for 24-hour care was introduced on 1 July 2007. Access to a cash benefit joint funded by the federal state (60 percent) and the nine provincial authorities (40 percent) is tied to the following eligibility criteria: First, a care worker from Austria or another EU member state must be properly engaged (see above). Second, the care client must be eligible for a universal LTC allowance of level 3 or higher with a condition requiring 24-hour care. Third, the net income of the care client is not to exceed €2,500 per month (since 1 November 2008 assets are no longer counted). Finally, the care worker must meet qualification and process-related quality requirements (see Table 8).

The grant for 24-hour care amounts to a maximum of €500 or €1,100 per month depending on whether the personal care worker is self-employed. At least one province, Lower Austria, provide access to the 24-hour care allowance for recipients of LTC cash allowances in benefit categories 1 and 2 who suffer from dementia. A medical certificate attesting to the need for 24-hour standby care is not necessary.

As of the end of August 2008, 2,293 care clients had made a request for the 24-hour care allowance; 1,372 had
Table 8. Allowance for 24-Hour Home Care (Eligibility Criteria and Financial Support)

<table>
<thead>
<tr>
<th>Eligibility Criteria</th>
<th>Financial Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs-based</td>
<td>Up to 1,100 EUR(^a) per month</td>
</tr>
<tr>
<td></td>
<td>For two care workers being employed</td>
</tr>
<tr>
<td>Income threshold</td>
<td>Up to 500 EUR(^{a, b}) per month</td>
</tr>
<tr>
<td></td>
<td>For two self-employed care workers</td>
</tr>
</tbody>
</table>

\(^a\)3.225 USD, 301975 JPY (10 Dec 2008).
\(^b\)516 USD, 48,316 JPY (10 Dec 2008).

been accorded the benefit so far (some requests might still have been under examination). Public expenditure on this benefit amounted to €1.4 billion at that point in time.\(^{22}\) Figure 4 displays the payment flows in the Austrian LTC system.

4. Challenges to the LTC System and Current Policy Debate in Austria

In European welfare states, it has not been long since long-term care as a social risk began to appear on policy agendas. Compared to social security systems against sickness, unemployment, or old age poverty, policy approaches to covering a risk that almost everyone will confront, at least at the end of life—long-term dependency on care—are comparatively new. Policy responses to this kind of risk are diverse. Some European countries, such as the Czech Republic and Slovakia, have not yet established a distinct LTC system. There, social security for people in need of long-term care is rooted mainly in health care, pension, and family support systems. Other countries, such as Germany and Austria, have established specific policy approaches to deal with the need for long-term care. Where policy solutions have emerged, however, they differ in coverage, funding structure, and so on, from country to country and even within countries.

As mentioned in the introduction, above, Austria (and other European countries) face a marked increase in the share of old people in the population as a whole. Even with optimistic predictions of the expected number of healthy years of life at age 50 or 60, it is common knowledge that the number of people in need of long-term care will increase in the future. Given that Europe will be aging at a brisk pace in the coming decades, one may
Figure 4. Payment flows in Austria’s LTC system. (i) Federal state-person in need of LTC and provincial authorities/communities-person in need of LTC: LTC cash allowances paid to the person in need according to either the federal or provincial acts on LTC benefits. (ii) Federal state-LTC provider and federal state-provincial authorities/communities (Art. 2 § 13 Bundespfllegegeldgesetz): for institutional care (e.g., nursing home), LTC cash allowance is paid directly to nursing home; only “pocket money” (10 percent of LTC allowance level 3) is paid to the client. If the nursing home is run by the provincial authority LTC cash allowances are directed to the provincial authority. The regulation on pocket money applies. (iii) Provincial authorities/communities-LTC providers: subsidies to establish and support social care facilities, patient-related payments in case of insufficient individual means. (iv) Federal state-person in need of LTC and provincial authorities/communities-person in need of LTC: shared public funding of24-hour care allowance. (v) Relatives-provincial authorities/communities: depending on provincial regulations, relatives may be obliged to refund benefits received by the social care client (mainly institutional care). Some authorities charge first-degree relatives (children, parents) when care clients’ income is insufficient and benefits are granted. Overlap with the health care system: (vi) Social insurance agency-LTC provider: social security agency pays for medical home care (injections, artificial feeding, etc.), according to § 151 Allgemeines Sozialversicherungsgesetz (ASVG); if the client is cared for by a provider not a contract partner to the social insurance agency, costs are reimbursed according to § 131 ASVG. (vii) Health funds-provincial authority/community: funds set up to plan, govern, and finance health care at the local level, contribute the building of nursing homes or support operating nursing homes. Private long-term care insurance is not popular in Austria, therefore is not displayed. Source: own display based on Arbeitskreisbericht (2007, 21).
well ask whether current provisions for frail older people can be considered successful and sustainable. On the one hand, future challenges to LTC systems stem from changes in the volume and diversity of needs. On the other hand, they also result from the specific structure of a nation’s social security system in general and from path dependencies in its approach to dealing with need for long-term care.

In Austria, the LTC system rests on two pillars, namely, family support and public provisions for long-term care. Families play an important role, as almost 70-80 percent of older persons in need of long-term care rely on spouses and children to provide help. The public LTC system is complementary and fulfills three important tasks: First, it should assure a landscape of different types of social services as well as services sufficient in both number and geographical coverage (see Sec. 3.2). Second, it should secure access to services. At present, this is done by granting universal and selective financial support to people in need of long-term care (see Secs. 3.2 and 3.4). Third, it recognizes relatives as important actors in long-term care. Benefits for informal carers were recently introduced (see Sec. 3.4).

In the current debate on the future of Austria’s long-term care policy, four challenges figure every prominently. The first of these is that long-term dependency still presents a serious risk of poverty to older persons. Today a major share of spending on social assistance consists of payments for older persons in residential care. Accordingly, debate on adjusting benefits to inflation on a yearly basis in ongoing. Efforts are also underway to prevent or delay institutionalization.

Second, all projections point to an increase in the number of frail older people and at the same time predict a shrinking population of family caregivers. Therefore, increasing attention is being paid to the support of informal care. One way to ensure that support is to invest in the supply of home care and day care services.

Third, with an increase in the number of the oldest old, dementia care is gaining importance. Recent legislation has improved access to care benefits for persons suffering from mental conditions by changing assessment rules (see Sec. 4.1). At the same time, there is a need to develop new approaches to caring for this group of frail older people.

Fourth, as public spending on long-term care is growing fast, provinces have begun to realize that they will not be able to assume the sole responsibility for securing adequate LTC infrastructure. As a consequence, the program of the new federal government (2008-13) suggests setting up a public fund to be earmarked for long-term care (Mühlberger et al. 2008a). Details about where the initial endowment (or continuous flows of funding) will come from and the extent to which responsibilities will be shared between the federal government on the one hand and provinces on the other hand still need to be worked out.

Notes
1 See
http://www.statistik.at/web_de/statistiken/bevoelkerung/volkszahlungen/bevoelkerungsstand/034208.html and
And, for Japan, see
2 The two systems also differ with regard to funding. Health care is predominantly financed by social insurance contributions.
3 Verordnung über die Beurteilung des Pflegebedarfs nach dem Bundespflegegeldgesetz (Einstufungsverordnung zum Bundespflegegeldgesetz—EinstV), BGBl. II Nr. 37/1999.
4 See
http://ris1.bka.gv.at/App/findbgbl.aspx?name=entwurf&format=html&docid=COO_2026_100_2_501255.
5 See
6 Rate of exchange: USD 4,202.02; JPY 393,458.93.
7 Rate of exchange: USD 1,410.56; JPY 1,32284.32.
9 In cases of dementia, care clients are eligible for support beginning with a placement at level 2.
10 Rate of exchange: USD 3,225; JPY 301,975 (10 December 2008).
11 Rate of exchange: USD 645-1,419; JPY 60,395-132,869 (10 December 2008).
12 Rate of exchange: USD 1.8 billion; JPY 169 billion.

References


OECD. 2005. The OECD Health Project: Long-Term Care for Older People. Paris: OECD.


Social Care Services in England: Policy Evolution, Current Debates, and Market Structure

Jose-Luis Fernández*

Abstract

England provides long term care services as a part of the social care. Approximately 1.7 million people use social care services organized by the 150 local councils in 2005. At 1.2 million, older people constitute by far the largest user group for social care. Of those, 1.0 million older people used publicly "brokered" community-based services that include domiciliary care (i.e., support to people in their own homes) and day care (services and activities available in other settings). Local authorities spent £8.0 billion on personal social care services in 2004/5, 1.6 billion of which was recouped from users through means-tested charges. A further 3.7 billion was paid out to individuals on non-means-tested benefits to help toward the costs of care. The amount of public support for dependent people varies significantly depending on the wealth and geographical location of individuals. This paper first follows the evolution of the English policy of social services since 1980's, then introduces the current debates on community care policy, and finally explains the market structure of the community care market in England.


1. Recent Evolution of the English Community Care System

1.1 Basic Structure

Approximately 1.7 million people in England use social care services organized by their local councils (CSCI 2005). At 1.2 million, older people constitute by far the largest user group for social care. Of those, 1.0 million older people used publicly brokered community-based services.

The 150 local councils in England have a statutory duty to assess the needs and circumstances of anyone seeking help. Councils with social services responsibilities (CSSRs) are funded by a combination of central resources allocated through the Revenue Support Grant and an additional element from local council taxes. They are the main commissioners of social care services. Commissioning services involve assessment and care planning alongside the procurement of services. A social worker or care manager will assess the needs of the person (and of any carers or other family members) and develop a care plan to meet those needs. The process will take account of the resources available to the local authority and will also assess the financial means of the service user to determine what, if any, contribution they will be required to make to the costs of their care. The amount of public support for dependent people thus varies significantly depending on the wealth and

* Researcher with the PSSRU, London School of Economics
geographical location of individuals.

The services arranged through local authorities are broadly classified in terms of residential/nursing care, domiciliary care (i.e., support to people in their own homes), and day care (services and activities available to support people in other settings). "Community care services" refers to domiciliary and day care services.

Local authorities spent £8 billion on personal social care services in 2004/5, £1.6 billion of which was recouped from users through means-tested charges. Expenditure on community care services for older people accounted for 56 percent of total expenditure. A further £3.7 billion was paid out to individuals on (non-means-tested) benefits to help toward the costs of care.

**Regulation of Care Services**

The Care Standards Act 2000 led to the establishment of the Commission for Social Care Inspection (CSCI) in April 2004 as the single independent inspectorate for all social care services in England. The CSCI brought together responsibilities that had formerly been split among the Social Services Inspectorate (SSI), the SSI and Audit Commission Joint Reviews Team, and the National Care Standards Commission. The CSCI is responsible for registering local care services that are required to meet national standards. Further changes in 2008 saw the merger of the CSCI with the Health Care Commission to create a single new inspectorate across health and social care.

The General Social Care Council (GSCC) was established in October 2001, also under the Care Standards Act 2000. The GSCC is the social care work force regulator for England (equivalent bodies exist in Scotland, Wales, and Northern Ireland). The development of a Social Care Register for those working in social care began with social workers. Protection of title means that since 1 April 2005 anyone calling himself or herself a social worker must be registered as such with the GSCC. Registrants must have completed appropriate training, abide by the GSCC Code of Practice, and be physically and mentally fit for the job. The register will be opened to other groups of social care workers in the future. It is believed that the next groups to be registered will be domiciliary and residential care workers (in both adult and children's services), accounting for more than 750,000 workers.

**1.2 Recent Evolution of Social Care Policy in England**

The origins of current community care policies in England can be traced back in part to the 1970s, when the need to expand services for the "priority groups" in health and social care was an indication of how little development of community-based services had been achieved. A consultative document issued in 1976 set out objectives for a redistribution of resources away from the acute hospital sector and into community services for older people and those with physical disabilities, mental illnesses, and learning disabilities (Department of Health and Social Security 1976). Over the next few years a series of policy documents set out the various objectives for these different client groups, all of which shared the emphasis on redirecting development toward the community and away from residential and institutional facilities.

From the 1960s onward attempts to coordinate health and social care also became evident. In the early days 10-year plans were developed for hospital and community care services, but were short-lived. By the 1970s it was increasingly evident that the separation of health and social care was problematic. The creation of integrated social services departments in 1971 was shortly followed by the reorganization of the health service in 1974, which served to move many health services out of local government control and into the National Health Service (NHS). Attempts to improve the coherence of health services were arguably at the price of creating further barriers, gaps and overlaps with local authority-controlled social services (Hudson and Henwood 2002).

The current phase of social care development dates from major debate and subsequent reforms that emerged in the late 1980s. In December 1986 Sir Roy Griffiths was commissioned by the secretary of state to undertake
an overview of community care policy. This marked the beginning of a period of significant reform that underpins social care of the present day. Specifically, the terms of reference required a review of "the way in which public funds are used to support community care policy" and recommendations about how such resources might be used more effectively.

The 1990s Community Care Reforms

The Griffiths proposals recommended that local authorities would be responsible for assessing local community care needs and setting priorities and objectives (Griffiths 1988). That is, they proposed devolving control over community care practice from the center to the 150 English local authorities. At the individual level they would also be responsible for assessing needs and arranging packages of care. The proposed idea of the local authority as broker and care manager, but not necessarily as direct provider was revolutionary at the time. The view that "the role of the public sector is essentially to ensure that care is provided," but that how it was provided was a secondary consideration, required a new way of working and a completely new role for the local authority social services department (Griffiths 1988).

The Griffiths report provided the foundation for the community care reforms subsequently set out in the 1989 White Paper Caring for People. Local authorities were assigned the lead role in planning community care (but would need to do so in cooperation with health service partners). The "key components" of community care were identified as:

- Services that respond flexibly and sensitively to the needs of individuals and their carers,
- Services that allow a range of options,
- Services that intervene no more than necessary to foster independence, and
- Services that concentrate on those with greatest needs (Department of Health 1989).

The 1989 White Paper was enacted in the NHS and Community Care Act of 1990, with implementation of most changes taking effect in April 1993.

NHS and Community Care Act 1990

The most prominent of the changes associated with the 1990 act were:

- The massive transfer of funding from central to local government (and with it the responsibility to coordinate care purchasing); in particular, the transfer to local authority social services departments of the large, uncapped, central government social security budgets used until then for paying for residential care of older people with low means;
- Clarification and rebalancing of the respective roles of the NHS and local authorities;
- Unprecedented rates of growth of independent sector services for older people, with local authorities given the primary role of "enablers" (later commissioners);
- Greater emphasis on—and some changes to—financial arrangements to encourage community-based care, rather than institutional care;
- More explicit emphasis on the identification of priority groups and the targeting of services on the neediest, with the introduction of care management processes for allocation care packages;
- Hence the leveling off and beginning of a reversal of the 50-year upward growth in care home provision;
- Recognition of the often pivotal roles of unpaid carers, and of the associated need to provide them with support;
- Encouragement of devolved decision making (including care management);
- Development and elaboration of regulatory and inspection procedures;
- A national debate and a royal commission on the financing of long-term care;
- A move away from supply-led provider-dominated hierarchies toward needs-led purchaser-dominated markets;
• The introduction and rapid development of social care markets, creating the need for local authorities to develop a whole new set of skills in the commissioning of services; and
• A sea change in local authority attitudes to, and sophistication of performance in, links with independent providers.

The shift of social security funds into local authority budgets after 1993 immediately put a cap on the intense growth in public expenditure on residential care services. In particular, access to state-funded support (now via the local authority) was made subject to a thus far nonexistent needs assessment.

A major influence on the 1990 legislation was the increasing recognition of the burden carried by Britain’s hidden army of unpaid family and other carers. And, of course, political ideology or preference played its part, with the Conservative government keen to reduce the provider role of local authorities (but unable to find any alternative to giving them the overall strategic, "enabling" role) and to encourage the (further) growth of voluntary and, especially, private sector provision.

The other main element of the 1990 act, which saw the development of a market in social care, needs also to be seen as part of a wider movement in which Thatcherite policies were seeking reform of public sector bureaucracy and the introduction of the discipline and rigor of the market place. Indeed, the importance attributed to achieving improvements in efficiency in social care services was apparent throughout the reform legislation (Fernández 2005). As other commentators have remarked, this brought some challenges to joint working and collaboration that had relied on cooperation between partners. In the new climate, competition became a more significant driver and the management of interorganizational networks became considerably more complex and demanding (Hudson and Henwood 2002).

In the wake of the 1990 act there were therefore significant challenges for social care.

Some of these difficulties owed as much to what was not in the act as to what was. In retrospect the failure of the act to address health and social care issues in the round is striking. The 1989 White Paper observed (notoriously) that "the key functions and responsibilities of the health service as a whole remain essentially unaltered by the proposals" (Department of Health 1989a, para. 4.2). Indeed, a separate document, Working for Patients (Department of Health 1989b), addressed reforms for the NHS. The failure to address these as an integrated agenda ensured that loose ends dangling from both would eventually unravel and require more fundamental attention.

The Labour Administration, New Means for a Similar Set of Objectives

Modernising Social Services (Department of Health 1998) defined the goals and priorities of the new Labour administration, in office since May 1997. Despite a different lexicon and some changes in emphasis, the new Government has shared most of the objectives previously phrased in Caring for People.

A sustained quest for efficiency. Arguably, the overall efficiency related objectives have remained broadly unchanged. Hence, the 1998 White Paper introduced "Best Value" policy, with strong threats from ministers that failure to open in-house services to competition resulting in lower value would be ruthlessly exposed.

The Labour government claimed no sectoral preference: "It is no longer who provides the social care that matters. It is the quality of care that counts" (Milburn 1999). The emphasis on achieving Best Value was reflected in the White Paper, which noted that "an important finding of the Joint Reviews so far is that there is scope for many authorities to get more for what they spend on social services" (Department of Health 1998, para. 1.4). Commenting on the expenditure implications of the White Paper, it was noted that "this is investment for reform and the Government expects to see improvements in quality and efficiency in return for the increased investment" (para. 7.9). Moreover, the new government concurred with the previous administration in the value placed on developing the local mixed economy so as to achieve more flexible user oriented services. Hence, the White Paper recognized that "the near-monopoly local authority provision that used to be a feature of social care led to a 'one size fits all' approach where users were expected to accommodate themselves to the services that existed" (para. 1.7).
However, the need for efficiency improvements was placed within a wider context, namely the pursuit of consistency across the system. Improvements in consistency, it was argued, were to be obtained in ways such as the production of clear eligibility criteria and more coherent charging policies. The government was therefore placing significant emphasis on the achievement of improvements in the system’s horizontal and vertical target efficiency levels. In consequence, among the 1998 White Paper’s list of objectives for social services, with a focus on the need to improve efficiency, were several that reflected concerns identical to those previously voiced in *Caring for People*:

- To identify individuals with social care needs who are eligible for public support, to assess those needs accurately and consistently, and to review care packages as necessary to ensure that they continue to be appropriate and effective.
- To maximize the benefit to service users for the resources available, and to demonstrate the effectiveness and value for money of the care and support provided, and allow for choice and different responses for different needs and circumstances. For adult services, to operate a charging regime which is transparent, consistent and equitable; and which maximizes revenue while not providing distortions or disincentives which would affect the outcomes of care for individuals. (Department of Health 1998, para. 7.6)

Keeping users at home and relieving carer’s stress remained the principal final policy aims for social services for the elderly. However, both objectives were placed within a new overarching objective: promoting independence. Achieving independence had already been mentioned in *Caring for People* as one of the “key components” of what community care should be about (Department of Health 1989, para. 1.10). Arguably not straightforward to operationalize, this concept was presented in the White Paper as a means of providing "direction" for social services, listed first in the catalogue of national objectives. Specifically, it designated the need to provide "the support needed by someone to make most use of their own capacity and potential" (para. 2.5), through the effective use of available resources in the production of the final policy objectives.

As mentioned above, the Conservative government instigated 1989 reforms had stressed the need to concentrate resources on the neediest. Figure 1 shows that by the time the new administration took over, changes in targeting had brought about significant reductions in the resources allocated to lower dependency cases and a reduction in the coverage of services among the population (Warburton and McCracken 1999). *Modernising Social Services* expressed concerns about the long-term effects of the new pattern of allocation of resources. For instance, the White Paper stated that “some people who would benefit from purposeful interventions at a lower level of service, such as the occasional visit from a home help, or over a shorter period, such as training in mobility and daily living skills to help them cope with visual impairment, are not receiving any support. This increases the risk that they in turn become more likely to need much more complicated levels of support as their independence is compromised. That is good neither for the individual nor, ultimately, for the social services, the NHS and the taxpayer” (Department of Health 1998, para. 2.6).

Together with the careful targeting of low-intensity packages, the White Paper argued for the development of services specifically aimed at the rehabilitation or recuperation of physical ability. It was felt that significant proportions of users could be helped to improve their physical dependency through the provision of such services, and that a significant reduction in hospital use would follow, as well as a general decrease in the levels of unwanted institutionalization. New funds were created to finance special rehabilitation schemes and programs fostering increased health-social care cooperation.

It is important to note that the doubts expressed in the 1998 White Paper about the extent of concentration of resources on the neediest were not out of universalist concerns or worries about the loss of public support for the services because of a reduction in the pool of recipients of care. Instead, such concerns had mainly to do with efficiency considerations and were expressed in terms of missed opportunities for investment, because of the potentially preventive effect of small packages of care. This question remains unanswered, with no hard quantitative evidence demonstrating the long-term preventive potential (or lack thereof) of low-intensity care packages.

As did the previous government, the Labour government has recognized the need for further assisting carers
in their role. The 1998 White Paper argued that the care system did not adequately recognize the contribution of informal carers to the welfare of people with care needs, and criticized the "patchy" implementation of the 1995 Carers Act. On 10 June 1998, the prime minister announced the development of a national carers strategy, which aimed to bring together activity across all government departments in support of carers. As illustrated by its key aims, the government’s policy objectives on carers went beyond providing support to avoid the breakdown of caring and recognized informal carers as rightful beneficiaries of publicly funded support.

In 1999, the government announced its National Strategy For Carers, which included the allocation of £140 million (for England) to enable carers to take short-term breaks from caring (Department of Health 1999). The earlier Carers (Services and Recognition) Act 1995 had entitled carers to a full assessment of their needs independently of the users of services.

1.3 New Incentive Structures for Better Health/Social Care Coordination

Partnerships driven by performance (Department of Health 1997) have been viewed as the "third way," to be contrasted with the hierarchical "command and control" model of the 1980s and the internal market of the 1990s. The Health Act 1999 introduced new "flexibilities" to allow the NHS and local authorities to work more closely in providing integrated services by allowing transferred and pooled funds. A recurrent theme of government policy since 1997—over many fields, not just health and social care—has been the emphasis on closer working between professionals, organizations, agencies, and ministries in order to meet the needs of individual service users or citizens (with terminology and breadth of concept variously discussed in terms of "joined-up government," "partnership," "integrated services," and "whole system approaches"). Local strategic partnerships (LSPs) have provided important frameworks for setting out local intentions.

The Royal Commission, set up by the incoming government to look at the financing of long-term care, reported in 1999, and the government responded a year later within the context of the NHS plan (Department
of Health 2000a). The funding of long-term care, and particularly the contributions expected of older people with the means to pay, have been prominent issues in recent years. The plan also promoted closer collaboration ("partnership" again) between health and social care agencies.

Substantial additional resources for health care were announced in the NHS plan, to be invested over the longer term, alongside a reiteration of previously espoused objectives for older people: better partnerships between health and social services; needs-led decision making, flexible patterns of working, promotion of the independence of older people, policies to tackle agism, an emphasis on prevention, and the development of more services to support rehabilitation (Department of Health 2000a). The National Beds Inquiry (Department of Health 2000b) highlighted the inappropriate use of acute inpatient beds by many older people because of a shortage of suitable alternative services and accommodation, as well as pointed to the wide variations in the availability and use of service across the country. 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.

The strategy set out in the NHS plan (Department of Health 2000a) had three interrelated strands incorporating an emphasis on "whole systems working" across health and social care economies, the development of intermediate care (to improve the integration of health and social care while also improving outcomes for individuals), and a "Cash for Change" grant to develop capacity across the health and social care systems, primarily to reduce hospital delays.

Building Capacity and Partnership, issued in late 2001, addressed the concern that restricted social care capacity was hindering the performance of the acute health care sector. The guidance focused particularly on relationships between public-sector commissioners (of both health and social care services) and private- and voluntary-sector providers. A "concordat" was established to build capacity in both home care and care homes. Additional funding would allow local authorities to set up better, longer-term commissioning arrangements and, if necessary, to raise fees to stabilize the sector (Department of Health 2001a, 2002b). A later initiative was to charge local authorities if their lack of service provision delayed a person's discharge from hospital.

The Priorities and Planning Framework 2003-2006 (Department of Health 2002a) set out detailed targets for health and social care for older people, with the aims of promoting person-centered care, independent living, healthy and active lives, user satisfaction through timely access to high-quality services, and partnerships between formal services and family and other carers. The specific targets indicate the policy priorities, including to increase the proportion of people supported intensively to live at home, to reduce the rate of growth of emergency hospital admissions, to speed up assessments following first contact with social services, and to speed up the provision of community equipment. Other targets related to diabetes and stroke.

Local strategic partnerships (LSPs) have been established to bring together agencies from across the public, voluntary, and private sectors to coordinate their efforts to tackle local issues such as deprivation and social exclusion. The Audit Commission (2004b) argues that LSPs "potentially offer an ideal forum for implementing independence and well-being strategies for older people" (p. 34), although their involvement thus far varies enormously across the country. Another and longer-standing policy plank for further service development is the Best Value review, aiming to promote the appropriateness, quality, and effectiveness of local authority services (whether directly provided or commissioned). This is what the Audit Commission calls "self-evaluation," which can go hand in hand with "external evaluation" in the form of performance assessments, audits, and inspections.
1.4 European Law And Community Care Policy and Practice in England

Little attention has been paid in the literature to the potential implications for the care sector of the growing body of European legislation. Overall, the general sentiment is that, with the notable exception of the European working time directive (EWTD), social care policy and practice have not been affected in any major way by European laws.

The impact of the EWTD on social care, in contrast, has been the subject of considerable research, particularly centered on the residential and nursing home care sector (Knapp, Hardy, and Forder 2001; Holden 2002). Goss and Adam-Smith (2001), for instance, have shown that the personal-services sector of the economy is by far the most seriously affected by the implementation of the EWTD. Using the results of a survey of private companies in the wider economy, Goss and Adam-Smith (2001) show that approximately 20 percent of providers of personal services had been affected by the limitation of the working week to 48 hours. Similarly, over half of providers were found not to be complying with requirements relating to holiday entitlements at the time the EWTD was introduced.

2. The Current Community Care Policy Debate

2.1 Overall Policy Framework

Published in May 2001, the National Service Framework for Older People (NSF) now dominates the practice landscape. Eight standards were set out, related to person-centered care (e.g., tackling age discrimination; developing person-centered care), whole system working (developing intermediate care services), timely access to specialist care (providing specialist hospital care; improving stroke services; improving falls services; improving mental health services), and promoting health and active life. Like other national service frameworks, the aim was to introduce standards that were clearly evidence-based, in this case citing 369 references in support of its recommendations (Department of Health 2001b).

The 1992 White Paper The Health of the Nation had paid little attention to the health needs of older people, perhaps one reason why the NSF was widely welcomed. The consultative and advisory processes employed in the development of the NSF also drew generally broad approval. Specific initiatives set out in the NSF included reaffirmation of the single assessment process, encouragement of intermediate care, and specification of defined service models for three need groups (stroke, falls, mental health). Concerns were expressed about some aspects. Swift (2002), for example, warns that the single assessment process is a potential burden, that there is no consensus supporting any particular assessment tool, that intermediate care may develop into a cheap and substandard diversion from hospital access, and that some the standards could merely be cosmetic. Age Concern (2001) commented that housing and transport, both of which can have a great influence on health and access to health care, were not adequately addressed, that the framework relied too heavily on a medical model of healthy aging, and that the roles of the voluntary and private sectors were not fully acknowledged.

The Priorities and Planning Framework (Department of Health 2002) sets out detailed targets for health and social care for older people, with the aims of promoting person-centered care, independent living, healthy and active lives, user satisfaction through timely access to high-quality services, and partnerships between formal services and family and other carers. The specific targets indicate the policy priorities, including to increase the proportion of people supported intensively to live at home, to reduce the rate of growth of emergency hospital admissions, to speed up assessments following first contact with social services, and to speed up the provision of community equipment. Other targets related to diabetes and stroke.

The Audit Commission (2004a) has provided a helpful overview of the current policy context. Policies are
discussed under a number of headings. First, the NSF has helped to change the approach to older people by tackling discrimination. The EU employment directive is adds support through its prohibition of age discrimination in employment and training from 2006. The NSF also requires the NHS and local authorities to involve older carers in their local implementation teams. A further policy dimension is the effort to join up services by encouraging the NHS, local authorities, and other agencies to work together to promote health and active life. Linked to this objective are the new responsibilities of local authorities to assume "community leadership," as required by the Local Government Act 2000, and their new duty to promote well-being.

2.2 Promoting Choice in Community Care

A green paper on adult social care issued in March 2005 set out a new "vision for the future." The approach outlined in that document is part of a wider reform of public services in the twenty-first century, and the introduction of "an entirely different dynamic" characterized by more personalized services offering "true choice, excellence and quality." While the focus of social care remains sharply on promoting independence, the latest policy developments are more concerned with the nature of service support and how it is provided. In short, the green paper stated, "it is not acceptable to continue to deliver social care in the way we do today" (Department of Health 2005b). The aspirations of a modern social care system are clearly a long way from the original (and minimal) intent of the 1948 act. In place of basic services for a small minority of the population, there is a shift in emphasis, which promotes the concepts of citizenship and choice.

The need for reform of social care was set in the context of rising demand (particularly associated with population aging and wider demographic trends), alongside rising public expectations. The 2005 green paper introduced a focus on key outcomes for social care that should be applicable to all adults—whether or not they use social care services. The underlying values on which services should be built were restated as independence, empowerment, and choice, objectives that have been voiced in previous policy documents.

In the community care context, the goal of empowerment has been translated into practice by a heavy, if largely unsuccessful, promotion from central government of direct payments (cash transfers rather than the direct provision of services to users).

Direct Payments

The Community Care (Direct Payments) Act of 1996 introduced powers whereby certain categories of people eligible for social care services could receive a cash payment in lieu of services. Initially older people were not included, but the scope of the arrangements was expanded in 2003, and the power to provide them was changed to a duty to offer direct payments to people able to make use of them. Direct payments for adult social care are designed to create flexibility in the provision of social services. In practice, recipients often employ their own personal assistants. Support or services can also be purchased through agencies. The key benefit is that direct payments increase the amount of choice, control, and flexibility disabled people have over the way they live their lives.

Direct payments are available to people who have been assessed as needing care services, including:

- Disabled adults, to purchase community care services;
- Disabled people aged 16 and 17, to purchase children's services;
- Disabled parents, to purchase childcare services;
- People with parental responsibility for a disabled child, to purchase services the child has been assessed as needing; and
- Disabled people (including children), to purchase housing support services.

In fact, a very small proportion of expenditure on older people's services is committed to direct payments (0.3 per cent in 2005). The take-up of direct payments is increasing, but from a very low base. Between 2001/2 and 2003/4 the numbers of adults receiving direct payments increased from 5,468 to 13,796 (Commission for Social
Care Inspection 2005b, para 5.27). Currently, the total number of direct payment users is approximately 42000 people (out of a total of 1.5 million social service users in England). Most of those using direct payments are people with physical and sensory disabilities, although the proportion of older people is increasing.

**Individual Budgets**

In order to make direct payments more attractive to potential users, the government is directing significant policy attention to the development of individual budgets (IBs), which are currently being piloted in 13 sites in England.

The IB system is underpinned by a number of key principles (Prime Minister’s Strategy Unit 2005, 131):

- A simplified resource allocation system, including one-stop assessment and information provision, enabling available resources to be allocated effectively according to need;
- Individuals able to take some or all of their budget as a cash payment or to have control over the budget (with support if necessary) without actually receiving the cash;
- Budgets available to meet agreed eligible needs but under the control of the person needing the support, with assistance if required;
- Self-assessment, with advice and information or advocacy support where required;
- Eligibility based on requirements arising from disabling barriers (e.g., cash payment for taxis when public transport is inaccessible) and additional requirements associated with impairment (e.g., voice-recognition software to enable someone to read text at home and work); and
- Access to advocacy where this is needed, with qualifications and standards for independent advocates.

IBs represent the current flagship policy in the community care arena, with the expectation that they might radically and cost effectively reconfigure how and what services are provided in the community. The creation of IBs has been welcomed as a means to give service users greater choice about how their care needs could be met. In particular, IBs are seen as a way to improve independent living outcomes for those who choose not to take up direct payments, but who would still like control of their social care. Users should be able to choose from a range of services and "buy" their service from the local authority.

### 2.3 Funding Care Services in England

Long-term care for adults is paid for by local councils, the NHS, the social security system, corporate and nonprofit organizations, and individuals themselves.

Almost all public funding for adult social care flows through local councils, who have the final say on what is actually spent on local services. A small amount is retained at the center in the form of specific national grants and to pay for infrastructure. For council resources, the government calculates an expected expenditure for each service the council provides (not just social care), adds them up, and gives councils the total, net of what councils are expected to raise locally through council tax revenues. The actual allocation to individual councils is according to a formula that aims to account for relative need and unavoidable cost pressures. In addition, the health system pays for about 5 percent of places in care homes, as well around 30,000 long-term geriatric and psycho-geriatric patients in NHS facilities.

Councils, not central government, then decide how to divide their lump sums between services. About three-quarters of required local expenditure comes from government grants, the rest from local council tax. Approximately 15 percent of that total is destined for adult social care. Overall, although councils do generally mirror the amounts implied by government calculations, they are free to make changes as they wish.

Councils are able (to some degree) to adjust the amount raised through council tax (their allocations being based on expected or assumed local tax revenue), although local council tax is subject to local political constraints.

Councils also raise revenue from private sources in addition to spending from public funds. Social care
services are means-tested and subject to charge for those with income and assets that exceed certain thresholds. This income for councils is in addition to public sources and pushes up the gross spending on adult social care by another £2 billion or so.

Persons whose assets and income exceeds the level eligible for public support, and a number who prefer not to use support for which they are eligible, must make their own arrangements for care and pay privately. Because this funding and expenditure is private, the data are less good—calculations suggest that more than £2 billion is spent privately on social care for older people. This figure will grow if we include other adult client groups.

**User Charges**

Where a local authority arranges a care home placement it is obliged by law to determine what financial contribution the individual concerned should make toward the fees. Local authorities work out the contribution by applying a standard set of national rules to the calculation of income and capital. The objective is that after contributing to fees, the individual will be left with a fixed amount to cover personal expenses—"the personal expenses allowance," currently £21.50 per week.

People with assets in excess of £21,500 are required to pay the full price of care themselves. In all other cases, where people have capital of less than £21,500, the council will pay but individuals are expected to make a financial contribution toward the fees. Indeed, the council can charge an amount equal to the person's regular income less the personal allowance. Persons are expected to spend some of their capital toward the service charges.

For individuals in institutional care, the NHS will pay a fixed amount in three bands toward the cost of residents' nursing care needs. In the short-term—up to three months—the value of a person's home is disregarded in the means test (only current income and other assets are taken into account). A person is thus not required to sell his or her home immediately on entering residential care.

For home care, charging policy varies by council. Some make no charge, but in most cases people are means-tested on income. Housing assets are not included. Generally, charges for home care have been modest. For example, charges for older people using nonresidential services constituted about 12 percent of gross expenditure in 2006/7 but over 33 percent for residential care.

**Fair Access to Care and Eligibility**

A number of high-profile test cases have established that councils can take account of their resources when deciding eligibility for care. *Fair Access to Care Services* (Department of Health 2003b) provided a rational framework for approaching the difficult issue of eligibility to care. It defined a consistent set of escalating levels of risk and need that could be used to characterize people's circumstances. Councils are then entitled to draw a line at some point of their choosing on this ladder of risk, such that people above the threshold are eligible for council support and those below are not and need to rely on universal benefits (such as attendance allowance). This system ensures that those in greatest need are given the most support.

**Aggregate Levels of Expenditure**

Hancock et al. (2003) make projections of total long-term care expenditure to 2051 and also project the possible split between public and private sources under various assumptions about life expectancy, dependency and care costs, and different financing arrangements (including "free" personal care). They analyze the distributional consequences of state-financed care. Projections of this kind almost always emphasize the wide "funnel of doubt," since so many influential factors could vary. Input prices are a particular source of uncertainty. The introduction of free personal care would increase public spending on long-term care from 1.1 percent to 1.3
percent of GDP, or more if it generated an increase in demand.

**A Mixed Economy of Funding**

Social care for older people is characterized by a mixed economy of financing. Local authorities started the 1990s with substantial roles in social care provision, purchasing, and regulation. Their purchasing powers have grown considerably, partly as a result of the transfer of what were formerly social security funds to their control (the special transitional grant and after), partly with the growth of the social care sector, and partly with the substitution of external contracting for traditional line management of in-house services. Laing and Buisson figures for 1986-95 demonstrated the changing nature of the mixed economy by enumerating the numbers of residents of independent-sector care homes for older people (and younger adults with physical disability in Great Britain) by funding source.

Netten, Dennett, and Knight (1999) calculated that about a quarter of residents in nursing homes and a third in residential homes were wholly privately funded in November 1996.

Clearly, local authorities are not the only purchasers of these (or other) social care services for older people, although their proportional contribution to the total has grown. The NHS was sometimes a substantial purchaser of nursing home provision. More generally, Primary Care Trust purchasing of social care is likely to grow (whether singly or jointly with local authorities).

Estimates for 2000 by the Personal Social Services Research Unit suggest that 27 percent of expenditure on long-term care in England was funded by the NHS, 38 percent by local authority social services departments, and 35 percent by individual service users or their families (Comas-Herrera, Wittenburg, and Pickard 2004). The last of these was split fairly evenly between user charges and direct private expenditures. We return to user charges in a moment but first look at their contributions to gross local authority expenditure.

Figure 2 shows the proportions of gross expenditure on local-authority-brokered social services funded through sales, fees, and charges for 1994/95 to 2002/03 in England. The proportion of expenditure funded through fees and charges varies considerably across services. Whereas around 26 percent of social services expenditure on older people was recouped through sales, fees, and charges in 2002/03, the equivalent figures

---

**Figure 2.** Sales, fees, and charges as a proportion of gross expenditure in older people's service, England. Source: Department of Health (2003b, 2004, 2005a).
for residential and nursing home placements were 37 percent and 34 percent, respectively, around 5 percent for day care and direct payments, and around 12 percent for home care services. Perhaps not surprisingly, over two-fifths of gross expenditure on meals on wheels was funded through user charges and fees.

### 3. The Community Care Market in England

#### 3.1 Size of the Market

As noted above, the domiciliary care market has seen a period of steady growth over the past two decades. Community care statistics published by the Department of Health estimate that 3.4 million contact hours were provided to around 355,600 households during a survey week in 2004, up by 6 percent from the previous year (Department of Health 2005a). On top of care provided or purchased by local authorities, however, there exists a significant market for privately purchased home care.

The level of home care procured directly by users is considered to be substantial, but it is difficult to quantify. Indeed, Laing and Buisson (2005) express uncertainty about whether the volume of such care is increasing or decreasing, although surveys probing demand for privately purchased care hint at some increases in provision (Wanless 2006). Based on government figures and a national provider survey by the UK Home Care Association (UKHCA), it is estimated that the level of privately purchased home care is approximately 500,000 hours per week (McClimont and Grove 2004). These figures relate only to care hours purchased through agencies and therefore exclude those purchased directly from carers.

#### 3.2 Provider Types and Market Maturity

In 2004, around 31 percent of local authority-purchased domiciliary care services in England were provided in-house. The remaining 69 percent were purchased by local authorities from private for-profit or voluntary firms in the independent sector. Voluntary providers tend to be defined by the fact that they are nonprofit distributing, nonstatutory, and autonomous.

Today most independent-sector providers are private for profit. According to the Commission for Social Care Inspection (CSCI), with whom domiciliary care and nursing agencies have been required to register in order to operate since 2003, 71 percent of its 4,371 registered domiciliary care services and 98 percent of 907 registered nursing agencies were private-sector providers in 2005 (CSCI 2005). The findings of a 1999 survey of independent-sector domiciliary care providers were broadly in keeping with these figures: from a sample of 154 providers, 67 percent of providers were private businesses and 26 percent charities, the remaining 7 percent being other not-for-profit organizations (Matosevic et al. 2001). From a legal perspective, 36 percent of organizations in this sample were limited companies and 24 percent were registered charities and other voluntary organizations.

Data collected from agency inspections carried out by the CSCI indicate that the average number of care staff working in providers owned and operated by the local council is significantly above the number in private or voluntary sector agencies, as shown in Table 1 (CSCI 2005).

Home care provision has been less concentrated in larger organizations than has the care homes market. There are a large number of small providers offering less than 530 hours per week—the median national level of care provided by independent sector providers—in most local markets (Laing and Buisson 2005 in CSCI 2005). There are, however, some signs of market consolidation through merger and acquisition (Hardy and Wistow 1999; Laing and Buisson 2003; Netten et al. 2004).

Ware et al. (2001) report on the changing characteristics of independent-sector home care providers between 1995 and 1999, based on two cross-sectional surveys in 11 English authorities. In 1999, most providers were
Table 1. Average Number of Care Staff per Provider

<table>
<thead>
<tr>
<th>Ownership of Services</th>
<th>Average Number of Care Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council</td>
<td>72.5</td>
</tr>
<tr>
<td>Private</td>
<td>39.3</td>
</tr>
<tr>
<td>Voluntary</td>
<td>32.3</td>
</tr>
</tbody>
</table>


still relatively new to the field, two-thirds having been established since 1993. Most were small enterprises covering quite a modest geographical span. Over a quarter of the sample in 1999 provided 250 hours or fewer per week, equivalent to about seven full-time care staff. Another quarter provided over 1000 hours per week, higher than in 1995 (14 percent).

3.3 Types of Users

While focusing primarily on agencies that provided care for older people, the 1999 survey of independent-sector domiciliary care providers (Matosevic et al. 2001) reported on the number of organizations providing services to a wider group of users. In the survey, 44.5 percent of providers reported that at least one quarter of their clients were under 65 years old, and only 6 percent indicated that they dealt exclusively with older people. Fewer than one in four clients were provided with specialized services.

Of the providers included in the 2004 UKHCA survey (McCliment and Grove 2004), around 85 percent offered services to older people and clients with physical disabilities, while fewer than one-third served children, those with infectious diseases, or those who abuse drugs and alcohol (see Table 2). Overall, a significantly greater proportion provided support as a generic service than as a specialist service.

Table 2. Generic and Specialist Care Provision by Service Group

<table>
<thead>
<tr>
<th>Service Group</th>
<th>As a Generic Service</th>
<th>As a Specialist Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people</td>
<td>86% (n=465)</td>
<td>41% (n=222)</td>
</tr>
<tr>
<td>People who are elderly, mentally infirm</td>
<td>74% (n=399)</td>
<td>29% (n=157)</td>
</tr>
<tr>
<td>People with dementia</td>
<td>79% (n=426)</td>
<td>32% (n=174)</td>
</tr>
<tr>
<td>People with a physical disability</td>
<td>85% (n=459)</td>
<td>33% (n=178)</td>
</tr>
<tr>
<td>People with a learning disability</td>
<td>64% (n=346)</td>
<td>30% (n=164)</td>
</tr>
<tr>
<td>People with mental health problems</td>
<td>62% (n=333)</td>
<td>22% (n=118)</td>
</tr>
<tr>
<td>People who abuse drugs, alcohol, etc.</td>
<td>30% (n=161)</td>
<td>8% (n= 43)</td>
</tr>
<tr>
<td>People with infectious/contagious diseases</td>
<td>27% (n=144)</td>
<td>7% (n= 39)</td>
</tr>
<tr>
<td>Children</td>
<td>24% (n=130)</td>
<td>11% (n= 61)</td>
</tr>
<tr>
<td>Young offenders</td>
<td>2% (n = 11)</td>
<td>1% (n= 4)</td>
</tr>
<tr>
<td>People with a sensory impairment</td>
<td>65% (n=349)</td>
<td>18% (n= 99)</td>
</tr>
<tr>
<td>People from minority ethnic groups</td>
<td>52% (n=279)</td>
<td>16% (n= 88)</td>
</tr>
</tbody>
</table>


Note. Number of respondents = 538. More than one category will have been ticked by each organization.
3.4 Types of Services

As shown in Figure 3, almost all of the providers in the 1999 survey provided personal and practical care; the majority also offered night sitting, day sitting, and respite for carers. Live-in services and nursing care were provided by only a minority of the sample (Matosevic et al. 2001).

As Table 3 shows, half of the providers that responded to the 2004 UKHCA survey indicated that they

![Bar chart showing the number of providers for different types of services.]

**Figure 3.** Domiciliary care services provided by independent-sector providers. Source: Matosevic et al. (2001).

<table>
<thead>
<tr>
<th>Service</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No additional service</td>
<td>266</td>
</tr>
<tr>
<td>Nursing agency</td>
<td>50</td>
</tr>
<tr>
<td>Meals on wheels</td>
<td>25</td>
</tr>
<tr>
<td>Care home</td>
<td>68</td>
</tr>
<tr>
<td>Care home with nursing</td>
<td>36</td>
</tr>
<tr>
<td>Short breaks / respite</td>
<td>102</td>
</tr>
<tr>
<td>Sheltered / very sheltered / extra care</td>
<td>48</td>
</tr>
<tr>
<td>Day care</td>
<td>94</td>
</tr>
<tr>
<td>Other services (most prominent)</td>
<td></td>
</tr>
<tr>
<td>Career support</td>
<td>16</td>
</tr>
<tr>
<td>Other housing support</td>
<td>19</td>
</tr>
<tr>
<td>Information and advice</td>
<td>15</td>
</tr>
<tr>
<td>Domestic services (all types)</td>
<td>26</td>
</tr>
</tbody>
</table>

Note: Number of respondents = 528; missing data = 10. Some respondents reported more than one additional service.
provided at least one other service in addition to home care, the most common being short breaks/respite (19 percent of providers), day care (18 percent), services provided in a care home (13 percent), and domestic services (10 percent). Providers indicated that practical care accounted for 22 percent on average of total care hours reported (McCliment and Grove 2004).

Figure 3 shows a significant increase in the numbers of older people receiving professional support and a small increase in the numbers attending day care centers during the period 2000/01-2002/03. Other widely used services include equipment and adaptations and the provision of meals.

Local authorities are giving day care a wider role, and many are also redesigning such services following Best Value or other reviews (SSI 2003). Day care places grew by 69 percent from 15,300 in 1977 to 25,900 in 1992, but the proportion of older people using them fell from 5 percent in 1985 to 3 percent in 1994 (Evandrou and Falkingham 1997).

Broadly speaking, services provided in-house by local authorities tend to be less flexible than those purchased from the independent sector, in terms, for instance, of readiness to provide visits over the weekend or late at night (Mangalore et al. 2000). Within the independent sector, additional services such as day care are more commonly provided by voluntary organizations than by private firms.

3.5 The Mixed Economy of Care

The independent sector's share of the home care market has grown much faster than the directors of local authorities expected in the early 1990s (Wistow et al. 1996). As Laing and Saper (1999) commented, the 1990 "community care reforms can be credited with kick-starting independent sector supply of home care services for state-funded clients." In fact, it was not really the legislation itself but the 85 percent rule governing spending of the special transitional grant that provided such impetus, followed over recent years by the irresistible influence of Best Value reviews, which brought home to a number of authorities the cost difference between in-house and externally provided services.

Independent-sector market shares—and home care arrangements generally—vary enormously across the country (Wistow and Hardy 1999), while commissioning arrangements generally remain rather simple, heavily reliant on spot contracts. For example, London authorities rely more on independent-sector provision. However, Ungerson (2000) hypothesizes that markets for home care may be less spatially diverse than those for care homes, because of the lesser reliance on suitable capital stock.

What was behind these changes in market share? Local authorities came to recognize the high relative cost of some in-house services and sought economies by contracting out. The SSI (2003) reports that some inspected authorities concluded from their Best Value reviews that it was most effective to switch more of their purchasing to independent-sector services, leaving only a specialist and short-term function for in-house services (see Patmore 2003). A major influence in the early part of the decade was the requirement attached to the redirection of public money from the Department of Social Security to social services departments that 85 percent of the grant revenue be spent outside the public sector.

McCliment and Grove (2004) stress, however, that "the growth of independent provision has been driven primarily by the growth in commissioned volume," rather than just by the reduction in local authority in-house services. This is illustrated in Figure 4. In 2003, local authority services still provided over 60 percent of the volume of service that they provided in 1993.

3.6 Growth and Intensification

Figure 5 shows the very significant increase in the volume of home care hours purchased by local authorities in England between 1993 and 2003. Particularly striking is the very rapid growth of the market share of the independent sector, leaping from 2 percent in 1992 and 5 percent in 1993 to 68 percent in 2003.

In contrast to the growth in number of hours of home care purchased, shows that the number of households
Figure 4. England: estimated number of clients (over 65) receiving community-based services during the period. Source: P2f.1 returns, "Referrals, Assessments and Packages of Care for Adults," Department of Health.

Figure 5. England: contact hours of home care by sector of provision. Source: Community Care Statistics, Department of Health (2004).
benefiting from home care decreased substantially, from around 540,000 in 1994 to 380,000 in 2003. Evandrou and Falkingham (2000) report that the proportion of older people receiving home care rose from 6.6 percent in 1974 to 8.8 percent in 1980 and remained around 9 percent throughout the 1980s. Since then it has fallen considerably.

Together, the growth in total hours and the fall in service users over the last 10 years have significantly increased the intensity of home care provision. The average number of contact hours per household per week rose from 3.4 in 1993 to 8.6 hours in 2003 (see Fig. 6). In other words, many fewer households are now receiving home care services, but those that do are receiving a much more intensive package of support. Generally, these are the people with greater needs (Mangalore et al. 2000). In 1993, 38 percent of home care households received only one visit per week of two hours or less, compared to 15 percent in 2003 (Department of Health 2004). Many of these people will now be purchasing home care services privately: the proportion has increased considerably (Pickard et al. 2001).

There have been many changes in the range and orientation of service. For example, the percentages of short-duration, weekend, out-of-hours, and dependency-contingent packages have increased (Hardy and Wistow 1999; Ware et al. 2001). Such changes appear not to have gone far enough. The NHS plan put great emphasis on the development of flexible services to ensure that older people were not admitted unnecessarily to hospital, and that they receive high-quality, need-based care if they are admitted. But the SSI concluded in 2003 that "there was widespread interest in extending service responses into evenings, nights and weekends. However, there was considerable scope for progress and some councils were not yet planning for this" (SSI 2003). Sinclair et al. (2000) describe the responses by local authorities to the excess demand for home care services, including renegotiating contracts to provide services at different times, developing routine services that can reap economies of scale, using user charges to ration and limit services, referring clients to private domestic care services, exporting difficulties to independent sector providers through the contractual arrangement, developing new styles of care management to develop more effective and cost-effective care packages, and tightening of controls on resource use. To address concerns about the competence of independent providers, authorities were offering training, introducing quality assurance and control mechanisms, and developing preferred provider

![Figure 6. England: average number of contact hours per household per week. Source: Community Care Statistics, Department of Health (2004).](image-url)
arrangements.

3.7 Financing and Motivations

Local authorities have been encouraging consolidation. They prefer to contract with larger providers, who are better at competing on price for the new block contracts that some authorities were beginning to offer in the early 1990s. Smaller providers, moreover, have struggled to meet some of the standards and quality requirements set by purchasers.

There was clearly some consolidation of the provider side of the home care market in the second half of the 1990s, with the growth of large organizations with individual branches operating across a number of different localities. Influences on this consolidation were local authority market management strategies, staff recruitment difficulties, the squeezing of prices and profit margins, and the anticipated introduction of new and tougher quality standards. Economies of scale were likely to be reaped in many of these dimensions.

As Table 4 demonstrates, voluntary and not-for-profit providers are particularly reliant upon local authority commissioning, with 87 percent of total hours delivered by noncommercial providers being purchased by local authorities. As in the residential care sector, local authorities enjoy a significant monopsonist power in the market, and are able to keep prices low.

The reliance on local authority funding of service providers is further highlighted in the Matosevic et al. (2001) study. More than half the providers in the 1999 sample had more than three quarters of their clients funded by local authorities, an increase in the proportion who were so heavily reliant on public funding four years earlier. The study identified growing concerns that local authorities would dominate the market, squeezing prices and making demands that some providers found hard to meet.

In both years, around two-thirds of the providers believed that the policies of their local authority favored in-house services. Over time, however, attitudes to the private sector appeared to have changed a little, with providers less likely to report what they saw as prejudiced views among purchasers. Nevertheless, a number of providers felt that their purchasers did not fully appreciate the constraints under which they operated: the bureaucratic burden of some contractual links, the impact of delayed payments (which were still quite substantial in some localities), and the general reluctance to share the market risk. Voluntary sector providers were treated differently, sometimes on the basis of long historical links.

Despite considerable pressures on prices, local authorities have demanded improvements in quality standards that further increase the financial burden on providers. One in five home care providers in 1999 reported being forced to reduce costs in response to local authority pricing policies, one in eight said that prices failed to cover costs, and 11 percent were seriously considering leaving the market. Price pressure has led to cutbacks in staff, pay cuts for some staff, and neglect of some of the administrative aspects of the business.

Table 4. Commissioning Sources for Commercial / Noncommercial Providers

<table>
<thead>
<tr>
<th></th>
<th>Private/Commercial (%)</th>
<th>Voluntary/Not for Profit (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased by local authorities</td>
<td>73</td>
<td>87</td>
</tr>
<tr>
<td>Privately purchased</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Purchased by NHS</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>N</td>
<td>357</td>
<td>168</td>
</tr>
</tbody>
</table>

Note: Number of respondents = 525; missing data = 13.
In relation to contracts, in 1995 three-quarters of the sample only had spot or call-off contracts, compared to 50 percent in 1999. In the later year, there was also wider use of a range of different contract types. There was clearly some distance to go to share the risk more equitably between purchasers and providers, but the direction of travel was generally seen to be appropriate.

The findings from this research also underline the extent to which the motivations of providers need to be understood not just in terms of financial or monetary reward, but also in terms of respect for their autonomy as independent operators, and recognition of their competence and professional achievements. There need to be better opportunities for communication and feedback between purchasers and providers. The institutional arrangements set in place by local purchasers—forums, review and planning processes, and contractual design—have failed to create such supportive conditions (Kendall et al. 2003).

3.8 Quality and Regulation

There is very little evidence about the quality of home care services. The SSI (2003, 28) noted "growing recognition that poor-quality services are ineffective and therefore inefficient in achieving non-residential outcomes." Greater flexibility, particularly to make services available when people need them, was urged, and generally many of the authorities inspected had problems with the quality of domiciliary care or with delays in access. Services that were unreliable or lacked continuity in staffing failed to give users the confidence and practical assistance they needed to continue living independently (SSI 2003).

User satisfaction levels are often rather low (Netten et al. 2004). Underlying problems include difficulty recruiting and retaining staff, underdeveloped relationships with providers, a poorly trained workforce, and a tendency to keep prices low, thereby threatening quality.

There have been moves toward registration and national regulation of care standards only quite recently. One of the new standards is that 50 percent of direct home care workers have an NVQ level 2 qualification or higher by April 2008 (Department of Health 2003a).

References


Social Long-Term Care Insurance in Germany: Origin, Situation, Threats, and Perspectives.

Katrin Heinicke *1
Stephan L. Thomsen *2

Abstract
This paper describes social long-term care insurance (SLTCI) in Germany. Following a short review of the history of long-term care organization and preceding laws in Germany, the implementation of SLTCI as a separate and self-sustaining pillar within the system of social insurances in Germany is presented, with detailed descriptions of eligibility criteria, service provision, and financing. Since SLTCI is a universal, contribution-financed insurance, the aging of society and corresponding shifts in the number of persons in need of care and the number of persons potentially providing informal care are challenges for its sustainability. Recently suggested reform options are discussed at the end of the paper, showing possible pathways to a sufficient provision of care services in the future.

[Key words] Social Long-term Care Insurance, Germany, Financial Situation, Sustainability, Reform Options

1. Introduction
This paper describes the organization of long-term care in Germany as part of the welfare state. We will focus on the social long-term care insurance (SLTCI) introduced in 1995, a main pillar of the German system of social insurance, along with unemployment insurance, health insurance, and the pension system. Like most (Western) societies, Germany faces a demographic transition that will more than double the number of elderly individuals in need of long-term care and that will at the same decrease the number of informal caregivers. As a consequence, public responsibility for the provision of long-term care will continue to grow. In the light of current and expected changes, the sustainability of the SLTCI must be questioned. In particular, maintaining the real value of benefits with an increasing number of benefit claimants, on the one hand, and a decrease in revenues due to shifts in the population of contributors, on the other, emphasizes the reform pressures on the current system.

The presentation of the paper will be organized chronologically. We will start in Section 2 with a characterization of SLTCI, including the discussion and organization preceding its introduction. Before 1995, when SLTCI was implemented, long-term care was considered a part of welfare assistance. However, that approach had two severe shortcomings. On the one hand, receiving welfare assistance is not without stigma for eligible persons. On the other hand, welfare assistance is administered by municipalities. Thus, rising numbers of benefit recipients lead to financial strains. The introduction of SLTCI augmented the system of social insurances. As with other types of insurances, it is financed by contributions from gross income subject to social

*1 Research assistant at the Chair of Labor Economics at Otto-von-Guericke-University Magdeburg.
*2 Assistant professor of Labor Economics at Otto-von-Guericke-University Magdeburg and research associate at the Center for European Economic Research (ZEW) Mannheim.
insurance contributions. SLTCI therefore covers almost everybody in Germany, except groups that are allowed to insure privately against long-term care risk. In the current state, Germany therefore provides a universal, non-means-tested, contribution-financed social insurance for long-term care that is intended to provide partially comprehensive coverage of the benefit claimant. Similar to the other social insurances in Germany, it is organized as a pay-as-you-go system.

The benefit scheme allows for some flexibility in the provision of services, since it recognizes different levels of care dependency and different types of benefits available, including cash allowances and support for institutional care. Currently, most claimants apply for cash allowances that should enable them to maintain home care arrangements with the help of informal carers. Details of the benefit scheme, the administration of services, the financial situation, and the shares of persons opting for the different types of benefits available will be presented in Section 3.

The sustainability of the system must be questioned given projections of the number of future benefit claimants and the number of future payers of contributions. Several authors have analyzed the threats to the German SLTCI system, and we will review those and corresponding reform proposals in detail in Section 4. Recognition of the options proposed for Germany could also be helpful for other countries facing a similar situation. Despite the array of options, the German legislature has only recently adopted a first reform, in 2008. The main changes resulting from that reform as well as an evaluation will be provided at the end of Section 4.

2. The German SLTCI

2.1 Background: The Situation before the Introduction of SLTCI in 1995

The foundation of the German welfare system is laid out in the German Constitution (Grundgesetz), which guarantees living in dignity (see Sec. 1, Art. 1). The welfare system today comprises unemployment insurance, welfare, health insurance, retirement pensions, and long-term care insurance. Despite its comprehensive nature, the individual facets of the system were introduced at different points over the last decades. Long-term care insurance is the most recent augmentation, introduced in 1995 as a self-sustaining pillar of the welfare system; however, the consideration of support for the requirements of care was not new within the German welfare system.

Support for long-term care was first considered in the federal law of welfare assistance (Bundessozialhilfegesetz) adopted in 1962. Besides the rules for social welfare, it contained a section defining so-called special public long-term care assistance (Hilfe zur Pège), and long-term care was organized as a part of welfare assistance. This special public long-term care assistance provided a means-tested allowance to support people in need of help. At that time, the notion of being "in need of care" was not explicitly defined, but every "helpless" person has, historically, been eligible for allowances. Such allowances were administered on the state level and differed between states because of the federalist system in Germany. Processing and funding was allocated mainly to local providers of welfare, such as counties or independent cities.

By the mid-1970s, an important debate on the prospects of people in need of care was initiated a report of Kuratorium Deutsche Altershilfe (1974). The report revealed that people in need of long-term care were "deported" to institutional care and viewed as cases of irreversible illness, along the lines of care rather than cure. It demonstrated (and postulated) that health insurers should be obliged to account for the expenses of institutional care by arguing that care cannot be separated from the definition of illness in insurance and legal definitions. At that time, people had to pay for institutional care themselves and, therefore, a rising number of older persons became welfare dependent. That development also put financial stress on the local authorities, who were in charge of providing the special public long-term care insurance. The number of people eligible for benefits more than doubled, from 165,000 in 1963 to 335,000 in 1973, and peaked in 1992 with 675,000.
(including the reunified Germany).

The starting points for discussion of adopting a self-sustaining long-term care insurance were, then, the growing number of elderly becoming welfare dependent even if they had worked their whole lives (which induced a kind of stigma effect) and the imbalance between welfare grants and costs for stationary care and the associated financial pressures on municipalities. These arguments, although important, were not the only ones put forward. Also mentioned, according to Götting, Haug, and Hinrichs (1994), were the strain of doing informal care with a shrinking supply of informal carers and concerns about the supply and quality of professional care for increasing demand. An early proposition for a self-sustaining insurance in Germany was made by the Association of Public and Private Welfare (Deutscher Verein für öffentliche und private Fürsorge 1981). They suggested integrating long-term care into the social insurance system, using the argument that being in need of care is a general risk of life. Furthermore, they pointed out that the principle of subordination— applicable for welfare—was constantly violated, because special public long-term care assistance claimed the largest part of welfare payments and therefore was not paid for exceptional circumstances of life. This early proposition similar to the later implemented SLTCI, but it took another 14 years to become law.

According to Campbell (2002) there are two main alternative ways to implement the provision of long-term care: (1) direct provision of services financed by taxes and (2) social insurance financed by contributions. The choice between those extreme alternatives is influenced mainly by the existing structure of insurances and the tax system. Both alternatives were part of the discussion in Germany as well, but in addition two insurance solutions were discussed: a private and a social insurance. While Liberals, the employer-oriented Christian Democrats, and the employers’ association clearly favored a private insurance, the employee-oriented Christian Democrats proposed a social insurance. In contrast, trade unions, the Social Democrats, and the Greens, together with smaller interest groups (physicians association, representatives of the handicapped, self-administered bodies of sickness funds, and small white-collar unions), first favored a tax-transfer scheme, but at least the Social Democrats and the trade unions later switched to supporting the idea of a social insurance.

After a long debate (delayed by German reunification in 1990), a universal, non-means-tested, contribution-financed long-term care insurance was finally adopted as part of the German social insurance system. On 26 May 1994 parliament passed the associated law. However, in contrast to health insurance, SLTCI was not intended to cover the full risk of being in need of long-term care. The new insurance was partially comprehensive and aimed at covering only basic needs. Therefore, special public long-term care assistance as part of social welfare.
was not abolished, but its relevance decreased significantly (see Fig. 1). From 1 June 1994, long-term care insurance funds were instituted at every health insurer and contribution payments started 1 January 1995. Benefit payment did not start before 1 April 1995 for out-patient care and before 1 July 1996 for in-patient care. Therefore, an initial stock of savings could be set up (more details of the financial structure of SLTCI will be presented below in Sec. 2.3).

### 2.2 Institutional Framework

As indicated above, SLTCI is part of the social insurance system, which consists of five pillars: unemployment insurance, health insurance, pension insurance, accident insurance, and long-term care insurance. They all follow the principles of solidarity, self-administration, and funding by social insurance contributions. Social insurance is generally compulsory for all employees, for health insurance and SLTCI, up to a certain income threshold, the so-called social insurance ceiling. There is no such threshold for the other social insurances. Contributions are calculated as the given percentage rates up to social insurance contribution assessment ceiling, that is, the maximum gross income up to which income is subject to social insurance contributions. Above the ceiling, only the social insurance contribution assessment ceiling is considered for deductions. In 2003, that ceiling was set to €45,900, to be increased by the ratio of per capita gross salary in the preceding year and the year before that. In 2008 it amounted to a yearly gross income of €48,600. Some groups are exempted from compulsory coverage: civil servants, soldiers, and people older than 65 are exempted from unemployment insurance; the self-employed are exempted from health and SLTCI insurance; and civil servants are exempted from pension insurance in addition.

Except for accident insurance, where financing is exclusively provided by employers, all other social insurances are financed by contributions on the basis of parity. Table 1 shows the development of contribution rates for the four insurances where financing is shared and the development of the number of all employees subject to social insurance contributions.

Unlike the other four pillars, SLTCI does not have an independent administrative organization. It is co-administered by the existing health insurance funds. In June 1994, SLTCI funds were instituted at every existing public health insurer. To compensate health insurers for taking over administrative tasks there is a fiscal equalization scheme requiring a portion of SLTCI funds. According to Arntz et al. (2006) there are about 250 SLTCI funds in Germany.

The general funding of SLTCI is organized as a pay-as-you-go scheme. Private long-term care insurance

| Table 1. Development of Contribution Rates for Social Insurance (%) |
|-----------------------|-----------------|-----------------|-----------------|-----------------|
| Unemployment insurance | 6.50            | 6.50            | 6.50            | 2.80            |
| Health insurance      | 13.20 (12.80)   | 13.60 (13.80)   | 14.20 (14.00)   | 14.00           |
| Long-term care insurance | 1.00            | 1.70            | 1.70'           | 1.95'           |
| Pension insurance     | 18.60           | 19.30           | 19.50           | 19.90           |
| Employees subject to social insurance contributions (1000s) | 28,118          | 27,826          | 26,178          | 22,500          |


'Values in brackets apply to East Germany.

'Employee contribution is 0.25 percentage points higher for childless people.
(LTCI funds rely instead on prospective entitlements. That is, funds are set aside to provide for each person insured, and for employees private LTCI funds also receive a grant from employers up to the same amount as for social LTCI (see Social Security Code [Socialgesetzbuch] [SGB] XI, sec. 9). The federal states are responsible for providing an adequate infrastructure for long-term care. The SLTCI funds must ensure that claimants receive the requested benefits to which they are entitled. SLTCI insurers therefore contract with ambulatory and institutional suppliers to guarantee provision of long-term care.

2.3 Funding

When payment of contributions started in 1995, the rate corresponded to 1 percent of gross income. In July 1996, the premium was increased to 1.7 percent. To account for the fact that childless people will on average receive higher benefits from the SLTCI funds than people cared by their own children, in 2005 an additional premium to be paid by childless people was introduced of 0.25 percentage points of gross income subject to social insurance contributions. In consequence, childless employees also contribute more than their employers and financing is no longer based on parity. Exempted are childless persons born before 1940, persons younger than 23, and recipients of unemployment assistance or persons in military or alternative service. Another increase of premia is in effect since July 2008. In the course of a revisiting of the SLTCI law (Pflege-Weiterentwicklungsgesetz) to finance adjusted benefits, contributions were further increased by 0.25 percentage points; premia for people with children are now 1.95 percent and for childless people 2.2 percent of gross income subject to social insurance contributions (see below for a more detailed discussion of this recent reform).

When SLTCI was introduced, employers were not in favor of adding another social insurance because of higher labor costs. However, employees agreed to give up a public holiday (the day of repentance) to keep the non-wage labor costs from rising. The economic activity of an extra working day (the abandoned public holiday) was thought to finance the employers’ contributions. Thus in fact SLTCI has never been a social insurance on the basis of parity. Although contributions were shared mathematically equally, employees indeed compensate the share of employers by working an additional day per year. Residents in the federal state of Saxony voted

![Figure 2](image)

**Figure 2.** Revenues and expenses of SLTCI from 1995 to 2008 in billion €. Data source: Federal Ministry of Health (2009b).
against this split and kept the public holiday in return for higher contributions by employees: in 1995, employees with children paid 1.475 percent and employers only 0.475 percent, 0.5 percentage points less than parity. Later adjustments of contribution rates took account of this initial difference.

Because payment of contributions started before benefit payments, a stock of savings was built up. In 1998, however, the positive difference in revenues and spending vanished and expenses exceeded revenues from 1999 to 2005 and again in 2007 (see Fig. 2). Higher contribution rates due to the recent reform in 2008 (see below) will temporally mitigate this development. SLTC insurers are obliged to withhold a stock of savings that consists of at least 50 percent of the monthly benefit spending designated in the budget. Therefore, on average the stock of savings at the end of each year corresponded to about two to three months of benefit spending.

An important facet of the long-term care insurance system in Germany is that insurance is compulsory. Members of social health insurance are automatically insured for SLTCI. Every person earning less than the social insurance ceiling is a member of this system. It covers all additional-insured persons such as spouses and children; altogether there are around 70 million people insured. Persons voluntarily insured under social health insurance are also automatically insured under SLTCI. Furthermore, there are another 9.25 million persons insured by private LTCI funds (associated with private health insurance funds). Thus, despite compulsory coverage, approximately 3 million persons are not insured for the risk of being in need of care.

3. Eligibility, Care Levels, and Provision of Services

3.1 Eligibility and Assessment

Persons are eligible for SLTCI payments when they are frail (see SGB XI sec.14a).

This term applies to "a person who requires for a minimum period of approximately six months, permanent, frequent or extensive help in performing a special number of 'activities of daily life' (ADL) and 'instrumental activities of daily life' (IADL) due to physical, mental or psychological illness or disability" (see Arntz et al. 2006). ADL consist of abilities necessary for fundamental functioning such as bathing, dressing and undressing, eating, using the toilet, or walking. IADL comprise in addition, "telephoning, shopping, food preparation, housekeeping, laundering, use of transportation, use of medicine, and financial behavior" (see Lawton and Brody 1969). These tasks provide the basis of an independent life and are affected at an early stage of disease or disability.

On behalf of SLTC insurers the Medical Review Board of the Statutory Health Insurance Funds (Medizinischer Dienst der Krankenkassen) is responsible for assessing the individual level of required care. The four basic domains of activities evaluated by the medical review board are personal care, nutrition, mobility, and housekeeping. The assessments guidelines enumerate a number of special activities examined in every domain (see Table 2).

Apparently, the notion of "being in need of care" is clarified in part by assessing ADL as well as IADL. The actual assessment of the individual is undertaken by physicians and nurses mandated by the medical review board. According to the Federal Ministry of Health (Bundesministerium für Gesundheit), the probability of being in need of care is 0.7 percent for persons younger than 60, 4.4 percent for persons between 60 and 80, and increases to 28.6 percent for persons older than 80.

After a person is evaluated to determine the level of care required, the corresponding demand of time for provision of services is assessed. Three different care levels are assigned according to the tasks and time needed. Care levels are differentiated by the severity of dependency on care. Table 3 shows the respective attributions of care level, need for help, and time necessary for provision.
Table 2. Assessment Guidelines of Medical Review Board

<table>
<thead>
<tr>
<th>Domain</th>
<th>Examined Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care</td>
<td>Washing, showering, bathing, dental care, combing, shaving, micturition and defecation</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Preparation of bite-size meals and assistance with ingestion</td>
</tr>
<tr>
<td>Mobility</td>
<td>Getting up and going to bed, changing position independently, dressing and undressing,</td>
</tr>
<tr>
<td></td>
<td>walking, standing, climbing stairs, leaving and entering accommodation (e.g. for consulting</td>
</tr>
<tr>
<td></td>
<td>a physician)</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>Shopping, cooking, cleaning, washing up, changing and laundering clothes, heating</td>
</tr>
<tr>
<td></td>
<td>apartment</td>
</tr>
</tbody>
</table>

Table 3. Care Levels and Care Needed

<table>
<thead>
<tr>
<th></th>
<th>Care Level I (Need for Considerable Care)</th>
<th>Care Level II (Need for Intensive Care)</th>
<th>Care Level III (Need for Highly Intensive Care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance for personal</td>
<td>At least once a day; at least two tasks in one or more areas</td>
<td>At least three times a day at different times of day</td>
<td>Round the clock</td>
</tr>
<tr>
<td>nutrition, or mobility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistance for housekeeping</td>
<td>Several times per week</td>
<td>Several times per week</td>
<td>Several times per week</td>
</tr>
<tr>
<td>Time need</td>
<td>At least 90 min/day on average; no more than 45 min/day for housekeeping</td>
<td>At least 3 hr/day on average; no more than 1 hr/day for housekeeping</td>
<td>At least 5 hr/day on average; no more than 1 hr/day for housekeeping</td>
</tr>
</tbody>
</table>

Note: Time need is calculated for nonprofessional carers.

3.2 Provision of Services

Services can be provided in three different ways: home care (family members or nonprofessional private persons), home help service (professional staff for ambulatory help), and institutional care. The latter can be provided in such different institutions as old age homes, residential care homes, and nursing homes (Lundsgaard 2005); the care dependency of residents is highest in nursing homes. Since the introduction of SLTCI in 1995 the number of benefit claimants has increased steadily. Figure 3 shows the total change in the number of benefit recipients and of recipients of home (home care and home help service) and institutional benefits, respectively. Assuming constant probabilities of becoming dependent on care, expected demographic development will lead to an increase of 50 percent in need of care or, in absolute values, one million additional claimants for benefits (Federal Ministry of Health 2009a).

SLTCI favors home care (including home help service) over the more expensive institutional care. This order of preference is also reflected in the variety of benefits intended to facilitate flexible care arrangements. The following numeration briefly characterizes available kinds of benefits. The first five kinds of benefits apply to both home care and home help service.

Benefits in Kind

Benefits in kind consist of help for personal care, nutrition, mobility, and housekeeping and are carried out by professional care providers. Providers must be licensed by the SLTCI funds and must sign provision contracts. The amount of care provided depends on a recipient's actual needs but is limited in value according to the
assigned care level and to services included in a predefined catalog. Table 4 shows the respective monetary amounts that may be spent for benefits in kind for each care level.

Additional benefits can be allocated for persons at care level III in cases of hardship, but only up to a maximum value of €1,912 per month if extraordinary effort is necessary (e.g., at the end stage of cancer). Moreover, these extra benefits can only be granted to 3 percent of all insured persons at care level III.

Cash Allowances

Alternatively, persons may opt for lump-sum payments, so-called cash allowances. With this kind of benefit, care can also be provided by persons other than the contract partners of SLTCI funds, namely, personal care assistants or informal carers (family members or other nonprofessionals). The person in need of care can decide

Table 4. Benefits in Kind according to Care Level (Monthly Values in €)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care level I</td>
<td>384</td>
<td>420</td>
<td>440</td>
<td>450</td>
</tr>
<tr>
<td>Care level II</td>
<td>921</td>
<td>980</td>
<td>1,040</td>
<td>1,100</td>
</tr>
<tr>
<td>Care level III</td>
<td>1,432</td>
<td>1,470</td>
<td>1,510</td>
<td>1,550</td>
</tr>
</tbody>
</table>

Table 5. Cash Allowances according to Care Levels (Monthly Values in €)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care level I</td>
<td>205</td>
<td>215</td>
<td>225</td>
<td>235</td>
</tr>
<tr>
<td>Care level II</td>
<td>410</td>
<td>420</td>
<td>430</td>
<td>440</td>
</tr>
<tr>
<td>Care level III</td>
<td>665</td>
<td>675</td>
<td>685</td>
<td>700</td>
</tr>
</tbody>
</table>
whether to use the cash allowance to purchase services from a provider of choice, to remunerate informal care givers, or to spend on something completely different. Thus, lump-sum transfers are not bound to the purchase of care but in turn are smaller than benefits in kind, as Table 5 shows.

It should be noted that cash allowances may be granted only when caring services for are provided by a third person, not the person in need of care. Compliance with this eligibility rule is checked by regular visits from agents of an information center licensed by SLTCI funds and takes place at least once in six months for persons at care levels I or II and at least once in three months for persons at care level III.

**Combination**

If benefits in kind are not exhausted, the rest of the entitlement could be paid proportionally as a cash allowance. These combinations of benefits in kind and cash allowances do not alter the overall level of benefits. The allocation is binding for the next six months and can only be changed afterward.

**Auxiliary Care Products**

Benefit recipients are entitled to auxiliary care products that facilitate care but only for basic equipment. Technical products like wheelchairs are provided without additional cost. Consumer goods such as disinfectants are provided up to monthly costs of €31. Measures that enable a person to live more independently in his or her own accommodation can be supported up to a value of €2,557, but with co-payment by the insured, depending on income.

**Respite Care**

When care is provided informally there may be need to substitute for the carer, for example, in cases of illness or leave. Therefore, the person in need of care could be entitled to so-called respite care for a maximum duration of four weeks per year. Requirements for receiving respite care are that the person taking over the care services is not a direct family member of the person depending on care and that informal care has been provided for at least six months before respite care is requested. If respite care is provided by professional carers additional benefits amount to a maximum value of €1,470 per year in 2008 (€1,510 in 2010 and €1,550 in 2012). If the respite caregiver is a family member or lives in the same household as the care dependent person only the lump-sum transfers are paid, but additional expenses (e.g., for traveling or loss of earnings) can be remunerated up to maximum values that apply for professional respite care.

**Day and Night Care**

As another example of the priority given to home care over to institutional care in SLTCI, when home care or home help service is not sufficient (e.g., because of special needs during the night), a part-time institutional arrangement may be offered. Day and night care includes transportation to and from the institution. It can be combined with benefits in kind or cash allowance, but the total value must not exceed 150 percent of the underlying type of benefit; that is, if day/night care is requested only up to 50 percent of the values in Table 6, the person in need of care is still entitled to 100 percent of benefits in kind or cash allowance.

**Short-Term Care**

Short-term institutional care may be available for a maximum duration of four weeks per year. It is granted if day/night care or home care is not sufficient, for example, after a stay in hospital when the person is still too frail for home care or day/night care. Benefits amount to the same values as for respite care (see Table 6).
Table 6. Day and Night Care Benefits According to Care Levels (Monthly Values in €)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care level I</td>
<td>384</td>
<td>420</td>
<td>440</td>
<td>450</td>
</tr>
<tr>
<td>Care level II</td>
<td>921</td>
<td>980</td>
<td>1,040</td>
<td>1,100</td>
</tr>
<tr>
<td>Care level III</td>
<td>1,432</td>
<td>1,470</td>
<td>1,510</td>
<td>1,550</td>
</tr>
</tbody>
</table>

Table 7. Benefits for Institutional Care according to Care Levels (Monthly Values in €)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care level I</td>
<td>1,023</td>
<td>1,023</td>
<td>1,023</td>
<td>1,023</td>
</tr>
<tr>
<td>Care level II</td>
<td>1,279</td>
<td>1,279</td>
<td>1,279</td>
<td>1,279</td>
</tr>
<tr>
<td>Care level III</td>
<td>1,432</td>
<td>1,470</td>
<td>1,510</td>
<td>1,550</td>
</tr>
<tr>
<td>Cases of hardship</td>
<td>1,432</td>
<td>1,750</td>
<td>1,825</td>
<td>1,918</td>
</tr>
</tbody>
</table>

**Institutional Care**

A person is entitled to institutional care if home care and similar forms of benefits are not adequate. Benefits are displayed in Table 7 and must not exceed 75 percent of total expenditures of the institution. The highest amount of benefit in cases of hardship cannot be granted to more than 5 percent of insured persons at care level III. If someone chooses this kind of care regardless of necessity, the person is entitled only to the maximum value of benefits in kind and must pay additional costs. If persons in institutions for disabled people are in need of care, SLTCI funds account for up to 10 percent of monthly charges but not more than €256 per month.

**Further Benefits**

In addition to cash allowances that may be given to carers there is some additional assistance. SLTCI funds pay contributions to pension funds if informal carers do not work more than 30 hours per week and spend at least 14 hours per week for care. Coverage for accident insurance is included automatically. If informal carers are on a leave scheme for providing care for a person they receive grants for contributions to unemployment insurance, social health insurance, and SLTCI. Furthermore, SLTCI funds pay for courses that teach family members and informal carers how to provide home care.

Until the reform in 2008 the notion of being in need of care did not include persons impaired by dementia, mental handicap, or psychic disease, as the definition was limited to physical restrictions. Since July 2008 persons with psychic impairment (eingeschränkte Alltagskompetenz) are also entitled to benefits. The benefits are not assigned for basic care or housekeeping but for supervision and amount to €100 per month for basic cases and €200 for more severe cases. The money can be used to purchase any kind of benefit desired.

Figure 4 shows the distribution of the shares of benefits over the years 1995-2006. It is apparent that the share of cash allowances has remained almost unchanged while the share of institutional care has increased steadily.

**3.3 Service Providers**

As mentioned above, benefit claimants opting for cash allowances can purchase services from any provider. For benefits in kind or institutional care providers have to be contracted with the SLTCI funds. Eligible for contracts...

are independent businesses when a person qualified in care is in charge and liable. The skilled person needs to have at least two years of experience in care acquired during the last five years. Furthermore, providers have to pay their employees common regional wages. In addition, all providers have to fulfill quality requirements that are examined regularly. If providers fulfill these criteria a so-called provision contract (*Versorgungsvertrag*) is signed between the service provider and the association of SLTCI funds of the state.

The catalog of services and the scale of charges for services are defined by governmental departments in cooperation with all affected parties. Thus prices of services are determined administratively, not by the market. There are regional differences between charges to account for general wage level and income differences across states.

All providers are monitored and advised by the Medical Review Board of the Statutory Health Insurance Funds. Principles and criterions for qualitative care are composed by all stakeholders of SLTCI and are examined regularly in intervals of not more than one year. In case of a special occurrence the examination will be conducted more diligently than for a regular evaluation. Results must be made available to all stakeholders.

4. Threats to and Perspectives on Sustainable LTCI in Germany

In an aging society, the expected increase in demand for long-term care challenges SLTCI. Figure 5 shows the expected development of the share of older people between 1990 and 2020. According to this projection, people older than 59 will make up almost one-third of the population in 2020. Together with a constant or even decreasing birth rate and a constant or increasing participation rate of women, the need for professional or institutional care will surely increase.
4.1 The Role of Informal Care

Strong reasons to prioritize home over institutional care in the German SLTCI are the ideas of solidarity and the family. Home care should enable a person in need of care to maintain a self-determined life in the home environment. Further, family members, relatives, and other persons usually provide more than just "technical help"—they also give emotional care. Of course, informal care presents some threats. Although the situation of the person in need of care is assessed regularly, quality of informal care can be inferior to professional care. Furthermore, the relationship between carer and patient is close and dependency offers opportunities for the undue exercise of power, or even negligence if the carer feels over-burdened. Göggen, Herbst, and Rabold (2006) find in a survey that about 15 percent of people in need of care report acts disregarding autonomy or dignity and negligence in caring.12

Home care could be strengthened by the provision of cash allowances that reward informal care. As almost 80 percent of all spending to benefit recipients is in the form of cash allowances, informal home care is currently the predominant way of providing care in Germany. Wasem (1997) explains how the existing system of benefits in kind and cash allowances strengthens home care. Benefits in kind enable persons to stay longer at home or to reduce hospital stays instead of having to rely on stationary care. However, Wasem (1997) further argues that the prevalence of cash allowances may lead to a situation where the share of professional home care is low. Of course, benefits in cash can also be used to purchase professional care services. According to Klie (1998), access to supporting networks is identified as the main determinant of the choice between benefits in kind and cash allowances.

Infratest Sozialforschung (2003) presents an overview of the structure of informal care in Germany. In a representative survey from 2002 of more than 25,000 households of persons receiving SLTCI benefits and other persons in need of care, about 92 percent were found to be receiving informal care.13 The majority of carers were family members, and 73 percent were female. The fact that one-third of all informal carers were 65 or older reveals the degree to which informal care is provided by the same generation. Sixty-nine percent of all carers were married; 60 percent were not working. However, about 33 percent were working more than 15 hours a week. It appears that a nonnegligible number of carers must shoulder two tasks. It should be noted that around two-thirds of informal carers in the survey lived in the same house or household and were therefore available around the clock. The average weekly time spent on care amounted to more than 36 hours. According to Klie (1998), about 50 percent of all informal carers receive monetary remunerations.
Given the demographics—increasing life expectancy and female participation rates combined with lower birthrates—there are doubts that the same level of care can be maintained by informal caregiving in the long run, as the number of people in need of care rises and the number of possible carers shrinks. Klie (1998) points out that people with a "pre-modern" lifestyle, that is, with more children, living with family, or living in rural areas, more often have a solid network available for informal help. Such networks are less likely for people with modern lifestyle, that is, individualization, urbanization, and fewer children. According to Klie (1998), such trends as individualization and urbanization have a large effect on the lifestyle of the next generation, which will accelerate the loss of solid networks for future benefit recipients and, in conjunction with the demographic shift, further reduce the number of (potential) informal carers.

4.2 Personnel and Care

Care is very labor intensive. An increase in the number of persons in need of care will also increase the demand for labor in the future. Felder and Fetzer (2008) point out that the combination of inelastic demand and limited technical progress will lead to an disproportionate increase of costs (a so-called Baumol effect). The theoretically derived argument is in line with the cost increases reported in Kronberger Kreis (2005) of 3.4 percent yearly for out-patient and of 5.9 percent for in-patient care.

In view of the growth in both expenses and the number of benefit recipients, SLTC insurers are attempting to maintain costs at level or at least to prevent them from increasing further. In part, labor-cost savings are achieved by remuneration of providers for certain bundles of services so that the time taken for single tasks is not accounted separately. The drawback of this approach is that service providers have an incentive to accomplish tasks in the shortest time possible. The result is an overly "technical" way of delivering care services, which has been criticized.14 In line with that criticism, the Council of Health Advisers (2005) reports that professional carers feel inferior to voluntary carers since the introduction of SLTCI, because their engagement is limited to providing this technical care whereas informal carers seem to be responsible for quality time with patients. Another aspect of bundling is that service providers limit their supply of services to bundles that can be remunerated according to the SLTCI catalog of in-kind services. As a result, persons who want to use cash allowances to purchase services not covered by benefits in kind may have trouble finding a matching provider (see also Council of Health Advisers 2005).

Another way to reduce labor costs and to meet the increasing demand for personnel is to change the qualification mix of employees. Council of Health Advisers (2001) reports that for institutional care there has been a reduction in qualification from 1996 to 1999; employees without qualification have increased by factor of six, from around 1 percent to about 6 percent. In addition, skilled employees have been substituted partly by assistants who receive lower wages. Cost pressure is very high: in 1997 only 31 percent of employees in institutional care facilities were skilled, although a quota of 50 percent is required by law.

From 2003 to 2008, the share of skilled nurses in general (for the whole health sector) has decreased slightly from 57 to 55 percent. However, the share of nurses without qualification has increased from 9 to 15 percent. For geriatric nurses the same pattern applies: the share of nurses with a qualification has decreased from 64 to 59 percent, while the share of those without qualification has increased from 17 to 23 percent.15

4.3 Revenues and Expenses

Status Quo

The aim of SLTCI to provide stable real benefits with stable contribution rates is at risk for two reasons. First, there will be less revenue as the number of contribution payers decreases in future years because of the demographic shift. Second, expenses will increase as high-birthrate cohorts become the benefit recipients in
future years, while life expectancy is increasing and with it the morbidity of older people.14 Thus there is a double pressure on the existing financing mechanism of SLTCI. Furthermore, benefits had not adapted to price increases in the period between 1995 and 2008. Hence, according to the Council of Economic Advisers (2004), the continuously shrinking real benefits can be seen as a privilege for the first benefit recipients shortly after SLTCI was introduced and as a disadvantage for recipients in the period before 2008. Fetzer, Moog, and Raffelhüschen (2003) even show that SLTCI is not an intergenerational contract because no generation balances future receipts with payments.

Projections

A number of authors provide projections for the sustainability of SLTCI in Germany in the face of increased spending, decreased earnings, and consequently sinking real benefits. However, all available analyses are based on the status quo until 2008 and thus do not take account of the adjustment of benefits introduced thereafter. Nevertheless, the development under a continued status quo in benefits and contributions is revealed quite consistently from the different projections. The Council of Economic Advisers (2004) and Kronberger Kreis (2005) point out that in 2050 real benefits will account for only about 50 percent of their 1995 value. For the time between 1995 and 2004, Kronberger Kreis (2005) reports yearly cost increases of 3.4 percent for out-patient care and 5.9 percent for in-patient care, assuming an annual inflation of 1.5 percent for the projection of real benefits. If cost increases in the health sector stay at a high level, real benefits will shrink even faster.

Concerning the number of future benefit recipients, assumptions must be made with respect to changes in the population and in the risk of needing care. Differences between the available projections therefore refer mainly to differing assumptions concerning population shifts and immigration. Assuming a constant age-specific risk of care dependency, Rothgang (2001) calculates about 2.9 to 3.3 million benefit recipients in 2040. These figures represent an increase of 55-76 percent compared to 2000. Similarly, the Council of Economic Advisers (2004) estimates a number of 2.4 to 3.5 million benefit recipients in 2040, assuming constant age-specific risks of care dependency. Nevertheless, Rothgang (2001) supposes that the risk of being in need of care will decrease because with increasing life expectancy the need for care also occurs later in life. Including this supposition, the estimated number of benefit recipients in 2040 changes to 2.5-2.7 million. Blinkert and Gräf (2009) likewise analyze scenarios of decreasing demand that result in 3.25-3.5 million people in need of care; however, their projection refers to the year 2050.

Even if the status quo of benefit payments up to 2008 is maintained, contribution rates will have to be raised tremendously. According to the Herzog Kommission (2003), rates will amount to (at least) 2.6 percent of gross earnings subject to social insurance contributions in 2030. The Council of Economic Advisers (2004) expects a further rise to 2.7-4.0 percent conditional on underlying assumptions about the growth of benefits and the growth of revenues. However, despite this significant increase, contribution rates will peak in 2055 between 4.5 and 6.5 percent (Fetzer et al. 2003). Afterward, the lower-birthrate cohorts will enter the pool of persons in need of care. Similar results obtain in my projections by Blinkert and Gräf (2009). They estimate a lower boundary for 2050 at 3 percent when a decreasing prevalence of need, a low adjustment of benefit levels, and a slowly sinking reserve of informal carers are assumed. The upper boundary when a constant prevalence of need and a high adjustment of benefit levels are assumed amounts to 7 percent of gross earnings subject to social insurance contributions.

Following Rothgang (2001), total expenses will increase by between 84 and 109 percent depending on the assumed shares of home and institutional care and the expected increase in the number of benefit recipients. In particular, he assumes an increased share of professional care, mainly due to a higher number of single households, which corresponds to a disproportionate increase in total spending compared to the increase of benefit recipients.

With regard to a projection of the revenues of SLTCI, Rothgang (2001) points out that a forecast of future contribution payers and immigrants as well as pensioners is required. On the one hand, because of the
demographic shift there will be fewer people working in jobs subject to social insurance contributions but, on the other hand, there will also be more pensioners, at least partly compensating for the expected loss. Rothgang (2001) further assumes an increased participation rate due to higher chances of employment when the high-birthrate cohorts leave the labor market. These effects results in an expected decrease in revenues between 0 and 17 percent; the decline will be lowest if adaptations on the labor market are considered. In addition, Blinkert and Gräf (2009) present figures for the relation of contribution payers and benefit recipients. The ratio in 2007 is 26 persons contributing for one recipient, but it will deteriorate to only 10-16 persons contributing for one recipient in 2050.

5. Reforming SLTCI: Options and Recent Changes

5.1 Reform Options

The different projections clarify the need to reform SLTCI. In the following discussion, we will outline a number of reform options that have been suggested recently. The range of suggestions covers concepts almost resembling the existing pay-as-you-go system as well as concepts proposing systems with funding principle that should be implemented immediately. The main aspects of the different reform options are summarized in Table 8.

Universal Flat-Rate Contribution (Bürgerversicherung)

The universal flat-rate contribution system augments the idea of the existing pay-as-you-go system, which considers only employees in jobs subject to social insurance contributions. In the universal flat-rate contribution system, all employed citizens, including civil servants and self-employed persons, will be required to contribute to the insurance. Since the professional groups so far no included have even higher incomes on average, the revenues of SLTCI will rise. Nevertheless, the social insurance contributions assessment ceiling should maintain in effect, but in addition tax allowances of capital revenues will be considered.17

Calculations of the corresponding figures of contribution rates for Germany are provided by Lauterbach et al. (2005). Compared to the status quo scenario (contributions before 2008), they calculate 0.36 percentage points lower contribution rates in the universal at rate contribution system. Regarding the increased population of contribution payers, the expected increase in contribution rates will be smaller as well with corresponding estimates of 1.85 percent in 2025 compared to 2.33 percent in the status quo scenario. Lauterbach et al. (2005) further suggest including people suffering from dementia and raising benefits for home care (level I to €704 and level II to €1,100). In that case, contribution rates of the universal flat-rate contribution system would amount to 1.88 percent in 2006 and would rise to 2 percent in 2025.

Intergenerational Burden Sharing (Intergenerativer Lastenausgleich)

Within the scope of a reform proposal for the whole social insurance system in Germany on behalf of the government at the time, the Rürup Kommission (2003) provided a suggestion for reforming SLTCI. To enable a sustainable level of care provision, they postulated an increase in benefits for the year 2005 up to €400 for care level I, €1,000 for care level II and €1,500 for care level III. Moreover, identical benefit levels for home and institutional care are recommended. The Rürup Kommission further proposed an annual adjustment of benefits at a rate of 2.25 percent assuming an annual increase of nominal wages by 3 percent and an inflation rate of 1.5 percent. To finance this increase in benefits, higher contribution rates of pensioners should be implemented. In their scenario, there should be a basic contribution rate of 1.2 percent of gross earnings for the working
### Table 8. Overview of Proposed Reform Options

<table>
<thead>
<tr>
<th>Model by</th>
<th>Universal Flat Rate Contribution System</th>
<th>Inter-generational Burden Sharing</th>
<th>Fixed Premia</th>
<th>Premia with Funding Principle</th>
<th>Phase-Out Model</th>
<th>Cohort Model</th>
<th>Funding Principle Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>Compensate risk structure; reactivate solidarity principle</td>
<td>Relief of younger generations</td>
<td>Disconnect SLTC from labor costs</td>
<td>Smooth transition to capital-covered scheme</td>
<td>Smooth transition to capital-covered scheme</td>
<td>Reduce sustainability gap; establish intergeneration justice</td>
<td>Prevent further costly payment commitments</td>
</tr>
<tr>
<td>Funding system</td>
<td>Pay-as-you-go scheme</td>
<td>Pay-as-you-go with fixed premia</td>
<td>Capital covered premia</td>
<td>Age-specific premia</td>
<td>Risk-adjusted premia</td>
<td>Risk-adjusted premia</td>
<td></td>
</tr>
<tr>
<td>Time horizon</td>
<td>From 2006 on</td>
<td>2004-2005</td>
<td>Transition period until 2030</td>
<td>Transition period 2005-45</td>
<td>Immediate</td>
<td>Mandatory minimum and voluntary additional benefits; additional state transfers for older people decreasing with time after reform</td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Raise home care benefits for levels I and II €704/€1100; enhance benefits for persons suffering dementia</td>
<td>Equal benefits for home and stationary care for all levels; adjust in 2005 to €408/€1500</td>
<td>No change of benefits</td>
<td>No change of benefits</td>
<td>No change of benefits</td>
<td>No change of benefits</td>
<td></td>
</tr>
<tr>
<td>Adjustment of benefits</td>
<td>No</td>
<td>Yes at a rate of 2.25%</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Yes, at a rate of 1.5%</td>
<td>N/A</td>
</tr>
<tr>
<td>Adjustment of ambulant and stationary benefits</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Contributions/ premia</td>
<td>1.88% contribution rate for increased benefits; all citizens contribute; all incomes except rental considered up to social contribution earnings ceiling</td>
<td>Basic contribution rate of 1.2%; additional 0.5% for employees (for provisions to smooth contributions at higher ages) additional (increasing) 2% for pensioners (as compensation for increased benefits)</td>
<td>Premia independent of age and gender; €25 in 2004, rising to €50-€162 depending on income and price development</td>
<td>Transition period contribution rate of 3.2% to build collective capital stock; maturity stage cohort-specific premia</td>
<td>Cohorts after 1962 pay specific premia and additional lump sums for older cohorts (only in transition period to 2045) and children; cohorts to 1951: fixed premia of €50 adding €1 for each year after 2005</td>
<td>Risk-adjusted premia not exceeding €50 at beginning</td>
<td></td>
</tr>
<tr>
<td>Social balance with tax transfer</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (Felder and Fetzter 2008)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
population and pensioners to be introduced in 2010. In addition, pensioners will be required to pay further 2 percent of their income to compensate for the increase in benefits. The working population should contribute additional 0.5 percent to the basic contribution rate, to build a stock of capital paid as a pension, which should enable payment of increased contribution rates during retirement. The additional rate should decline until 2030 while the overall contribution rate is held fixed at 1.7 percent. The increase in the basic contribution rate for the working population should guarantee the stability of the pay-as-you-go system in face of the aging population. Only the basic contribution rate should be equally shared between employees and employers and between pensioners and the pension insurance institutes, respectively; the additional contribution rate should be deducted from individuals’ earnings. The Rürup Kommission (2003) calculated that contribution rates of pensioners will rise to 4.5 percent in 2040 (the last year considered in their analysis) and the capital stock accumulated will amount to about €125 billion. This setup allows a sustainable funding of SLTCI until 2040, when the demographic shift is expected to reach its turning point.

**Fixed Premia (Umlagefinanziertes Pauschalbeitragssystem)**

An alternative approach is recommended by the Council of Economic Advisers (2004), where premia are favored that are independent of individual earnings and can be combined with building a capital stock. In that sense, the fixed premium model is similar to a universal at rate benefit system but with lump-sum contributions. Children will be mandatorily insured with the contribution payer (as in the current system); however, in contrast to the current system spouses will also be required to pay contributions on their own. The fixed premium should be adjusted over time to account for increased overall spending on long-term care. The Council of Economic Advisers (2004) suggested an introductory rate at €25 independent of gender and age. Depending on increases in earnings, overall inflation, and inflation in care services, the fixed rate is expected to rise to €50-€162 in 2050. It should be noted that no adjustment of benefits is considered in this concept, although the Council of Economic Advisers (2004) mentions the necessity to do so. If adjustment of benefits is regarded, premia would be clearly higher. Moreover, if a funding principle is considered, contributions will differ by gender and age.

**Premia with Funding Principle (Kapitalgedecktes Prämienmodell)**

The reform options presented thus far propose to maintain the pay-as-you-go character of the current SLTCI system or to adopt flexible combinations or hybrid systems with funding principle. In contrast, the Herzog Kommission (2003) suggests the transition into a capital-funded system in the long run by phasing out the pay-as-you-go components completely. In their proposal, the transition period will last until 2030, and afterward cohort-dependent fixed premia will be imposed. During the transition period, there should be a constant contribution rate of 3.2 percent of gross earnings subject to social insurance contributions. These higher contribution rates compared to the existing status quo should be used to build up a collective capital stock that will subsidize contributions of older people from 2030 onward. The expected level of premia for a 20-year-old in 2030 will amount to €52 per month and will be higher for older persons. Children and spouses will be covered mandatorily. Those who are unable to account for premia will receive subsidies paid from tax transfers. The Herzog Kommission (2003) suggests compensating employers by abolition of another paid holiday and further recommends the adjustments of benefits.

**Cohort Model (Kohortenmodell)**

Besides the fixed premium model, the Council of Economic Advisers (2004) suggests the transition to a system with funding principle. In their original proposal, starting in 2005, persons born after 1951 would drop out of SLTCI and pay cohort-specific premia in a private long-term care insurance. Cohorts born before 1951 would remain in the old SLTCI system but pay fixed premia of €50 per month that to be adjusted by €1 annually from
2005 onward.

The transition period would last until 2045; then almost every living person would be insured in the cohort-specific premium system with capital covered insurance. Benefits would remain the same, but with an increasing number of older people in need of care younger cohorts would be forced to pay additional contributions for the older cohorts and also for children. With regard to the expected demographic change, these additional contributions for older cohorts would reduce to zero in 2045. Again, the Council of Economic Advisers (2004) generally recommends the adjustment of benefits, but no scenarios for adjusted benefits are considered in their calculations.

**Phase-Out Model (Auslaufmodell)**

Using a method of generation accounting, Häcker and Raffelhüschen (2004) calculate that all living generations are net receivers of SLTCI whereas all future generations will be net contributors. Therefore, the current status quo of the SLTCI includes a sustainability gap (*Nachhaltigkeitslücke*) that stems from the difference between the budget restriction and future net payment flows of all cohorts. Overall, the sustainability gap for all future years amounts to about 50-89 percent of German GDP for the year 2000, where differences are due to the underlying assumptions concerning cost pressure for prices of care.

To reduce this burden, Häcker and Raffelhüschen (2004) suggest a phase-out model in which the current pay-as-you-go scheme is slowly converted into a capital-covered scheme with the following characteristics: in 2005, persons younger than 60 will drop out of SLTCI and instead will contract with a (compulsory) private insurance. Persons 60 and older will start to pay a fixed premium of €50. Benefits will be adjusted at an annual rate of 1.5 percent, and as older persons’ fixed premia are not sufficient to compensate for benefit payments the younger cohorts have to pay a solidary contribution of 1.2 percent of their income. This additional contribution will rise to 1.7 percent in 2027 when the high-birthrate cohorts become the risk group of people in need of care; afterward, the additional contribution will phase out gradually until 2047. In this setup, the sustainability gap reduces to 0-4.3 percent (of German GDP for the year 2000) and the financial situation will be almost balanced. Felder and Fetzer (2008) suggest a similar model, differing only in that it begins the phasing-out period in 2007 and that older cohorts will be required to pay increasing income-related contributions instead of fixed premia.

**Immediate Fully Capital-Funded Model (Sofortige Kapitaldeckung)**

The most radical reform option is suggested by Kronberger Kreis (2005). They criticize the other reform options for keeping too many aspects of the existing system or for waiting too long to introduce a system with funding principle, respectively. Particularly, the linkage to wages and the combination of insurance and redistribution are assessed as the main weaknesses of the current system. They recommend to switch to a fully capital-covered system with risk-adjusted premia. A transition period as proposed by the Council of Economic Advisers (2004) and Häcker and Raffelhüschen (2004) is assessed to be too costly and for the same reason contributions paid so far should not be refunded. Furthermore, Kronberger Kreis (2005) recommends combining health insurance and long-term care insurance.

This compulsory private health and long-term insurance should be based on the cost-of-service principle, so that every insured person pays for possible future benefits approximately according to the inherent risk. Only basic coverage should be guaranteed by the compulsory part of the insurance, but further protection will be voluntarily available. Premia should not exceed €50 per month in the beginning and the accumulated stock of savings should be completely transferable if the insured person changes the insurer. Every person in need of care will have to pay an excess for benefits received. Kronberger Kreis (2005) suggests offsetting benefits with state transfers when older persons’ benefits surpass their contributions. This compensation will be up to the full level of benefits in the old pay-as-you-go scheme in the first year and will decrease with every additional year after the reform. It will end in the eleventh year after introduction of the capital-covered private insurance. For
persons not able to afford the private insurance, subsidies from tax transfers should be provided.

5.2 Reform of SLTCI in 2008

A reform of the long-term care law (Pflege-Weiterentwicklungsgesetz) was adopted in 2008 changing it in a number of important aspects. First of all, following the recommendations and postulation of several advisers, among them the Herzog Kommission (2003), Rothgang (2008), the Rüup Kommission (2003), the Council Economic Advisers (2004), Häcker and Raffelhüschen (2004), and the Council of Health Advisers (2005), an adjustment of benefits was introduced. In addition, the required contribution period for eligibility of benefit receipt was reduced from five to two years. With regard to respite care, the minimum duration until entitlement was reduced from 12 to 6 months.

Since benefits were not adjusted to inflation from 1995 to 2008, real benefits were shrinking. The reform raises benefits in three steps in 2008, 2010, and 2012. To prevent real benefits from decreasing again, payments will be adjusted from 2015 onward. Every three years, the amount of adjustment will be assessed. According to the law, raises will be oriented toward the cumulative inflation of the last three years but must not exceed the increase of gross incomes. Rothgang (2008) makes the criticism that no rule-based procedure for the adjustment of benefits was implemented. Linking the adjustment of benefits to a regular examination of whether adjustment is required carries with it the danger that constant real values of benefits over time are not guaranteed. The sole change adopted to raise the revenues of SLTCI to finance the adjustment of benefits is the increase of contribution rates by 0.25 percentage points. Rothgang (2008) notes that the additional revenues obtained will be sufficient to finance only the rise of benefits until 2012 and do not provide a mechanism for the targeted adjustment of benefits afterward. He calculates that if increases in benefits are spread proportionally over the years 1996-2015, there must be an additional annual increase of 0.4 percent. Hence, the adopted benefit increases will mitigate the loss of real value of benefits but are still not able to compensate for it. Klé (2008) further argues that funding has not been detached from its basis solely on labor earnings. All reform proposals described above recommend an enlargement of the basis of contributors or even an introduction (partly) capital coverage. The recent reform therefore provides only a continued status quo. Given the unchanged risks SLTCI faces, another increase in contributions must be expected soon or, put differently, another fundamental debate about reforming the funding system in general.

Second, the group of people eligible for benefits was augmented by people suffering from dementia or other psychic impairments, even if no care level is assessed. This inclusion has also been postulated by a number of advisers (e.g., Lauterbach et al. 2005; Rüup Kommission 2003: Council of Health Advisers 2005). However, a clearer definition of who is in need of care is missing in the reform. Therefore, asymmetries in the eligibility criteria are imposed. According to Klé (2008) the major reason for the delay in providing a general definition of "being in need of care" is that limitations caused by psychic diseases are difficult to integrate into a notion now largely oriented toward somatic concepts.

Third, in order to improve the quality and sustainability of home care, so-called care stations (Pegestützpunkte) are established that provide benefit claimants and their carers with intensified counseling. In addition, regular quality controls will be conducted at least annually starting in 2011. However, Igl and Naegel (2008) criticize these innovations as being too much concentrated on infrastructure. In addition, in their opinion federal institutions take over a too large a part of the organization of care, a responsibility that that originally rested at the level of the federal states and municipalities.

Fourth, relatives of persons in need of care are entitled to a leave scheme that guarantees continued social insurance, and incentives for voluntary commitment should be raised. The implemented leave scheme and contributions to social insurances can provide appropriate measures, but it is an open question whether they will prove effective in reaching the intended goal.

Moreover, it is now possible for groups of people in need of care to pool benefits and to use saved expenses for supplementary services. Further measures adopted in the new law include a reduction of the processing
time for applications, an improvement in the cooperation between institutional care providers and medical assistance, and an increase in the number of certified professional carers. Finally, incentives to apply for prevention measures are expanded.

6. Summary

This paper has provided an overview of the German SLTCI system. In the current state, Germany provides a universal, non-means-tested, contribution-financed social insurance for long-term care. This insurance should partially cover the care needs of the benefit claimants. Similar to the other social insurances in Germany, it is organized as a pay-as-you-go system. The benefit scheme allows some flexibility in the provision of services as it recognizes different levels of care dependency and different types of benefits available, including cash allowances and support for institutional. At present, most claimants apply for cash allowances that should enable them to arrange care at home with the help of informal carers.

The aging of society will increase the number of persons in care dependency and will reduce the number of potential informal carers. Both developments challenge the sustainability of German SLTCI. Therefore, a number of reform options have been suggested by several authors. Some of these reform options suggest adjusting the status quo system only slightly to take account of the change in demand, whereas other proposals postulate the radical reform of abolishing the pay-as-you-go system in favor of one with funding principle. Despite the availability of options and the concerns about the status quo, the German legislator introduced a first reform of the SLTCI system only in 2008. Although remarkable innovations were adopted, such as the nominal adjustment of benefits to maintain constant real values, the reform must already, be criticized as nonsustainable even in the medium run. Further reforms will be necessary in the near future.

Acknowledgement

This research has been supported in part by a research grant to Hitotsubashi University from the Ministry of Education of Japan (grant number 18002001). Further financial support from the Stifterverband für die Deutsche Wissenschaft (Claussen-Simon-Stiftung) is gratefully acknowledged. The usual disclaimer applies.

Notes

1. Countries that have opted for direct service provision on a tax basis often also have a health care system financed by taxes (thus, institutional resources play a crucial role in the choice). According to the OECD (2005), countries with provision for contribution-financed long-term care are Germany, Japan, Luxembourg, the Netherlands, partly Switzerland (differs across cantons), and partly in the United States. Tax-based systems are implemented in Scandinavia and also in Australia, Austria, Canada, New Zealand, the United Kingdom and (partly) in the United States.

2. See Götting, Haug, and Hinrichs (1994) and Meyer (1996) for an extended discussion of the arguments and timeline of the debate of the different parties and interest groups involved.

3. Some minor exceptions should be noted. Unemployment insurance contributions consist of employers’ and employees’ contributions and a third item, contributions for the promotion of job creation. Those are not shared on a basis of parity in all cases.

4. This adjustment became necessary following a judgment of the Federal Constitutional Court in April 2001 and was included in the so-called children consideration law (Kinderberücksichtigungsgesetz).

5. The Herzog Kommission (2003) notes that renouncing a paid public holiday is equal to 0.5 contribution rate points.
Employees from Saxony put forward an institutional complaint that their additional contribution overcompensates an extra holiday. However, the Federal Constitutional Court decided that a calculated "compensation gap" of €40 (for average salary) was bearable and was not an obstacle to the principle of nondiscrimination.

The surplus in 2006 was due to the shift of contribution payments to the end of a month. SLTCI funds took 13 payments in 2006 instead of 12.

The maximum grants are €133.73 (€113.30) for care level I, €267.46 (€226.59) for care level II and €401.18 (€339.89) for care level III. Values in brackets apply to East Germany.

Maximum grants for unemployment insurance are €7.06 (€5.98) (term in brackets applies to East Germany), €130.20 for health insurance and €16.38 for SLTCI.

Before the reform there was also the possibility to obtain some benefits (maximum €460 per year) but there was no clear-cut definition of eligible persons.

Quality assessment was introduced with the reform in 2008. Until 2010 one examination was required for every service provider; from 2011 on regular examination began.

The sample is not representative as only those able to answer the questions are subject to the survey. However, the study provides at least a qualitative hint that this hazard might exist.

Similar results are obtained by other studies for Germany. With regard to the Freiburger Pegestudie, e.g., Klie (1998) mentions that 87 percent of all help is provided through informal care.

The Ministry of Health has commissioned research for a new definition of being in need of care and suggestions for new ways to implement more holistic care.

Figures are taken from the Federal Bureau of Statistics (2008). "Unqualified employees" include those who have not started an apprenticeship training or do not possess a university degree.

Medical progress has restricted mortality more than morbidity. People get older but often are in poor health during their last years (see Kronberger Kreis 2005).

For the reform of health insurance, rental incomes should also be considered for deductions.

Further details of the major changes are provided by Federal Ministry of Health (2008).

The federal government will examine the need for an adjustment of care benefits for the first time in 2014.

References


https://www-genesis.destatis.de/genesisonline. Table code: 12421-0002.
http://www.bmg.bund.de/cln_179/nn_1168300/SiteGlobals/Forms/Suche/DE/Publikationen__Formular/templateId=processForm.html?__nn=true.
www.cdu.de/tagesthema/30_09_03_soziale_sicherheit.pdf.


What Has Long-Term Care Insurance Brought to Japan—
A Critical Survey of the Japanese Economic Literature

Seiritsu Ogura*1
Masayoshi Sumi*2

Abstract
In the 10 years since its introduction in Japan, long-term care insurance has already become an indispensable part of the Japanese social insurance system for most families. Partly for this reason, economists have actively researched how that insurance has changed the way our families and institutions care for the elderly and the economic consequences of those changes. The purpose of this paper is to provide an overview of their findings of effects in four major areas, namely, on family caregivers' burdens, on labor supply, on the service quality of providers, and on social hospitalization. At the same time, we pay close attention to the quality of the data used and to the estimation methods. Through our analyses, we hope to identify the issues that are still waiting for further research.

[Key words] Long-Term Care Insurance, Zarit Burden Index, Family Caregiver, Social Hospitalization. JEL classification codes: I11; I12; I13; I18

1. Introduction
Long-term care insurance (LTCI) was introduced in Japan in the year 2000. Since then, the insurance has become one of the most important social institutions, particularly for the elderly in the last stages of their lives. The insurance is designed to provide long-term care to those at age 65 or older who need such services. The users pay 10 percent of the cost of the services, and the rest is paid by the insurance system. The elderly themselves contribute about 20 percent of the cost of benefits to LTCI, the governments contribute 50 percent, and the working generations at or above age 40 contribute the rest (which is 30 percent or less). The day-to-day operation of the insurance is run by the municipalities and the approved providers, including the decision whether a particular elderly person needs long-term care. As the national government spent 10 years in perfecting the care-need certification system before its introduction (Tsutui and Muramatsu 2005), municipalities were able to start providing the benefits after a six-month trial period with little confusion.

LTCI services are classified as at-home services and institutional services. At-home services, which include home helpers, day care, and bathing at home, are open to the new entry of profit and nonprofit organizations. With the introduction of LTCI, the special nursing homes, elder health facilities, and hospital nursing beds were classified as providers of LTCI institutional services, and LTCI began paying their running costs; but these institutional services remain in the hands of municipalities or special nonprofit organizations.

In the at-home services, in addition to the free entry policy, reimbursement prices were set at profitable

*1 Professor at Hosei University, Tokyo, Japan (e-mail: sogura@hosei.ac.jp).
*2 Assistant professor at Miyazaki University of Industry and Management.
levels, and a large number of new businesses actually entered to meet the new demand, and the number of beneficiaries increased very fast. In the institutional services, on the other hand, capacities were limited and the increase in the number of beneficiaries were moderate. As a result, in just a few years, controlling the growth of the cost of benefits, particularly those of at-home services, became the most important policy issue for LTCI.

In the first major revision of the system, in 2005, the government tried to find the answer in lowering the reimbursements to providers, cutting off benefits to those with the lightest care need, emphasizing the prevention principle, putting the care plans for the entry-level beneficiaries under the direct control of the municipalities, and so forth. More important, in the institutional services, in order to restore proper balance between the beneficiaries of at-home services and institutional services, most residential and meal costs were removed from LTCI benefits, which increased the financial burden of beneficiaries very substantially.

The reduced reimbursements, however, soon resulted in reduced supply and a lower quality of long-term care services, even cases of systematic overcharges by a national provider. The government tried to strengthen the regulations to solve these problems, but the austere regulations simply caused providers to lose money and forced many out of the industry. Not surprisingly, the working conditions of the care workers kept deteriorating. Soon providers began to experience higher quit rates, and the industry as a whole lost a large number of trained workers. As a result, in April 2009, the government finally gave up the policies of lower costs and stringent controls, increased reimbursements by 3.0 percent, and took measures to redress the low wages of the care workers.

Undoubtedly, the most important factor leading to the introduction of LTCI in Japan is the rapid increase in the number of the elderly who need long-term care. Japan has experienced one of the fastest aging rates in modern world history; in 1970, the elderly accounted for only 7.1 percent of its population; but in 1994—that is, just 24 years-the ratio doubled to reach 14.1 percent, and in 2010, it reached 23.1 percent (Cabinet Office 2011). According to the official population projection, the proportion of elderly persons is expected to reach 28.7 percent in 2025 and 35.7 percent in 2050. The number of the bedridden, demented, or frail elderly also kept pace with the increase of the elderly population: 2.0 million in 1993, reaching 2.8 million in 2000, and expected to reach 5.4 million in 2025.

At the same time, families that had taken care of the bedridden, demented, or frail elderly members were no longer always capable of undertaking the task. In the urban areas, not only have three-generation households become less common, but also a substantial number of men and women have remained either single or childless. In rural areas, which have been depopulated and aging for decades, single elderly households or elderly couple households have become very common. When an elderly member needs long-term care, quite often, social care either must supplement the family care or is the only choice.

Before the introduction of LTCI, social care was provided as protective measures of municipal governments, funded by the general tax revenue. Since most municipalities have been running financial deficits for the last two decades or more, it was not easy for them to find funds to provide such care and what care they could provide tended to be of barely "socially acceptable" quality. In these circumstances, it was natural that the elderly who could not get sufficient family care began to concentrate in hospitals that could not compete with large hospitals in the acute-care market. They tended to be either smaller ones in urban areas or medium-size ones located in depopulated areas, almost always understaffed and with substandard buildings and equipment. Many of the elderly patients there were first admitted for acute care, in some cases to large hospitals from which they were transferred to these substandard ones, but their families refused to have them discharged because they were unable to provide proper care at home.

Their numbers grew rapidly, and so did their medical costs. By the late 1980s, reducing the social hospitalization became one of the top priorities of health policy authorities. At the same time, they were also aware of the need for long-term care service that, unlike the administrative protection available only to the low-income families, would be accessible to middle class families as well. An alternative system for providing such long-term care had to generate enough revenue to pay for the service, to be accessible to middle class families, and to allow families a choice of providers and services in order to weed out the inferior service that had
prevailed under the administrative protection scheme. That was essentially what the LTCI was intended to achieve.

Increased reliance on social care is surfacing also in other developed countries. For example, although the United States does not have public long-term care insurance as such, Medicaid still covers the services of skilled nursing homes. According to Brown and Finkelstein (2011), in 2008, long-term care costs accounted for 9 percent of health care costs, and public funds paid 60 percent of those costs, which was not very different from other OECD countries. Brown and Finkelstein warn that unless Americans starts buying more private long-term care insurance policies, the burden on the public sector will increase very substantially as its population continue to age.

In this respect, Damiani et al. (2011) conducted a principal component analysis using the comprehensive public database on long-term care of 29 European countries. They have confirmed that there are four types of long-term care in Europe as is commonly believed. The first type represents the Nordic countries, which have generous long-term care insurance. Although the financial burden is substantial, because of its generous benefits the insurance enjoys strong public support. The second type represents the Western European countries that provide less generous public benefits, but still sufficient, given the availability of family care. The third type represents the Mediterranean countries (Greece, Spain, Czech Republic, Poland) whose long-term care insurance fall short of the socially needed level. The other Central European and Mediterranean countries have sufficient resources for long-term care but suffer from serious mismatch with what the population needs. The authors note that some countries moved from one type to another between 2003 and 2007. They expect the European countries will reexamine their long-term care insurance as the number of the elderly needing the service and its cost continue to grow in the near future.

There are many policy questions about Japanese long-term care insurance (LTCI) that can be answered only by careful empirical analyses. In this paper, we will examine the economic literature published in various professional journals that has analyzed the effects of LTCI on the elderly who receive care services, on the family who give care and utilize the services, and on the service providers. We pay close attention to the econometric issues in each paper, particularly the quality of the data and the empirical methodologies. In reforming LTCI or in designing new research on LTCI, defining what we know for certain from these studies should be very important.

The rest of the paper is constructed as follows: in the second section, we will examine the empirical works addressing the effects of LTCI on the burden of family caregivers. In the third section, we will examine the effects on the labor supply of the family members who care for the elderly. In the fourth section, we will examine LTCI’s effects on the quality of the service and the efficiency of for-profit providers. In the fifth section, we will examine whether or not the insurance has succeeded in reducing social hospitalization. In the sixth section, we will summarize our findings and outline what is left for the future research.

2. Burdens of Family Care and LTCI

2.1 Subjective Burden

Perhaps the most important criterion in evaluating the success or failure of Japanese LTCI is whether or not it has succeeded in alleviating the burdens of the family caregivers. The general public has dreaded the burdens of family caregiving as a kind of hell that resulted often in abuse of the care receivers, the depression or illnesses of caregivers, and, in extreme cases, in murders and suicides involving both the care receivers and caregivers. Even in Western countries, the negative aspects of family care seem to be a serious concern; and we found a large number of studies on this point. For example, Schneider et al. (2002), Goldstein et al. (2004), and Visser-Meily et al. (2004) have found that risk factors for heavier burdens are the caregivers who do not
have support of family members or relatives, the care receivers whose health status is poor and show frequent problem behaviors, and the young caregivers. Furthermore, Tessier and Gamache (1995) and Rose-Rego et al. (1998) state that giving care reduces the subjective happiness of the caregivers. Furthermore, as the burden of care increases the caregiver feels greater psychological stress (Joling et al. 2008), and experiences deterioration in health (Rose-Rego et al. 1998; Schulz et al. 2009). Caregiving increases social isolation (Bodnar and Kiecolt-Glaser 1994; Sherwood et al. 2005), induces depression and abusive behaviors on the part of caregivers (Sherwood et al. 2005). It also increases the probability of premature death (van Exel et al. 2004; Schulz et al. 2009). On the other hand, some point out the positive aspects of family care as well. For example, Farfan-Portet et al. (2009) and Carbonneau et al. (2010) have reported that by performing family care, caregivers feel sense of fulfillment and importance.

An overwhelming majority of existing studies, however, admit that family care imposes substantial burdens on the caregivers. In the studies of subjective burdens, as an instrument for such a burden, Zarit index (Zarit Caregiver Burden Interview, or ZCBI) is the one that is most frequently used. This index is due to professor Zarit and others (Zarit, Reever, and Bach-Peterson 1980; Zarit and Zarit 1990). Normally, the interviewer reads 22 (originally 29) questions to the caregiver, and ask her or him to choose one of the five standardized answers ranging from "never" to "nearly always." Each question is scored on a 5-point Likert scale (0 to 4) and the total scores range from 0 (low burden) to 88 (high burden). The questions are designed to capture the impacts on health, schedules, social life, and finance of family caregiving. A Japanese language version of Zarit index was published by Yumiko Arai and her associates of the National Center for Geriatrics and Gerontology (Arai et al. 1997), who later developed a shorter version (J-ZBI-8) of the index (Arai, Tamiya, and Yano 2003) too.

How did the introduction of LTCI into Japan affect the psychological burden of family caregivers? The only study we could find that has directly addressed to this question is Arai et al. (2002a). They followed 47 pairs of elderly persons and caregivers living together in a small town in Miyagi Prefecture since 1998: 22 of the caregivers were daughters-in-law, 11 were wives, six were daughters, five were husbands, one was a son, and two were the daughters-in-law of a grandson (Arai et al. 2002b). They analyzed the change in the subjective burden of the family caregivers as the long-term care insurance was introduced in 2000. Because of deaths or placement in long-term care institutions between 1999 and 2000 in their sample, however, they could use only 18 samples for their pre- and post-LTCI comparative analyses. Using analysis of variance, they found that the number of different services the care receivers actually received have shown a statistically significant increase, while the amount of care time of primary family caregivers has shown a statistically significant decrease. Nevertheless, paradoxically, they could not find a statistically significant decrease in caregivers feeling of burden as measured by the Zarit (J-ZBIC-22) index. As possible explanations for this paradox, they point out such factors as the complicated red tape the families must go through to qualify for benefits and the new economic burden of 10 percent out-of-pocket costs. These factors indicate that the change in the burden needed to be measured sometime after the new system has been in place; their survey was conducted shortly after the insurance was introduced. Furthermore, their sample size is very small (18 individuals), and just the difference between the means of the two groups were tested with no other factors controlled.

Furthermore, in another study, Arai et al. (2004) analyzed the subjective burden of the family caregivers under LTCI using a sample of 46 families receiving home-nursing service in Kyoto. They found that family caregivers of elderly with problem behaviors reported significantly higher burden, and that family caregivers who could take more than three hours off reported significantly lower burden. They also found weaker evidence that family caregivers who find it inconvenient to use the service report a higher burden. Thus they concluded that it is important to design LTCI services that can temporarily release the caregivers totally from home care to reduce their burdens.

Following the pioneering works of Arai and her associates, Kishida and Tanigaki (2007) measured the psychological burden of family caregivers under the LTCI by Zarit index. They tried to identify the home services that should be offered to reduce the burden and to rate the patients in term of priorities for institutional services. In 2004, through personal interview by public health nurses, they collected information about the
household characteristics and characteristics of care receivers and primary caregivers of a random sample of 725 families, selected from those who had applied for institutionalization in two small cities in a prefecture in western Japan.

Kishida and Tanigaki conducted OLS regression in which the left-hand-side variable is Zarit index (J-ZBIC-22 index). They classified their explanatory variables into four groups; severity, support conditions, characteristics of the caregivers, and the factors impeding the utilization of services. To represent the care need of the receivers, they tried two instruments simultaneously, namely, an "activities of daily living" (ADL) instrument and a dementia instrument.

Through OLS regression results, they show that caregivers' psychological burden seems to be heavier when patients have few difficulties with ADL but more severe dementia, and for patients with more serious ADL deficits but lighter dementia. On the other hand, when the official care-need grades are used to control the patient's condition, the coefficient increases with the care-need grade but decreases in the highest grade. Particularly heavy burdens are found for the cases where the patient's dementia is serious but their providers do not offer sufficient short-stay services. The instability of the patient's condition increases the burden, but the availability of emergency care nearly offsets all the effect. However, when patients are receiving nighttime care, the caregiver's burden is heavy, which seems to suggest that available LTCI service is still insufficient for these elderly.

Thus, Kishida and Tanigaki (2007) have shown, on the basis of a random sample of decent size, collected by professional's interviews, that the Zarit index is a very useful tool in evaluating the quality and quantity of LTCI home benefits. There are two problems with their analyses: one with data and the other with the estimation methodology. Their data covered an extremely small area, which might have given unknown biases to their results. The other problem is the endogeneity in key variables in their regression; for example, they have used subjective health as an explanatory variable and found that poor subjective health increases the burden of care. The causality could be the other way around; namely, it may be the higher burden of care that is lowering the subjective health of the carer.

Following Kishida and Tanigaki (2007), Suzuki, Ogura, and Izumida (2008) tried to resolve their shortcomings; they applied a framework to detect the effects of the rationing in the LTCI benefits that had been quietly put into place as the insurance started to run deficits in many urban areas before the 2006 reform. Through a national internet survey, they secured a sample of 2,530 families practicing family care, and collected information about various health and behavioral problems of the elderly, socioeconomic information about the caregivers and the family, and information about the utilization of LTCI benefits. They collected answers for the short Zarit index (J-ZBIC-8 index), however, rather than the full-length version. They dealt with the endogeneity problems concerning the caregiver's subjective health and LTCI benefits wanted by TSLS estimation.

Their results shows that the rationing of short-stay, day-care, and home-helper services significantly affected the subjective burden of caregivers; if the amounts of these services fall short of what the family wants, the caregiver's subjective burden increases. When the elderly have behavioral or sleeping problems, the burden is higher, which suggests that the current LTCI benefits are insufficient to cover such risks. Moreover, the caregiver reports high burden when the receiver shows no gratitude or even explicit hostility to the caregiver, or when other relatives do not help him or her, which suggests that personal relationships existing before the start of family care are an important determinant of the subjective burden. As to the self-evaluated health of the caregivers, their two-stage least squares results show that Kishida and Tanigaki's (2007) causality is reversed; it is the higher subjective burden that is lowering self-evaluated health, rather than the other way around.

### 2.2 Economic Burden

Iwamoto, Kohara, and Saito (2001) have approached the economic burden of the family care, by analyzing the changes in the household consumption when one of its member starts needing long-term care. They took
advantage of the income information of more than 15 thousand households of regular employees in the Comprehensive Survey of Living Conditions of the People on Health and Welfare (hereafter simply Comprehensive Survey) for the year 1995, and estimated household income function and household expenditure function. According to the estimated income function, having a member with care need reduces household income by 11 percent. At the same time, the other household members, particularly spouses, tend to give up employment, reducing the number of income-earning individuals by 5 percent. According to the estimated consumption function, as one-percentage-point decrease in income reduces the consumption by 0.23 percent, the reduction in income reduces the household consumption by 4 percent, which the authors call "indirect effect." The cost of care reduces the consumption of the other goods and services by 22 percent, which they call "direct effect." The sum of the direct and indirect effects hence reduces the household consumption by almost a quarter. They argue that when LTCI is introduced, a substantial portion of this reduction is expected to be paid by the insurance, increasing the economic welfare of these households.

Iwamoto, Kohara, and Saito (2010) followed up on their earlier work (2001) to examine by how much the LTCI introduced in 2000 affected the consumption level of a household with a member receiving long-term care. In the later study, they used two sets of Comprehensive Surveys, one for the year 1998 (pre-LTCI) and the other for the year 2001. According to the estimated results, the sum of the direct and indirect effects amounts to 11.7 percent; that is, the consumption expenditure of a household decreases by 11.7 percent when one of its members starts consuming long-term care. Using the 2001 data, they have obtained a significant indirect effect of 9.4 percent, but no significant direct effect. The difference between 11.7 percent and 9.4 percent is found to be statistically significant, and hence the LTCI compensates some welfare loss of the household whose member start receiving long-term care. They also reported that the households utilizing institutional service in 1998 spent almost 20 percent less than the other households, but in 2001 they could not find a statistically significant negative effect.

There are two problems, one substantive and the other technical, in these two papers by the same authors. The substantive problem is the huge gap between the estimated burden of 22 percent using the 1995 data and that of 12 percent burden using the 1998 data, both years before the introduction of LTCI. In fact, the difference between 1998 data and 2001 data is very small, compared with this variation. Looking back at the chaotic Japanese labor market in the late 1990s, when the so-called Japanese lifetime employment practice came to an end in many firms, we wonder if the magnitudes of the burden obtained by these authors may reflect more these uncontrolled structural labor-market changes than the effect of the introduction of LTCI.

The technical problem mainly concerns the household disposable income functions. In both papers, household consumption expenditure functions contain the estimated value of disposable income, for which the authors needed to estimate the disposable income function through the instrumental variables method. The identification of disposable income function is characterized by the exclusion of two dummy variables—one for being a student and the other for homeownership from the consumption function—and the inclusion of squared age of household head and the number of workers in the household. These are rather problematic set of assumptions, to say the least, and yet the authors failed to provide the results of statistical tests for their assumptions. While this failure could be simple oversight, it will not look good to a growing number of econometricians who are skeptical of the results obtained by instrumental variables estimation from pooled cross-section data.

3. Effect of LTCI on Labor Supply

One of the secondary objectives of LTCI is to protect women workers of older workers from the sudden onset of family obligations and to make it possible for them to keep or return to their careers even with the onset of such obligations. Many studies in developed countries report that family care reduces the labor supply of female and elderly workers. For example, Covinsky et al. (2001) and Koerin, Harrigan, and Secret (2008) report that
almost 21 percent of Americans are practicing some kind of family care, and a majority of them are either voluntarily or involuntarily adjusting their work schedules accordingly. Negative effects are most pronounced on natural daughters when they live their parents. Thus it is necessary for the society as a whole to provide work environments for them that make work compatible with their family care.

Furthermore, Kniesner and Lo Sasso (2001) report that as more American women hold jobs and have job-related social responsibilities, they are now finding it harder to perform traditional family care and keep their jobs. Their empirical analyses suggest that women who have jobs with social responsibilities tend to provide monetary support but substantially reduce their time for family care, while women who have jobs with little social responsibility show no such reduction in family care time.

Carmichael and Charles (1998) report also that English women who spend less than 20 hours a week on family care seem to have easier time in finding jobs in labor market, but their hours at work are significantly shorter than those of women who spend no time for family care. The labor force participation of women who spend more than 20 hours for family care declines sharply, and even when they work, their hours drop substantially. Furthermore Bolin, Lindgren, and Lundborg (2008) examine the impacts of family care on labor market using a large European data set of 22,000 individuals above age 50 who care for family members. They conclude that family care tends to reduce employment and wages of both men and women. Also those who perform family care tend to occupy lower positions at work, holding their other properties or qualifications constant. The work-deterring effects of family care seem to vary according to the type of social care available, with the strongest effect in the Central European and Mediterranean counties.

Given the substantial evidence of the negative effect of family care on labor supply, has the introduction of long-term care in Japan worked to increase the labor supply? Female labor is expected to play a key role in Japan's aging and diminishing labor force. From such a viewpoint, Shimizutani, Suzuki, and Noguchi (2008) argued that LTCI has actually encouraged labor market participation.

Shimizutani et al. (2008) claim that the LTCI encourages family members to seek outside employment by freeing them (at least partially) from family care. They pooled two parallel surveys in their analyses; one conducted by the Cabinet Office on the utilization of long-term care services by families needing such care, and the other conducted by Japan Center for Economic Research on families caring for a chronically ill elderly member. These surveys were conducted in 1999, 2001, and 2002, and altogether included 2,000 households. Pooling the two surveys of different care needs, the authors defined the former as a treatment group affected by the introduction of LTCI and the latter as a control group not affected by LTCI. They then carried out the difference-in-differences analysis on the labor supply of female family members. In particular, they compared the employment rate, days worked per week, and working hours per day of the principal caregivers and female spouses of the two groups. According to their estimation, in the fall of 2001, or one and a half years after the introduction of LTCI, they could find no positive effects of LTCI on female labor supply; but in the fall of 2002, or two and a half years after the introduction, they found statistically significant positive effects on female labor supply. In fact, they found quite sizable effects: probability of employment increased by 8 percent, and days worked per week and hours worked per day increased by 10-20 percent.

There are three possible problems in their framework. First is that their treatment group and control group may be heterogeneous. Long-term care may involve different kinds of work, different hours of the day, different psychological burdens, different availability of respite care, and so on, from care for the chronically ill elderly. For instance, in a family with a chronically ill elderly person, a typical caregiver may have cared for much longer time in the past and will find it more difficult to return to the labor market if someone unexpectedly offered to share a part of the care responsibility. The second problem is on the estimation methodology; their difference-in-differences analyses are based on a pooled cross-section data, without controlling for individual fixed effects. Thus their results are most likely to contain cross-section biases. The third problem is in their survey methodology: the data were obtained by internet surveys. Since those who respond to internet surveys are known to be younger and more computer literate, they are more employable in today's labor market than an average caregiver at home. This is something to think about when we compare their results with those of the
next paper.

In contrast with Shimizutani et al. (2008), Sakai and Sato (2007) analyzed the impacts of home care and LTCI on the work and retirement decisions of elderly caregivers. They compiled balanced panel data from 814 married men and women who responded to all four surveys conducted by a private research institute in 1997, 1999, 2001, and 2003. Incidentally, in this panel data, most of the care receivers are the natural mothers of the husbands, and the primary caregivers are the wives (or daughters-in-law); this fact seems to be a key in understanding their results. They have estimated logit functions for labor supply of husbands and wives separately, using the estimated reserve wage rate, health status, a mandatory retirement dummy variable, and a dummy variable for the family needing home care. They then conducted Hausman specification tests, and selected fixed effect models. According to their results, the onset of the need of home care significantly reduces the husband’s employment probability, but, interestingly, it does not have a statistically significant effect on wife’s employment. Using separate dummy variables of home care needs before and after the introduction LTCI (in 2000), they rejected a null hypothesis that the impact on husband’s employment was reduced by LTCI at the significance level of 10 percent. Thus, unlike Shimizutani et al. (2008), Sakai and Sato claim that LTCI has not removed the negative impact of home care on employment at least for the elderly male workers.

One thing to note, however, is that, in their estimation, failure to control for the differential burden of home care or for LTCI care-need grades may have introduced omitted-variable biases. Second, their sample consists of couples who are rather old and for whom LTCI is more or less a policy shock; thus it is quite possible that the labor supply of younger generations, who have time to take full advantage of LTCI, will show a more positive response.

4. LTCI and the Quality and Efficiency of Service Providers

In Japan, for-profit firms had long been excluded from the social services and medical care on the principle that profits would be made at the expense of the welfare recipients or medical patients. From the second half of the 1990s, however, in a national movement for more efficient government, the general public wanted improvements in quality of public services at a lower cost. Realizing that competition is the only way to achieve these conflicting goals, they forced the reluctant government to end the exclusion of for-profit organizations in many fields. Home care benefits of LTCI was one of the new fields opened to for-profit firms. Has the change improved the quality and efficiency of the service providers? Let us first introduce some preceding work in the United States and then examine the work on Japan.

In the United States, where for-profit firms were permitted to participate in the health and long-term care markets much earlier, Cohen and Spector (1996); Spector, Seldon, and Cohen (1998); and Chou (2002) examined the qualities of the long-term care services using various indices of staff-quality (ratios of regular workers, registered nurses, and practical nurses) and of consumer satisfaction (among care receivers and their families). From these empirical analyses, Cohen and Spector (1996) and Spector et al. (1998) claim that not-for-profit organizations offer higher-quality services than for-profit organizations, but Chou (2002) claims that the opposite is true. Furthermore Grabowski and Hirth (2003) in effect claim that there is no difference between the two in the long-term care services. Hence there does not seem to be a consensus on the systematic difference due to ownership status.

In the Japanese market for home-helper service, Shimizutani and Suzuki (2007) were the first to investigate whether there is a systematic quality difference across different types of providers. Their data were obtained from a large survey conducted by the Cabinet Office in 2001 on LTCI home care providers. The providers were first selected randomly from a list of WAM-NET® home service providers in Kanto Area, and questionnaires were sent.

The questionnaire asked about financial situations, characteristics of staff, nature of the organization (for-profit, nonprofit, and public), and the quality of the services. For their analyses, the sample size was 442.
According to their analyses, there is no difference in the quality of the service between for-profit and nonprofit providers, but the quality of public providers is clearly lower. Comparison of new and existing providers reveals that new providers offer higher-quality service.

They estimated cost functions taking the service quality into account, and concluded that new providers are more efficient producers of home-helper service than existing ones. This conclusion, however, needs to be taken with some reservation, because the service-quality variable they have included in the cost function most likely has introduced endogeneity biases in the coefficients of the equation. In any case, according to them, the admission of for-profit firms has worked to increase competition, improve the quality, and reduce the costs in the home-helper market. Opening more services to for-profit providers, they argue, will enable the entire long-term care market to produce services of better quality, at lower cost.⁴

An argument may be made that in the long-term care service market, as in medical care, there is an asymmetry of information between consumers and providers that makes it difficult for the market mechanism to function effectively. Kadoya (2010) examined this hypothesis in the Japanese market of group homes with care, a residential service for persons with light dementia, and found a negative answer to the question.

Kadoya collected, from the WAN-NET, such information as the finances, staff characteristics, ownership, physical environment, and service quality for providers of group-home services in the Kanto area in 2006 and 2007. The sample size of his analyses is 1,093. He found no clear difference in the third-party quality evaluations of service between the for-profit and nonprofit providers, and no statistically significant difference in the service quality between the competitive and noncompetitive areas. Furthermore, new providers offered services in the year of their entry that was inferior to the established ones; in the next year, however, they showed significant improvement in quality compared with the existing providers. Thus, Kadoya argues, in the Japanese market for long-term care services, market mechanism works effectively and improve the quality of the service.

We should note, however, that Kadoya simply divided his sample into two groups and, for each variable in question, carried out the test for the statistical significance of the difference in the two means. In other words, unlike the case in the regression analyses, he has not controlled for other relevant factors. In the editorial commentary, accordingly, Sugahara (2010) points out that Kadoya should have controlled for the difference in prices of the group-home service, as they partly account for the difference in quality. Furthermore, Sugahara argues, the market mechanism should include such market structures as the excess demand, and the oligopoly in the region, and the Herfindahl-Hirschman index should have been computed not just for the group-home market, but also for all the services competing with group-home service as well. These are important points to be resolved in proving Kadoya’s claims.

5. LTCl and Social Hospitalization

When LTCl was introduced, it was presumed that it would provide long-term care as its benefit, so that hospitals could concentrate on acute care. As we have seen, with the introduction LTCl, the variety and the availability of services supporting home care, and their financial accessibility, have increased dramatically for families that undertake long-term care for their elderly. At the same time, the quality and the availability of institutional care has grown too, although more slowly than home care services.

Has LTCl contributed to reduce the social hospitalization? In this regard, we should note that social hospitalization can be affected not only changes in the long-term care system but also by changes in health care systems (both acute and chronic) (Innami 2009). With the introduction of LTCl, the patients who had been hospitalized in long-term care beds could choose one from three alternative services, depending on their care needs: namely, at-home services, LTCl hospital long-term care beds, and LTCl health facilities. Hanaoka and Suzuki (2007) analyzed how the introduction of LTCl affected the discharge behavior of elderly patients who had been hospitalized for extensive periods. They estimated hazard functions of inpatient days using individual health insurance claims records of 3,043 patients during the period May 1998-March 2003.⁵ The independent
variables are the increases in the institutional and at-home care services (e.g., the increases in the number of LTCI hospital beds, in the capacity of LTCI health facilities, and in the capacity of day-care services), disease dummies (cerebral infarction, heart diseases, dementia, and diabetes); availability of medical long-term care beds; the dummies for the revision of medical insurance reimbursement fees in 2000 and 2002; the dummy for the revision of out of pocket payments; age and sex of the patients; and the quarter dummies.

They estimated this model with and without individual hospital fixed effects, but ended by selecting the fixed effect model, when the null hypothesis of no individual fixed effect had been rejected. According to their estimated parameters, for both the 2000-2001 period and the 2002 period, the increase in the number of LTCI beds shortened the hospital stay significantly, but the magnitude of the latter period effect amounted to eight times that of the former. Other available LTCI resources did not have expected signs or statistical significance.

There are two possible problems in their results. First is the large positive sign for the dummy variables that stand for the increases in out-of-pocket costs. During the period, several measures were taken that substantially increased the out-of-pocket costs of elderly patients, but Hanaoka's result indicates that they had actually prolonged the hospitalization. This counterintuitive result needs to be explored more carefully as to both theory and empirics. The second is their year dummy for the revision of the reimbursement rules in 2003. The revision increased the elderly patient's costs but at the same time strengthened the incentive for hospitals to discharge patients by decreasing the payment in several steps as hospitalization gets longer. Clearly, handling both demand and supply sides by a single dummy variable is inappropriate.

Subsequently, Tokunaga and Hashimoto (2010) analyzed the effect of increased long-term care resources resulting from LTCI on the long-term hospitalization of the elderly patients. They point out that the data used by Hanaoka and Suzuki (2007) came from a single prefecture, contains no information about where the patients had been discharged, and does not contain much information after 2003.

Tokunaga and Hashimoto had access to the aggregated data of the discharged inpatients of Patient's Survey conducted in 1999, 2002, and 2005, aggregated specially for each of the 249 secondary medical zones in Japan. On average, each zone contained around 270 discharged patients who were no less than 65 years old at discharge and had been hospitalized for more than 30 days paid by medical insurance alone. They used the data to estimate the average number of days in hospital. Their main explanatory variables are those that stand for the increase in resources for long-term care; that is, capacity of special nursing homes, special nursing beds in hospitals, and the number of home-care service providers.

Other control variables are the proportion of the elderly in the zone, the proportion of cerebral infarction patients among the discharged inpatients, the average age, the proportion of females, the proportion of patients who had undergone surgery, and the proportion of patients who had home addresses outside the zone. They estimated the average length of stay in hospitals using OLS, and found that the number of days in hospital increases by two and a half days, for a one-percentage-point increase in the cerebral infarction proportion, but decreases by almost two days, for a one-percentage-point increase in the proportion of surgery patients. As to the long-term care resources, during the 1999-2002 period, the number of days in hospital decreased significantly in the medical zones where resources increased, but their effect disappeared during 2002-05 period.

They have estimated a similar equation using the proportion of home-discharged patients as the dependent variable. In almost all secondary medical zones that had experienced an increase in the average age of the elderly, the home discharge proportion decreased. Furthermore, as to resources of long-term care, in the zones where home service providers had increased, the home discharge proportion increased during the 1999-2002 period, but not in the period 2002-05. For both periods, in the zones where the proportion of cerebral infarction had increased, the increase in the number of home care service providers worked to increase the proportion of home-discharged patients.

From these observations, Tokunaga and Hashimoto concluded that after the introduction of LTCI, the one-shot increase in the resources was rapidly absorbed in many zones, and newly discharged patients could not longer be admitted to long-term care institutions.

For the period 2002-05, Tokunaga and Hashimoto's results seem to contradict in part some of Hanaoka and
Suzuki's, but neither do the periods in the two papers coincide completely nor are the dimensions of the critical variables involved the same. Hanaoka and Suzuki looked at the relationship between the length of hospital stay and the increase in long-term care beds: Tokunaga and Hashimoto looked at the relationship between the increase in the length of stay and the increase in long-term care beds. Tokunaga and Hashimoto moreover had to work on aggregated data, and hence, unlike Hanaoka and Suzuki, they could not estimate hazard functions. One worry about Tokunaga and Hashimoto's data is their aggregation of patients who had been hospitalized for 30 days or more, which involves incidental truncation and bias the coefficients obtained. Another is the heteroschedasticity; since the secondary medical zones vary substantially in population, adjustment for sample sizes is needed in using mean values, but it is not clear from the paper whether they have done it or not.

Most recently, Noguchi and Shimizutani (2011) have examined whether the price mechanism can be used to reduce social hospitalization. The used individual patients data obtained in the provider's survey conducted in 2000 by the Ministry of Health and Welfare. The sample consists of 1,556 individuals in welfare facilities, 14,134 individuals in health facilities, and 2,828 individuals in long-term care medical institutions. These individuals had been either discharged from the institutions in the previous month or cared for in the institutions in the survey month, with known health conditions at both admission and discharge.

Using the Cox proportional hazard functions, their estimation shows that in response to a one-percentage-point increase in an inpatient’s out of pocket cost, the probability of discharge from welfare facilities increases by 1.7 percent and the probability of discharge from health facilities by 1.8 percent, but the probability of discharge from hospital long-term care beds increases by only 0.2 percent. Furthermore, they have fitted a probit model to the selection of the institutions by the discharged patients. A one-percentage-point increase in the out-of-pocket cost increases the probability of coming home by 0.4 percent for welfare facilities patients and 3.7 percent for health facilities patients, but has almost no effect on hospital long-term care beds patients. Since an increase in the out-of-pocket cost induces substantially different changes in the discharge or transfer behaviors in different types of institutions, they concluded that it is possible to use it as a policy instrument to reduce the length of stay in institutions, and to reduce social hospitalization.

Given the specifications of their models, however, the conclusions by Noguchi and Shimizutani do not seem to be warranted. In the normal Cox proportional hazard functions, if the explanatory variables are measured in natural units, the coefficients stand for effect off the unit change in the variable on the log of the odds ratio of the hazard of the treatment group to the baseline hazard; that is,

\[ h(x_1, x_2, \ldots ; t) = h_0(t) \exp (x_1 + b_1 x_1 + \cdots) \]

\[ \ln (h(x_1, x_2, \ldots ; t)) = \ln (h_0(t)) + (b_1 x_1 + b_2 x_2 + \cdots) \]

\[ \ln (h(x_1, x_2, \ldots ; t) / h_0(t)) = (b_1 x_1 + b_2 x_2 + \cdots). \]

The left-hand side of the last equation is the dependent variable, and the right-hand side are the explanatory variables.

Assuming all values of the explanatory variables are zero in the baseline hazard function, and all but x1 are set equal to zero, we have indeed

\[ \frac{\partial \ln \left( \frac{h(x_1, 0, 0, \ldots ; t)}{h_0(t)} \right)}{\partial x_1} = b_1. \]

and hence

\[ \left( \frac{\partial h(x_1, 0, 0, \ldots ; t)}{h(x_1, 0, 0, \ldots ; t)} \right) \frac{1}{\partial x_1} \]

However, Noguchi and Shimizutani measured the out-of-pocket cost in the natural log. Thus a unit increase in the natural log of the out-of-pocket cost equals one-percentage-point increase in the out-of-pocket cost.

\[ x_1 = \ln (z) \]

\[ \frac{\partial x_1}{\partial z} = \frac{\partial z}{z} \]

Hence

\[ \left( \frac{\partial h(x_1, 0, 0, \ldots ; t)}{h(x_1, 0, 0, \ldots ; t)} \right) \frac{\partial z}{z} = b_1. \]
<table>
<thead>
<tr>
<th>Source</th>
<th>Data</th>
<th>Sample Size</th>
<th>Estimation Methods</th>
<th>Research Questions and Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arai et al. 2002</td>
<td>Own survey conducted on caregivers and impaired elderly receiving regular home-visiting nursing care in a town in Miyagi Prefecture (2000)</td>
<td>18 pairs</td>
<td>Analysis of variance between 2 groups</td>
<td>Examines caregiver burden by Zarit Caregiver Burden Interview index. Concludes that after introduction of LTCl there was no statistically significant improvement in Zarit index, despite reduced hours of care.</td>
</tr>
<tr>
<td>Arai et al. 2004</td>
<td>Own survey conducted on impaired elderly receiving regular home-visiting nursing care in Kyoto Prefecture (2001)</td>
<td>46 pairs</td>
<td>Correlation analysis, Logit analysis</td>
<td>Examines determinants of caregiver burden under LTCl by ZBIC. Problem behaviors and difficulty of use of the care service are given as the causes of caregiver burden.</td>
</tr>
<tr>
<td>Kishita and Tanigaki 2007</td>
<td>Interview survey of families requiring care and waiting for admission to special nursing homes in two cities in the Chugoku region (2004)</td>
<td>725 impaired elderly</td>
<td>OLS Using the J-ZBIC-22 index for explained variables</td>
<td>Examines determining factors of caregiver burden under LTCl. Concludes that caregiver burden is especially heavy where level of impairment is light but dementia is severe and where impairment is severe and level of dementia is light.</td>
</tr>
<tr>
<td>Suzuki, Ogura, and Izumida 2008</td>
<td>Data from survey conducted nationwide on caregivers in households requiring family care (2006)</td>
<td>2,530 caregivers</td>
<td>IV (Using the J-ZBIC-8 index for explained variables)</td>
<td>Examines determining factors of caregiver burden under LTCl. Mismatches and deficiencies in use of nursing care service is given as cause of increased caregiver burden.</td>
</tr>
<tr>
<td>Iwamoto, Kohara, and Saito 2010</td>
<td>Ministry of Health, Labour and Welfare Comprehensive Survey of Living Conditions (1998 and 2001)</td>
<td>Approx.15,000 households (each year)</td>
<td>IV (Explained variable is the log of level of consumption)</td>
<td>Examines impact on consumption in households where persons require nursing care. Concludes that after introduction of LTCl statistically significant improvement is seen in such households.</td>
</tr>
<tr>
<td>Shimizu and Suzuki Naguchi 2008</td>
<td>Data pooled from two internet surveys: (1) on use of nursing care services by households where person required nursing care, by Cabinet Office; and (2) of households with chronically ill elderly, by Japan Center for Economic Research (1999, 2001, and 2002).</td>
<td>Approx. 2,000 households (total for 3 years)</td>
<td>Difference-in-difference</td>
<td>Examines the effect of LTCl on female labor supply in households with a person requiring nursing. Concludes that a statistically significant positive effect was seen roughly 2.5 years after the introduction of LTCl.</td>
</tr>
<tr>
<td>Shimizu and Suzuki 2007</td>
<td>Questionnaire survey on long-term care providers conducted by the Cabinet Office (2001)</td>
<td>442 providers of home-helper service</td>
<td>Test by average of two groups Estimation of a cost function.</td>
<td>Examines quality and efficiency of home-visiting nursing care (home-helper) market after introduction of LTCl. Comparing new and existing businesses, survey concludes that new businesses provide higher-quality services than existing businesses and provide services more efficiently.</td>
</tr>
<tr>
<td>Kadoya 2010</td>
<td>Questionnaire survey on providers of group home service in Kanto area (2006 and 2007)</td>
<td>1,093 providers of group home service</td>
<td>Test by average of two groups</td>
<td>Examines quality and efficiency of group homes. Concludes that the market mechanism functioned to improve quality of services after introduction of the system.</td>
</tr>
</tbody>
</table>
Thus, for example, a one-percentage-point increase in the out-of-pocket cost does not increase the probability of discharge from welfare institutions by 0.04 percent, but by 1.004 percent, which is the size of the estimated coefficient. Likewise, the probability of discharge from health facilities did not increase by 3.7 percent but by 1.037 percent, and the probability of discharge from long-term care hospitals by 1.019 percent. Therefore, the elasticity of discharge regarding the out-of-pocket cost in these three institutions is one for all practical purposes.

6. Concluding Remarks

We have examined in detail the hypotheses, the data, the econometric techniques, and the conclusions in the existing studies on the effects of the Japanese LTCI introduced in 2000. The summaries of these studies are shown in Table 1.

The authors of these articles almost all had to live with the imperfection of the data. Most relied on administrative data for their analyses, which, despite offering sufficient sample sizes, are almost always cross-sectional and not ideal for controlling individual heterogeneity. Inevitably the use of these data left the authors with estimates susceptible to the criticism of endogeneity due to the omitted variables problem. Some were fortunate enough to have access to high-quality data compiled by public health professionals, but often they found the sample sizes too small to control even the minimal covariates, or found that their data might be considered too parochial to permit generalized conclusions.

The hypotheses these authors tried to prove were very natural and plausible ones, which may have been taken for granted even without rigorous, scientific proofs. As these authors discovered, however, even "natural" hypotheses are hard to prove in the absence of experimental data designed to single out the conceivable effects. They controlled the factors other than the LTCI-related changes using information available in the data sets, but typically we found that some important aspects of the relevant information was missing in the data set and hence remained uncontrolled. Frankly, we do not know how seriously these shortcomings have affected the conclusions, but today, in economics, few top journals publish empirical works that are not based on panel data, even for most plausible hypotheses. This stricture is quite understandable in the United States or in European countries where economists have access to high-quality panel data, but Japanese economists have been forced
to work mostly with cross-section data. Insisting on the same standards as these top journals in Japan is obviously not very productive.

We should then accept their conclusions as they are offered but also start accumulating stronger empirical evidence one way or the other. Several attempts are being made in academia and in government to compile panel data, and there are smaller but established household data sets maintained by private research institutions. In the next few years, as more economists gain access to these data sets, the problems we have pointed out in our paper will be resolved. In the meantime, we have some evidence for the favorable effects of LTCI, but they are far from conclusive.

Acknowledgement

This paper is a part of the academic project "Economic Analysis of Intergenerational Issues: Searching for Further Development," funded by the Grant-in-Aid for Specially Promoted Research from Japan’s Ministry of Education, Culture, Sports, Science and Technology (grant number 22000001).

Notes

1. Very detailed description of the cash benefits of five European countries (Austria, England, Germany, France, and Holland) can be found in Nadas et al. (2012). In the European Union’s Mutual Information System on Social Protection (MISSOC) database, the latest information on the Social Protection and Social Inclusion of 27 EU countries and four EFTA countries (Iceland, Lichtenstein, Norway, and Switzerland) are provided (http://ec.europa.eu/employment_social/missoc/db/public/compareTables.do?lang=en). For long-term care, the items are statutory basis, basic principles, field of application, conditions, organization, benefits in kind, cash benefits, combination of benefits, accumulation, benefits for the carer, user charges, and taxation.

2. As an index of caregiver’s burden, Caregiver’s Reaction Assessment (CRA) takes positive as well as negative aspects of caregiving into account. See Given et al. (2007). For a Japanese language version, see Misawa et al. (2009).

3. WAM-NET, run by the Welfare and Medical Service Agency of Japan, offers comprehensive information on social welfare, health, and medical services by internet for local governments, health centers, social welfare offices, in-home care support centers, and other relevant organizations. (http://hp.wam.go.jp/english/tabid/90/Default.aspx).

4. For example, Noguchi and Shimizu-Guini (2007) claim that, in the market for home-helper services, not-for-profit providers tend to pay higher wages than for-profit providers, who lack the economic incentives to do so.

5. The number of days in hospital function is specified as a log-logistic hazard function.

6. They cite earlier work by Izumida (2004), who obtained a similar result for a dummy variable for the dummy of July 1997 increase in the out-of-pocket cost in his hospitalized-days function. Izumida raised the possibility that the increase in copayment actually increased the probability of reaching the upper-limit system in the out-of-pocket costs for many patients, who enjoyed zero-marginal cost from then on.

7. By long-term care resources, authors refer to the public nursing homes, health facilities, long-term care beds, and home care services.

References


Caregivers Looking After Impaired Elderly in Japan under the Long-Term Care Insurance System., *Psychiatry and Clinical Neurosciences* 58: 396-402.


Joling, K. J., et al. 2008. "(Cost)-Effectiveness of Family Meetings on Indicated Prevention of Anxiety and Depressive


Sustainability of Comprehensive Universal Long-Term Care Insurance in the Netherlands

Frederik T. Schut*1
Bernard van den Berg*2

Abstract

The Netherlands was the first country to introduce a universal mandatory social health insurance scheme to cover a broad range of long-term care (LTC) services in a variety of care settings. Compared with spending in most other OECD countries, both total and public expenditure on long-term care is high, particularly since the Dutch population is relatively young. On the other hand, coverage of LTC services is relatively comprehensive. In this paper we examine the past experiences, current deficiencies, and future prospects of LTC financing in the Netherlands. We discuss whether the proposed reforms offer a perspective on a sustainable system of comprehensive LTC insurance.

[Keywords] Long-Term Care, Social Health Insurance, Health Care Reform, The Netherlands

1. Introduction

In many OECD countries public expenditures on health and long-term care are a matter of great concern in view of an aging population and increasing constraints on public budgets. These concerns are particularly vexing for countries with relatively high public expenditures on long-term care, such as the Netherlands. In comparison with most other OECD countries, both total and public LTC expenditures in the Netherlands are high, particularly since the percentage of elderly is similar to the OECD average (OECD 2005). The high rate of spending can be explained at least in part by the relatively generous social health insurance scheme.

Nevertheless, the growth of public spending on health and long-term care in the Netherlands was quite successfully limited until 2000 via the implementation of cost-containment policies that acted essentially through the supply rationing, wage moderation, price controls, and postponement of investment in LTC facilities. However, longer waiting lists and rising consumer expectations about the quality and variety of LTC services have substantially reduced the scope for containing LTC expenditures along those lines. Hence the Dutch government plans to reform the current LTC financing system to increase incentives for efficiency and consumer-directedness.

The main aims of this paper are, first, to describe the background, past experience, and proposals to reform the system of LTC financing in the Netherlands and, second, to discuss whether the proposed reforms can create incentives to sustain the comprehensive LTC insurance scheme in view of the aging population and the expected rise in demand for LTC services.

Section 2 provides a short background of the Dutch public health insurance scheme. In the third section we

*1 Professor of health economics at the Institute of Health Policy and Management, Erasmus University Rotterdam, the Netherlands.
*2 Reader at the Centre for Health Economics, University of York.
discuss the main features of the current public insurance scheme. In Section 4 we analyze the empirical evidence for the growth of public expenditure on long-term care over the period 1985-2005. Then we focus on the implications of personal care budgets for the object of increasing consumer direction and choice, including the consequences for informal care. In Section 6 we discuss the projections and determinants of future long-term expenditure growth. Section 7 discusses the shortcomings of the current system of LTC financing and the proposals for reforming the system. In Section 8 we discuss the prospects of the reform and in Section 9 the issue of sustainability and the questions that remain to be answered.

Since a uniform definition is lacking, we will first indicate what we mean by long-term care. The term is often used only in the context of elder care. In this paper, however, we use a more comprehensive definition, which includes care for the mentally and physically handicapped and care for chronic psychiatric patients. This definition coincides with the types of services covered by the public insurance scheme for long-term care in the Netherlands.

2. Background of Public LTC Insurance

The Netherlands was the first country to introduce a universal mandatory social health insurance scheme to cover a broad range of LTC services in a variety of care settings. In the Netherlands public LTC insurance was introduced in 1968; other countries have followed only quite recently, Germany, for example, in 1995 and Japan in 2000.

There are several reasons why the Netherlands chose a separate universal public health insurance scheme for long-term care. First, before 1968, the financing of LTC facilities was highly fragmented and increasingly insufficient to provide adequate long-term care for lower income groups. Strong economic growth during the 1960s substantially increased general social welfare, but because of a lack of funding the availability and quality of LTC facilities lagged behind the overall welfare increase. Since the financial risk of long-term care was considered to be largely uninsurable on the private market, there was broad political support for an expansion of public financing of long-term care. Second, because a social insurance scheme for curative health services, the Sickness Fund Act (Ziekenfondswet, hereafter ZFW), was already in place, the choice was made for public insurance rather than tax financing (as, e.g., in Sweden and Norway). However, the ZFW covered only two-thirds of the population (primarily lower- and middle-income groups). A straightforward expansion to include long-term care in the mandatory benefits package was therefore not an option, because higher-income groups would not be covered and not would contribute to the financing. An alternative would have been to expand the prevailing mandatory social health insurance scheme to the entire population and to expand the benefits package to include long-term care. Although this option was seriously considered and actually proposed by the government, it was soon withdrawn because of strong resistance from private health insurers (who feared a substantial loss of business), employers (who feared increasing employer contributions), and the medical profession (who feared government control of fees for services to privately insured patients).

Since an expansion of the prevailing social insurance scheme (as, e.g., in Belgium and Switzerland) was not feasible, a separate mandatory insurance scheme for long-term care for the entire Dutch population was proposed and enacted in 1968: the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, hereafter AWBZ).

Initially, the AWBZ covered primarily nursing home care, institutionalized care for the mentally handicapped, and hospital admissions lasting more than a year. However, coverage was expanded in 1980 to home health care (e.g., for rehabilitation at home after hospital admission and care for elderly with impairments); in 1982 to ambulatory mental health care; to family care in 1989 (e.g., home help in cases of frailty or psychosocial problems, or after childbirth); and to residential care for the elderly in 1997. Residents in homes for the elderly receive less frequent and less intensive nursing care than residents in nursing homes. Moreover, residents in elder homes have their own apartments, whereas residents in nursing homes usually share a room with one or
more others.

3. Main Features of Public LTC Insurance (AWBZ)

The AWBZ constitutes a mandatory insurance scheme for long-term care for the entire Dutch population. Every Dutch citizen older than 15 years of age with a taxable income has to pay an income-related contribution (up to a certain maximum amount) that is collected through the income and payroll tax systems, along with the contributions for the other national insurance schemes (e.g., unemployment and disability). In addition, for most LTC services covered by the AWBZ, income-related copayments are required. For higher-income groups the maximum copayment can be so high (about 1,800 euro per month for residential care) that private facilities are often more attractive.

Income-related contributions, copayments, and an annual state subsidy are collected in the General Fund for Exceptional Medical Expenses (Algemene Fonds Bijzondere Ziektekosten, hereafter AFBZ). Table 1 provides an overview of the different sources of funding of the AWBZ in 2008. Total expenditures from the General Fund were 21.4 billion euro in 2008. Consequently, in the same year there was an overall deficit of 2.1 billion euro (to be compensated by an extra increase in the 2009 contribution rate). As Table 1 shows, more than 75 percent of the AWBZ is financed directly by households, while the residual amount is paid by the state out of general taxes. Table 2 provides an overview of the most important categories of LTC users and their relative share in LTC expenditure.

Formally the AWBZ is administered by health care insurers that provide coverage for curative health services. In practice, however, health care insurers have delegated various responsibilities—in particular the

<table>
<thead>
<tr>
<th>Table 1. Funding of the AWBZ Scheme in 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of Funding</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Income-related contribution</td>
</tr>
<tr>
<td>Copayments</td>
</tr>
<tr>
<td>State subsidy (from general taxation)</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Note: In 2008 the income-related contribution was 12.15 percent of a maximum of 31,589 euro taxable income (implying a maximum contribution of 3838 euro per year, exclusive of various possible tax deductions).

<table>
<thead>
<tr>
<th>Table 2. Different Groups of AWBZ Beneficiaries by Numbers and Expenditures in 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Long-Term Care User</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Elderly and chronically ill</td>
</tr>
<tr>
<td>Mentally handicapped persons</td>
</tr>
<tr>
<td>Physically handicapped persons</td>
</tr>
<tr>
<td>Chronic psychiatric patients</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
contracting of health care providers, the collection of patient contributions, and the organization of regional consultations—to the largest regional health care insurer. At present, the Netherlands is divided into 32 care regions and in each region a single health insurer (known as the "regional care office") carries out the AWBZ on behalf of all health insurers for all residents living in that region. Regional care offices receive a fixed budget for the administrative tasks. All LTC expenses are directly paid out the General Fund (AFBZ). Hence, neither regional care offices nor individual health insurers are at risk for long-term expenses covered by the AWBZ scheme.

Before a person can qualify for care under the AWBZ, it is necessary to establish whether care is really required and, if so, what type of care and how much care is needed. Initially, health care providers were responsible for the required needs assessment, but in 1997 this task was assigned to regional independent needs assessment organizations, and since 2005 to a single national organization, the Center for Needs Assessment (Centrum Indicatiesstelling Zorg, or CIZ).2 The idea was to make needs assessment more objective and uniform and independent of the self-interest of health care providers. Notice that the access to long-term care is based solely on a person's health—as in Germany and Japan—and does not depend on income or wealth—as does the Medicaid program in the United States.3

Before 2003 the LTC benefits covered by the AWBZ scheme were defined in terms of the type of care or health care provider people were entitled to. To encourage innovation, consumer choice, and an efficient substitution of LTC services, in 2003 entitlements were radically redefined into seven broad functional care categories. In 2007 one of these categories—domiciliary care—was excluded from coverage and responsibility was transferred to the municipalities under the new Social Support Act (Wet Maatschappelijke Ondersteuning, or WMO). The remaining six functional categories of LTC services that were covered under the AWBZ in 2008 are summarized in Table 3.4

Except for the functional category "accommodation," clients who are entitled to care have a choice of receiving care "in kind" or in the form of a personal care budget (or a combination of both). The personal care budget is set at about 75 percent of the average cost of care provided in kind because the personal care budget can be spent on informal care, which is expected to be less expensive than professional formal care.

<table>
<thead>
<tr>
<th>Functional Category</th>
<th>Examples of Care Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Personal care</td>
<td>Help with taking a shower, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking</td>
</tr>
<tr>
<td>2 Nursing</td>
<td>Dressing wounds, giving injections, advising on how to cope with illness, showing clients how to self-inject</td>
</tr>
<tr>
<td>3 Supportive guidance</td>
<td>Supportive guidance: e.g., helping the client organize his/her day and manage his/her life better, as well as day care or provision of daytime activities</td>
</tr>
<tr>
<td>4 Activating guidance</td>
<td>Talking to the client to help him modify behavior or learn new forms of behavior in cases where behavioral or psychological problems exist</td>
</tr>
<tr>
<td>5 Treatment</td>
<td>Care in connection with an ailment, such as serious absent-mindedness</td>
</tr>
<tr>
<td>Accommodation (for those not capable of independent living)</td>
<td>Sheltered housing or continuous supervision in connection with serious absent-mindedness. Care requirements too great to address in a home environment may necessitate admission to an institution</td>
</tr>
</tbody>
</table>
4. Expansion of LTC Services and Expenditure, 1968-2005

The enactment and gradual expansion of the public long-term insurance scheme (AWBZ) paved the way for a strong growth of LTC facilities and of public expenditure on long-term care. The percentage of GDP spent on long-term services covered by AWBZ increased from 0.8 percent in 1968 to 2.0 percent in 1980 and further to 4.0 in 2005. Part of this increase, however, is due to an expansion of AWBZ coverage.

As shown in Figure 1, from 1985 to 2000 the percentage of GDP spent on LTC services that were covered by AWBZ in 2000 was more or less stable, around 3.5 percent (in 1985, however, only 2.0 percent was covered by AWBZ and 1.5 percent was financed in other ways). Hence, taking into account the expansion of AWBZ coverage, the expenditure on LTC services as a percentage of GDP has been quite constant over a considerable period of time. This is remarkable given the aging of the population (although it was fairly moderate during that period) and the susceptibility of long-term care to Baumeist's cost disease, caused by the limited scope for productivity gains in the provision of long-term care (Oliveira Martins and de la Maisonneuve 2006).²

The main reason for the limited growth of public spending on long-term care has been the implementation of cost-containment policies. Since the 1970s the entry and capacity of new LTC institutions had been strictly regulated. Building and major investment in facilities required a license from the government, and such a license was granted only if investments were judged to be of sufficiently high priority. Particularly important, however, was the introduction in 1984 of a system of global budgeting for all inpatient long-term health services. In addition, especially during the 1980s the government successfully mitigated wages of nursing personnel. In the 1990s, prompted by an economic recession, the budgetary controls were expanded to comprise home health

![Graph](image)

**Figure 1.** Percentage of GDP spent in each year from 1985 to 2005 on LTC services that were covered by AWBZ in 2008 and in 2005. From 1997 to 2005 the services covered by AWBZ were the same as in 2005, so lines overlap. The bubble in the dotted line from 1992 to 1995 is caused by a temporary inclusion of outpatient drugs into the WBZ benefits package. Source: Ministry of Health (2004); Eggink et al. (2008).
care and other outpatient LTC services.

The persistent rationing of supply, postponement of investment, and budgetary controls resulted in growing waiting lists and a general perception of a deterioration of quality, particularly compared to the general increase in standard of living and the rising expectations about the quality of care people would like to receive in old age. In 1999 the long waiting lists for home health care were successfully challenged in court. The court ruled that public LTC insurance entitled people to timely access to home health care, and that budgetary considerations were no valid reason for withholding care. In fact, the court decision implied that a too stringent rationing of health services was not compatible with the "right to care" guaranteed by the AWBZ. Urged by the court decision and by mounting public and political pressure to improve access to and quality of LTC services, the government decided in 2000 to lift the budgetary controls and to reimburse all extra production necessary to reduce waiting lists. Indeed, from 2000 to 2003 waiting lists were substantially reduced: for home health care by 64 percent, for nursing homes by 39 percent, and for elder homes by 23 percent (Van Gameren 2005). As a consequence, during that period the expenditure on long-term care rapidly increased to more than 10 percent per year (see Fig. 2), resulting in an increase from 3.5 to 4.0 percent in the share of GDP spent on long-term care (see Fig. 1).

During the period 1985-2005 the average annual growth of real expenditure on LTC services covered by AWBZ was 3.3 percent, whereas the average annual increase of GDP was about 2.7 percent. The average difference of 0.6 percent, however, is caused entirely by cost inflation during the short period from 2000 to 2003. As shown in Figure 3, the largest share of expenditure growth can be explained by an increase in relative prices (2.0 percent) while about 1.3 percent can be attributed to an increase in production6.

From Figure 3 it can be concluded that for four of the five major categories of LTC services the annual cost growth was about 4 percent, which is well above the annual increase of GDP. This relatively high cost increase is largely compensated, however, by a relatively low cost increase of residential elder care (on average about 1.3 percent per year). These lower costs are the result of a decrease in production (on average — 0.7 percent per year) due to reductions in the capacity of elder homes and a substitution toward home health care. As a result, the annual production growth in home health care is the largest among the five categories of LTC services (on

![Bar chart](https://example.com/bar-chart.png)

**Figure 2.** Annual growth of LTC expenditures financed by AWBZ. Source: IBO-werkgroep AWBZ (2006), p.42.
average about 2.5 percent per year). Clearly, this reflects the trend toward treating elderly people at home for a longer period.

As shown in Figure 4, labor productivity for all LTC services decreased by 0.3 percent over the entire 1985-2005 period, contributing slightly to the overall price increase. This corroborates the supposition that Baumol’s cost disease is particularly relevant for LTC services (Oliveira Martins and de la Maisonneuve 2006). Contrary to the general trend, labor productivity in home health care increased by on average 0.7 percent per year during

**Figure 3.** Average annual percentage growth of LTC benefits covered by AWBZ, 1985-2005. Source: Eggink et al. (2008).

**Figure 4.** Components of the growth of real prices of LTC benefits, 1985-2005. Source: Eggink et al. (2008).
the same period. The increase was particularly pronounced after 1995 and is attributed to a tightening of the budgets for home health care agencies, which led to a relative decline in administrative and managerial personnel and the introduction of benchmarking and time management to increase the efficiency of production (Eggink, Pommer, and Woittiez 2008).

As we look at the development of LTC expenditure in the period 1985-2000, supply regulation and budgetary restrictions were clearly quite effective in containing cost. The downside of the prolonged rationing policies, however, were long waiting lists, a growing public discontent, and a growing mismatch between the legally established entitlements and changing LTC needs. For this reason, in 2000 a continuation of the prevailing cost-containment strategy was no longer politically feasible. On the other hand, the radical change toward an open-ended reimbursement policy proved to be no solution either, since the resulting excessive cost inflation—without accompanying incentives for efficiency—was not sustainable. In 2004 the government tried to regain control over LTC expenditure by concluding agreements with the interest associations of LTC providers to limit the growth of expenditure and to increase productivity. In addition, particularly for home health services, copayments were increased. In 2005, the government reinstated budgetary controls by imposing regional budgets for each of the 32 regions based on past LTC expenditure in that region. Regional care offices were made responsible for allocating these budgets and negotiating with regional providers about prices and maximum output levels. By reintroducing tight budget constraints, the government runs the risk that waiting lists will increase, which could again generate a conflict with the existing legal entitlement to long-term care. In contrast to the late 1990s, however, there is an important safety valve: the personal care budget. Personal care budgets do not fall under the scope of regional budget constraints. Thus LTC providers can exceed their budgets if they can persuade their clients to apply for a personal budget and to use it to pay the provider. Indeed, this is one of reasons for the vast increasing popularity of personal care budgets.

5. Personal Care Budgets and Informal Care

Personal care budgets were introduced in 1995 as a small-scale experiment to give consumers the option to buy and organize their own home health services instead of using in-kind services contracted by the regional care offices (Van den Berg and Hassink 2008). Since 1995, the personal care budget scheme has been significantly expanded both in scope and expenditure. In 2008 personal care budgets made up about 7 percent of LTC expenditure covered by AWBZ and were used by more than 10 percent of LTC consumers. Table 4 provides some key figures concerning personal budgets in 2005.

Several reasons were put forward for the introduction of personal care budgets (Hessing-Wagner 1990). First, they were considered a means of empowering consumers and motivating providers to meet consumer preferences more effectively. During the 1990s, LTC providers were increasingly criticized for not being able to deliver the right services at the right time. Moreover, the new generation of LTC users had higher expectations and was viewed as better able to express its preferences for long-term care. The option to choose a personal budget instead of contracted LTC services would allow people to arrange care according to their own preferences.

A second reason was to encourage the use and provision of informal care as a cheap alternative to professional formal care. Informal care is a crucial part of long-term care all over the world. In the Netherlands, however, informal care plays a relatively minor role, in part because of the relatively generous coverage of professional formal LTC services.

Using 2004 data from the Survey of Health Aging and Retirement in Europe (SHARE), Albertini, Kohli, and Vogel (2007) show that within Europe the annual amount of informal care per caregiver is lowest in the Netherlands, Denmark, France, and Sweden (around 300 hours) and highest in Italy (almost 1,500 hours). Also using SHARE data, Bolin, Lindgren, and Lundborg (2008) show that the mean hours of informal care received by single-living elderly per year in the Netherlands is among the lowest in Europe (approximately 50 hours),
Table 4. Key Figures in the Personal Care Budget in 2005

<table>
<thead>
<tr>
<th>Age Distribution</th>
<th>Percentage of Total Budget Holders (77,883)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-55</td>
<td>32.5</td>
</tr>
<tr>
<td>56-65</td>
<td>12.6</td>
</tr>
<tr>
<td>66-75</td>
<td>14.3</td>
</tr>
<tr>
<td>76-80</td>
<td>8.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Health Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatic</td>
<td>67</td>
</tr>
<tr>
<td>Psychogeriatric</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
</tr>
<tr>
<td>Physical handicap</td>
<td>14</td>
</tr>
<tr>
<td>Mental handicap</td>
<td></td>
</tr>
<tr>
<td>Sensory handicap</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net Budget Amount (in €)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 2,500</td>
<td>27.7</td>
</tr>
<tr>
<td>2,500-5,000</td>
<td>24.9</td>
</tr>
<tr>
<td>5,000-25,000</td>
<td>30.5</td>
</tr>
<tr>
<td>&gt; 25,000</td>
<td>16.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proportion of Budget Spent on Informal Care</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident providers</td>
<td>21</td>
</tr>
<tr>
<td>Nonresident providers</td>
<td>17</td>
</tr>
</tbody>
</table>


*Net of copayment by budget holder. The average gross personal care budget was about 14,000 euros, of which about 1,000 euro was paid by the budget holder out of pocket.

whereas in Greece, Italy, and Spain the single-living elderly receive the most informal care (over 200 hours). Conditional on receiving informal care, the amount of care received by the single Dutch elderly is also among the lowest in Europe (about 130 hours per year).

For professional home care use the opposite pattern seems to hold. Bolin et al. (2008) show that the Netherlands (together with Denmark and France) are in the top European ranks for professional home care use. Approximately 25 percent of single-living Dutch elderly use professional home care, while the percentage for this category is lowest in Italy (6 percent).

Although the share of informal care in the Netherlands is lower than in most other European countries, the majority of home care is nevertheless provided by informal caregivers. Table 5 shows that also in the Netherlands the amount of home care used in 2001 was just around 15 percent of the total amount of informal care provided. Nevertheless, Table 5 also shows the enormous growth of professional home care use (especially skilled housework) during the relatively short period 2000-2003.

The rapid expansion of personal care budgets was an effective way to encourage the provision of informal care. In 2005, 38 percent of personal care budgets were spent on informal care, while two-thirds of budget holders use the budget to pay informal caregivers (Ramakers and van den Wijngaart 2005). Along with personal care budgets, the role of informal care was also increased by restricting the possibilities for substituting
Table 5. Hours of Professional and Informal Home Care Provided per Year (2000-2003)

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours (1,000s)</td>
<td>Share (%)</td>
<td>Hours (1,000s)</td>
<td>Share (%)</td>
</tr>
<tr>
<td>Home Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unskilled housework</td>
<td>13,220</td>
<td>22.4</td>
<td>13,512</td>
<td>21.3</td>
</tr>
<tr>
<td>Skilled housework</td>
<td>16,425</td>
<td>27.9</td>
<td>18,911</td>
<td>29.9</td>
</tr>
<tr>
<td>Total housework</td>
<td>29,645</td>
<td></td>
<td>32,423</td>
<td></td>
</tr>
<tr>
<td>Personal care *</td>
<td>23,029</td>
<td>39.1</td>
<td>23,877</td>
<td>37.7</td>
</tr>
<tr>
<td>Nursing †</td>
<td>6,259</td>
<td>10.6</td>
<td>7,028</td>
<td>11.1</td>
</tr>
<tr>
<td>Total home care</td>
<td>58,933</td>
<td>100</td>
<td>63,328</td>
<td>100</td>
</tr>
<tr>
<td>Informal Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All tasks ‡</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>375,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Inclusive of specialized personal care.
†Inclusive of specialized nursing.
‡Calculated assuming that informal caregivers provide on average five hours care per day, four days per week, 25 weeks per year.

professional for informal care. Initially, informal care was considered to be a voluntary choice. Even people who had a social network of potential informal caregivers could always apply for professional care that was covered by the AWBZ. In practice, however, the needs assessment agencies increasingly took into account the amount of informal care a client already received in order to determine the amount of professional care the client could legally claim (Jörg et al. 2002). Since 2003, this practice has been formalized and strict protocols developed regarding needs assessments, taking into account the informal care that can potentially be provided by the recipient’s social network.

Another way to encourage the provision of informal care is to support informal caregivers. To protect the health of the caregivers themselves, needs assessment agencies were permitted to refer them to regional support centers that developed such respite programs as daycare and short nursing home stays, for care recipients, and holidays and informational support for caregivers (see, e.g., Koopmanschap et al. 2004 and Van Exel et al. 2006).

Evaluative studies point out that, as intended, personal care budgets induced a substitution of informal for professional care and were valued by many clients as an effective means to purchase and organize care that met their preferences better than regular care contracted by regional care offices (Ramakers et al. 2007).

However, personal care budgets also had several unintended negative effects. First, they induced a substitution of paid for unpaid informal care. Informal care by relatives, neighbors, and friends that had often been provided for free was now increasingly paid. A study among informal caregivers found that 76 percent would be willing to provide the same care without receiving payment, although 78 percent indicated that getting paid nevertheless was important to them (Ramakers and van den Wijngaart 2005). In addition, an increasing number of brokers became active, offering for a fee to assist in applying for a personal care budget. Van den Berg and Schut (2003) calculated that a substitution of paid for unpaid informal care from the personal care budget could increase AWBZ costs by approximately 4 billion euro per year (about 20 percent of total AWBZ expenditure). The strict needs assessment protocols mentioned above, which explicitly take into account potential informal care provided by the recipient’s social network, were implemented precisely to counteract the substitution of paid for unpaid informal care. According to those protocols, needs were based not only on health
status or functional impairment but also on the availability of "usual care." The care partners provide each other for at least three months, for example, is defined as usual care. Hence, the magnitude of the personal care budget became explicitly dependent on the social network of the beneficiary. Nevertheless, it is unclear to what extent people still can use personal care budgets to replace unpaid with paid informal care. The rapidly growing number of personal care budgets to assist young people with psychiatric disorders, especially, has been attributed to the substitution of paid for unpaid informal care provided by their parents.

A second unintended consequence was that personal budgets were increasingly used by home health care agencies to escape the imposed budget constraints. As a further consequence, people who did not want to purchase and arrange care by themselves were more or less forced to do so in order to be able to keep the same home care provider.

It is difficult to assess to what extent personal care budgets were successful in accomplishing the aims behind their introduction. The rapidly increasing number of people opting for a personal care budget suggests that for substantial proportion of users of outpatient long-term care the budgets offered better opportunities to meet consumer preferences than care in kind. There is not much empirical information, however, about the true motives of people who opt for the personal care budget. The growing demand can be explained at least in part by the desire to evade waiting lists for traditionally financed long-term care and to pay formerly unpaid informal caregivers. It is also unclear to what extent personal care budgets induced an efficient substitution of informal for formal care or merely expanded paid informal care. For instance, the increasing number of parents opting for personal care budgets to provide care for their children seems to point to a substitution of paid for unpaid informal care. Moreover, for this group of clients it is unlikely that empowerment and more consumer choice were the main drivers. In contrast, it seems fair to conclude that personal care budgets really do help people with long-term disabilities to empower themselves and to purchase care that meets their preferences better than care in kind.

6. Projections of Future LTC Expenditure

Future expenditure on long-term care depends on a number of factors, both demographic and non-demographic. Several projections of future LTC expenditures have been made, but they are not completely comparable because they are based on different definitions of long-term care and use different assumptions and methodologies. In a study of the drivers of public LTC expenditures (primarily elder care), Oliveira Martins and de la Maisonneuve (2006) explicitly model the potential determinants of future expenditure to project the expected share of GDP spent on long-term care in 2050 for 30 OECD countries. The main results of their projections for the Netherlands and average OECD are summarized in Table 6.

Dependency on long-term care increases sharply with age, and thus demographic effects contribute to a substantial increase in LTC expenditures. The effects of aging on LTC consumption might be mitigated by a "healthy aging" process, if longevity gains are fully or partially translated in additional years of good health. Since empirical evidence about the occurrence (and extent) of a healthy aging process is mixed, Oliveira Martins and de la Maisonneuve (2006) assume that only half of longevity gains are translated into a reduction in dependency. In addition, they also estimate the effects of a full healthy aging process (compression of disability) and a complete absence of healthy aging (expansion of disability).

In projecting future LTC expenditures, Oliveira Martins and de la Maisonneuve (2006) capture the Baumol effect by assuming that unit costs rise in line with aggregate labor productivity, a proxy for wage growth of care staff. As shown in Table 6 this full Baumol effect induces a steady increase in relative prices, pushing LTC expenditures to 3.7 percent of GDP in the Netherlands and to 3.3 percent for the OECD countries on average. In addition, the effects of potential cost-containment policies were simulated, assuming that governments would be able to mitigate the cost pressures associated with the Baumol effect by stimulating productivity gains and mitigate wage increase.
Table 6. Projection Scenarios for Public LTC Expenditures, 2005-50 (Percentage of GDP)

<table>
<thead>
<tr>
<th>% of GDP in 2005</th>
<th>Demographic Effect</th>
<th>Full Baumol Effect</th>
<th>Cost Containment</th>
<th>Sensitivity Analysis (Compared to Cost Containment Scenario)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Unitary Income Elasticity</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1.7</td>
<td>2.4</td>
<td>3.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Average of 30 OECD countries</td>
<td>1.1</td>
<td>2.3</td>
<td>3.3</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Note: Projections are estimated using a narrow definition of long-term, primarily elder care (which accounts for about 45 percent of expenditures covered by AWBZ).

Under the base scenario, Oliveira Martins and de la Maisonneuve (2006) assume an income elasticity of zero, since they argue that long-term care can be characterized as a necessity. Although empirical evidence of income elasticities for long-term care are lacking, estimated income elasticities for health care in general are all above unity at a country level (Getzen 2000). This suggests that—at least for industrialized countries—health care can be considered a luxury. Since the substitution of professional care for informal care can be seen as a luxury that may be publicly affordable only if a country as a whole reaches a certain aggregate income level, long-term care may well be a luxury rather than a necessity. If this is true, the result of the sensitivity analysis using a unitary income elasticity may be more relevant. Table 6 shows that using a unitary income elasticity implies that in 2050 an extra 0.5 percent of GDP would be spent on long-term care.

The authors also estimate the effect of an increase in dependency as a result of rising disability rates (assumed to be 0.5 percent per year) caused by a continuation of the current trends in obesity. Finally, the authors examine the impact of an “increased participation” scenario in which the availability of informal care is dramatically reduced by the assumption that all countries converge toward a labor participation ratio in the 50-64 age group (which is used as a proxy for the availability of informal care) of at least 70 percent by 2050. As shown in Table 6, both an increase in dependency and an increase in labor market participation are likely to have substantial impact on LTC expenditure in the Netherlands and other OECD countries.

Projections of the future cost of long-term care specifically in the Netherlands have been made by the Netherlands Institute for Social Research (SCP) and the Dutch National Bureau for Economic Research (CPB). Based on the expected growth of the number of users, the SCP study projected an annual growth of expenditure on home health care, elderly homes, and nursing home care of about 1.3 percent in constant prices for the period 2005-30 (Eggink et al. 2008). That the projected cost increase is higher than the projected increase in number of users can be explained by the higher expected growth in the number of users of the most expensive LTC facilities (especially nursing homes).

The CPB followed another methodology to project future expenditures on long-term care (SER 2008). After making the observation that such expenditures are very sensitive to government policy, the CPB made a distinction between two extreme scenarios. The first is based on a prolonged policy of supply and price regulation, as in the period 1990-2000, during which the annual growth of LTC expenditure was 0.6 percent lower than the growth of GDP. The CPB assumes that under this scenario the same difference in growth would occur during the next decade and would result in a decline of the proportion of GDP spent on long-term care to 3.5 percent in 2020 (using a broad definition of long-term care, as in this paper). The second scenario is based on a prolonged policy of laissez-faire, as was prevalent from 2000 to 2006. During this period the annual growth
of expenditure on long-term care was about 3.8 percent higher than the growth of GDP. If this figure is used as the relevant difference under the second scenario, the resulting share of GDP spent on long-term care in 2020 would be 6.4 percent.

Since both extreme scenarios are unlikely, the 3.5 and 6.4 percent of GDP can be perceived as lower and upper bounds on LTC expenditure in 2020 (using a broad definition of long-term care). The crucial role of health policy is in line with the observation by the OECD (2005) that the correlation across countries between LTC spending and aging is rather weak, suggesting that the ways long-term care is organized and financed play an important role.

The overall conclusion emerging from these projections is that future expenditures on long-term care are extremely uncertain and very sensitive to the exact number of elderly persons, changes in real prices of long-term care (due to changes in labor productivity and the quality and intensity of care), changes in health policy, changes in labor market participation, and trends in disability among the elderly.

7. Deficiencies of Current LTC Financing

The projections of future expenditure on long-term care make it clear that a laissez-faire policy without supply and demand constraints (as in the period 2000-2003) is likely to jeopardize the sustainability of the public LTC insurance scheme. On the other hand, a return to the stringent top-down rationing policy of the 1990s has serious drawbacks and does not seem feasible either. Faced with this dilemma, the government has temporarily opted for a mixture of both policies, halfheartedly relying on both supply constraints and arrangements to improve efficiency by increasing consumer direction and choice. For the following reasons, this inconsistent policy compromise can neither contain costs nor increase efficiency.

First, the currently imposed supply constraints in the form of regional care budgets are not effective in controlling cost because they can be circumvented by opting for a personal care budget. Because personal care budgets are not included under the regional budget, the regional budget constraint is not binding. Although the government introduced a separate macro budget for personal care budgets, particularly since 2005 the demand for personal care budgets has been much larger than the available funds. Rather than denying personal care budgets, the government regularly adjusts the macro budget upward to meet the growing demand. In 2007, for instance, the government decided four times to raise the budget, resulting in a total annual budget increase of 35 percent (Ministry of Health 2007).

Second, the regional budget mechanism punishes providers who do a good job and consequently attract more clients than the target number on which the regional budget is based. If these presumably efficient providers cannot effectively motivate their clients to apply for a personal care budget, they must refuse clients or run a deficit.

Third, regional care offices have no incentive to allocate the regional budget to the most efficient providers because they have a regional monopoly and are not at risk for the cost of care. Since LTC users cannot choose another regional care office, these offices have no incentive to allocate budgets to providers that best meet consumer preferences. Again, consumers may opt for a personal care budget (except for inpatient care), but that option is not likely to discipline the behavior of the regional offices because they do not benefit from having more customers. Moreover, since regional offices get a fixed budget for administrative cost, they have a financial incentive to negotiate with a limited number of large providers in order to minimize the cost of contracting. For the same reason, regional care offices have no incentive to take action against too-lenient needs assessment procedures.

Finally, the definition of entitlements in terms of six functional categories (see Table 3) has proved too imprecise to provide a firm basis for uniform and unambiguous needs assessment. In particular, the number of clients that were assessed to be in need of "supportive guidance" increased dramatically, by 37 percent, from 2005 to 2007 (Ministry of Health 2008).
8. Proposals to Reform LTC Financing

In view of the serious deficiencies of the current system of LTC financing, the government asked a number of advisory and supervisory bodies to draft proposals for reforming the system of LTC financing in order to guarantee a sustainable, efficient, and consumer-directed provision of long-term care.

This move resulted in five different advisory reports, which were not all equivalent. The reports of the Council for Public Health and Health Care (RVZ) and the Health Care Insurance Board (CVZ) recommended abolishing the separate public long-term insurance scheme, integrating most of the benefits covered by AWBZ into the new national Health Insurance Act (Zorgverzekeringswet, or ZVW) for curative health services, and integrating benefits related to social support and participation into the new Social Support Act (WMO) in 2007. The main line of reasoning was that the new ZVW—based on the model of managed competition (Van de Ven and Schut 2008)—would provide much stronger incentives than the AWBZ for efficiency and meeting consumer preferences. Moreover, integrating curative and long-term care into a single scheme would also create incentives and possibilities for a better coordination of care for people with chronic diseases. Next, the original reasons for a separate public insurance scheme (see Section 2) were no longer valid, since the mandatory insurance scheme for curative services had been extended to the entire population in 2006. Finally, the 2007 WMO provided an integrated legal framework for social and community support under the responsibility of municipalities, so the transfer of social care benefits from the AWBZ to the WMO would also improve the coordination of social care and welfare assistance.

The radical proposals to abolish the AWBZ scheme, however, also had serious potential shortcomings. Most important, it is questionable whether the model of managed competition underlying the new health insurance scheme for curative services is adequate for the provision and financing of long-term care (Van de Ven and Schut 1994). A key element of the managed competition model, which makes it possible to guarantee universal access in a competitive health insurance market, is an adequate system of risk adjustment (Van de Ven and Schut 2008). At present, there are no appropriate risk adjusters for long-term care and it is unclear that adequate risk adjustment is feasible for many of these services (IBO-werkgroep AWBZ 2006). Given the typically high level of expenditure per LTC user and the intertemporal nature of the risk, imperfect risk adjustment for these types of services may result in unfair competition among insurers and huge incentives for risk selection if insurers are obliged to charge community rated premiums (as is the case under the 2006 ZVW).

Another reason why the managed competition model may not be appropriate for LTC services is that consumers are not able or willing to make an informed choice among health insurers that contract for many of these services. Substantial empirical evidence suggests that the propensity to switch health plans declines substantially with age and the presence of health problems (Strombom, Buchmueller, and Feldstein 2002; Schut, Gress, and Wasen 2003; Buchmueller 2006). When the number of critical buyers of LTC services is too small, competition may result in a deterioration of quality, since competitive health insurers may have an incentive to reduce quality in order to reduce cost if doing so does not result in a significant loss of market share (Van de Ven and Schut 1994). Finally, the experience with both the new Health Insurance Act and the new Social Support Act is limited and it unclear whether health insurers and municipalities are willing and able to perform as prudent purchaser of health and social services. Therefore, a major expansion of the scope of the responsibilities of health insurers and municipalities would be premature.

In view of these shortcomings, other advisory reports proposed maintaining a separate insurance scheme for several categories of long-term care, comprising at least care for the mentally handicapped. Among these reports, the latest and the most important was the proposal by the Social and Economic Council (SER) to reform the AWBZ along the following main lines:

1. A much more precise and unambiguous delineation and definition of entitlements;
2. An improvement of needs assessment through the development of uniform protocols, benchmarking, and a permanent supervision of the assessment bodies;
3. A reduction of coverage by transferring short-term rehabilitation services to the national insurance scheme for curative health services (ZVW) and by bringing the provision of social care under the responsibility of the municipalities (WMO);

4. A far-reaching separation of the financing of residence and care, such that that accommodation would no longer be reimbursed by public insurance; a subsidy scheme for lower-income groups to pay the cost of accommodation; all of which should lead to innovative combinations of residence, care, welfare, and participation; and

5. A replacement of provider-based budgeting by client-based budgeting. Rather than clients having to follow the money—as in the current provider-based budgeting system—the money should follow the client. Clients would have the option to choose a personal care budget (as in the current system), and arrange all care by themselves, or to choose among providers contracted by individual health insurers (that would have to replace regional care offices in 2012). Providers can increase revenues if they are able to attract more clients by offering better service (for a fixed budget per client). The client-based budgets should be based on the categorization of clients in “care-severity packages” (ZorgZwaartePakketten, or ZZPs) by the needs assessment bodies. A ZZP describes the type and amount of care needed by the client. For each ZZP a budget will be calculated (SER 2008).

In June 2008 the government endorsed the main lines of SERproposals and announced the first steps to implement its recommendations, including a more precise demarcation of entitlements and an exclusion of recovery and social support from coverage by 2009 (Ministry of Health 2008). In a subsequent policy letter in mid-2009, the reform plans were further elaborated (Ministry of Health 2009). In this letter the government stated its aim to abolish the regional care offices in 2012 and instead make individual health insurers responsible for the purchasing and contracting LTC services on behalf of their insureds (next to maintaining the option for clients to choose for a personal care budget or voucher and to purchase care by themselves). However, this decision is contingent on the possibility of making health insurers financially accountable for LTC expenses of their insureds and on the feasibility of an adequate system of client-based budgeting.

9. Toward Sustainable LTC Financing?

Whether the proposed reform will lead to a sustainable financing and more consumer-directed provision of LTC services crucially depends on the ability to develop a clear-cut definition of entitlements, improve the accuracy of needs assessment, and develop appropriate ZZPs as a solid basis for client-based budgeting. The feasibility of these three requirements is highly uncertain. In particular, client-based budgeting may turn out to be complicated. In 2008 ZZPs were developed for inpatient care, and were phased in from 2009 to 2011, to determine the budgets for inpatient care LTC facilities (i.e., nursing homes, elder homes, institutions for mentally and physically handicapped, and mental care institutions). The experience with these ZZPs for financing inpatient care may make clear whether these packages can provide a firm basis for client-based financing. A key question will be whether the predictable cost variation per care package will be small enough to avoid problems of cream-skimming and misallocation of funds.10 The Dutch Healthcare Authority (Nederlandse Zorgautoriteit, or NZa) evaluated the first experiences with client-based budgeting for inpatient long-term care and reported receiving signals from both health care providers and regional care offices of strategic upcoding (classifying clients into higher ZZPs than indicated) and risk selection (avoiding patients that are unprofitable given the ZZP capitation payment) (NZa 2009).

The main reason put forward for such behavior was that for several ZZPs, or for several patients classified within a certain ZZP, capitation payments were insufficient to cover the costs. With the limited data available, the NZa could not determine whether upcoding and risk selection indeed occurred, but it announced that it would monitor this type of behavior and to examine the accuracy of ZZP payments.

An important unanswered question is how future client-based budgets should be determined: should they be
based on the average cost of all providers that offer the care package? Given the increasing pressure to contain public expenditure on LTC services, the most likely outcome may be that the client-based budgets will be derived from the regional budgets (or a national budget) set by the government, using the ZZPs as relative weights for the determining the (regional) level of the client-based budget for each care package. How budgets are determined will be closely related to another still unanswered question, namely, for which party the client-based budget should be binding. In other words, if the actual cost of providing a care package differs from the client-based budget, then who should bear the additional costs? Or who may keep the residual: the client, the provider, or the insurer contracting the provider? At present, providers receive the full ZZP capitation payments for each client served, and neither clients nor regional care offices bear financial risk (except for the income-related copayments). However, if risk-bearing health insurers will replace regional care offices by 2012, it is conceivable that ZZP capitation payments will be given to the insurers, who must subsequently negotiate prices per ZZP with various LTC providers.

In theory, the proposed Dutch reforms involve appropriate incentives to improve the sustainability of the comprehensive LTC insurance scheme. In practice, as argued, the success of the reforms will depend heavily on the way entitlements are defined, an improvement in the accuracy of needs assessment, and the feasibility of determining appropriate client-based budgets. For adequate client-based budgeting it is crucial that the care-severity packages currently being developed are relatively homogenous in terms of predicted costs, as substantial variation involves clear incentives for upcoding and risk selection.

Although the proposed reform offers a promising perspective on combining a sustainable and universally accessible LTC financing with a consumer-directed provision of care, a number of complicated issues have to be resolved. The Dutch experiences in implementing the reform may therefore provide important lessons for countries with public insurance schemes for long-term care—such as Japan and Germany—that also struggle with the question how to guarantee a sustainable system of LTC financing.

Acknowledgement


A previous draft of this paper was presented at the Seventh World Congress of the International Health Economics Association in Beijing and at the International Conference on the Policies and Regulations of Health and Long-Term Care Costs of the Elderly in Tokyo. Part of this research has been supported by a research grant to Hitotsubashi University from the Ministry of Education of Japan (grant number 18002001).

Notes

1 There are several reasons why private markets fail to provide adequate insurance for long-term care. The absence of private LTC insurance has been explained (e.g., Cutler 1996; Brown and Finkelstein 2007) by the nature of intertemporal risk, by supply side market failure (resulting from high transaction costs, adverse selection, and imperfect competition) and by demand-side factors such as limited consumer rationality, limited foresight, and the availability of imperfect but cheaper substitutes.

2 In 2008 the CIZ had one main office, six district offices, and 30 local offices.

3 Following the typology recently proposed by Ariizumi (2008), the Dutch public insurance system can be characterized as a health-based rather than a means-tested program.

4 In 2009 two functional categories—supportive and activating guidance—were combined into a single category.
"guidance." At the same time, guidance aimed at social participation is excluded from coverage and brought under the scope of the WMO.

5 When productivity growth in the LTC sector lags behind that in other sectors while wages grow at the same rate, relative prices of long-term care vis-à-vis other goods and services will rise. In the case of a low price-elasticity of demand for LTC—which is likely in the presence of public insurance—the share of LTC expenditure in GDP will also increase over time.

6 Production of LTC services is measured by the Netherlands Institute for Social Research (Eggink et al. 2008) using indicators of production (e.g., admissions, day treatments, length of stay, number of patients) weighted by the type and intensity of treatment.

7 This number was based on the assumption that a substantial percentage of informal caregivers already are paid from personal care budgets (see also Van den Berg and Hassink 2008). Average pay is around 10 euro per hour. Multiplication of this average with the informal care hours presented in Table 5 makes approximately 4 billion euro.

8 For the Netherlands this assumption might be an underestimation. In the Netherlands the ratio of disability-freelife expectancy to life expectancy at age 65 was 79 percent for men and 67 percent for women in 2000 (OECD 2005). The ratio increased since 1990, particularly for women.

9 Specifically, the Social and Economic Council (SER), the Council for Public Health and Health Care (RVZ), the Health Care Insurance Board (CVZ), the Dutch Healthcare Authority (NZa), and a governmental working group (IBO).

10 The determination of adequate ZZP capitation payments for outpatient long-term care may be more complicated, because the need for outpatient care crucially depends on the availability of a social network of informal caregivers, which typically varies substantially across individuals.

11 Using a national rather than a regional budget may be politically attractive because the government may avoid socially controversial regional variation in the level of client-based budgets.

References


OECD. 2005. *Long-Term Care for Older People.* Paris: OECD.


Aging and Old-Age Care in Sweden: Administrative, Demographic, Political, and Financial Aspects

Gerdt Sundström*

Abstract

A historical overview shows how ancient are the roots of the Swedish welfare state. Expenses for older people—pensions, housing allowances, institutional and community care—kept growing in the postwar years but stagnated in the 1990s. Since that decade, cutbacks in some services have led to more care and support from families and the streamlining of services, but also more efficient targeting. Diversification and rationing of services have meant that older people are still served reasonably well, usually through the joint efforts of family and state. To give perspective to the findings, historical and demographic aspects are considered.

[Keywords] Old-Age Care, Welfare State, Public Services, Family Care, Local Variation

1. Introduction

The aim of this presentation is to clarify current patterns of care for older people in Sweden. Historical perspective is required, but also knowledge about contemporary factors that affect demand for support and variations in supply of public services and family care. These are primarily aspects of demography, family patterns, and characteristics of the public services.

To understand Swedish old-age care—both the large part that takes place inside the family and the smaller part that is publicly provided—requires a historical odyssey. A very common misunderstanding, often among by Swedes as well, is that "modern" services for old people in Sweden and the other Nordic countries are just that, modern constructions, and that indeed the whole welfare state is a modern invention. This notion is flattering to the Swedish self-image among laymen, politicians, and administrators and is propagated in Swedish textbooks. Modern Sweden is seen as a product of liberal and socialist efforts to create welfare for everybody, not just for the rich few, coinciding somewhere in the early 1900s with universal franchise. An example often used is the "universal" old-age pension introduced in Sweden in 1914 (which was not even nearly universal before 1937; see below). The image of Sweden as a modern, progressive state was being spread by influential books already in the 1930s. The most well known was Marquis Childs' Sweden: The Middle Way (1936), about a country that somehow chose the best from both capitalism and socialism. (Extensive social security and services are sometimes erroneously seen as "socialism.")

Seeing these modern and modernizing ambitions, it is easy to overlook the path dependency of the "modern" welfare state: its many roots that go back to older structures. Modern Swedish (and other Nordic) welfare is unthinkable without contemporary political ambitions and conflicts, and it is just as unconceivable without its historical past. Creativity is based on continuity. Another theme in the following discussion will be the local

*Professor at the Institute of Gerontology, School of Health Sciences, Jönköping University and a consultant for SPF, Sveriges Pensionärsförbund (Association of Swedish Senior Citizens).
variations. There are bigger variations in old-age care within individual Nordic countries than between them. We all tend to "homogenize" countries and cultures, and more so the farther away they are in time and space.

2. Historical and Administrative Aspects

2.1 Seeds of the Swedish (Nordic) Welfare State

The Nordic countries were christened in early medieval times, around 1100-1200 AD, and the church established administrative routines that continue to this day. The approximately 2,500 Swedish parishes, transmogrified (in 1862) into municipalities, have mostly remained intact. Special features of the Nordic countries were the far-reaching amalgamation of religious life and secular administration and a socially and culturally quite homogeneous population. Indeed, the keeping of population records was a task of the local parish office until 2000 in Sweden, when the church and the state were finally separated.

Already in the 1300s the local parish administrations were granted a degree of autonomy in their own matters. The Nordic parishes were on the periphery of the civilized world and far from the administrative centers of the Roman Catholic church. They therefore were permitted to collect the poor tithe locally and use it locally to provide for the poor. (On the continent, the funds were transferred up the church hierarchy.) Decisions about who should get support from the parish were taken jointly at regular meetings-open to everybody-by the priest and six men trusted by residents in the parish (Odén 1985). This practice helped to reinforce and stabilize an existing tradition of local autonomy and also helped to create local commitment to solving social issues routinely by communal and standardized decisions. It is hard to overemphasize the significance of this historical heritage for today's welfare programs. Although the size of the undertaking is much larger now, because of rising standards of living and increased productivity, the Nordic countries, including Sweden, have a very long history of systematic, local, and collective provision for the destitute, poor, sick, and frail, including older people. The foundation of the welfare state is ancient indeed.

After the Reformation, in the early 1500s, parishes continued to care for their poor but with more meager means. In 1571 they were required by law to do so and to build poorhouses. They were reminded from time to time by central authorities, and the bishops regularly inspected the parishes to monitor the situation, but fulfillment of this duty took centuries. Priests educated, monitored, and registered their parishioners, and also controlled their morals and their adherence to the law. (The church had a handsome income from fines levied for breaches of the Ten Commandments.) Transparent poor-relief taxes were collected, and communal decisions were taken on the use of these funds.

Law and order applied not only to the poorer segments of society. Sweden prides itself on a tradition of civil servants who strive to treat all people equally. Examples of poor people winning their rights against richer or more powerful adversaries are easy to find in old court records. There are certainly exceptions, but in general Swedes expect to meet with neutrality and objectivity when they have to deal with bureaucracies, although Swedish administrations have very little of the legalistic character found in some other countries. In the 1992 Eurobarometer study, many older people in southern and continental Europe reported being better treated than others because of their age, but just as many said that they were treated worse in contacts with, for example government agencies, post office staff, and doctors. The Danish and Swedish elderly mostly said that they had not noticed any difference (Walker 1993).
2.2 Administrative and Legal Aspects of Old-Age Care

In 1862, poor relief and other worldly tasks—mainly elementary schools—were assigned to a secular body created for the purpose and geographically the same as the parish: the municipality (kommun). The Nordic countries have of old a simple administrative structure. Beyond the municipality, Sweden has 23 regional associations of municipalities (landsting) that were established in 1869 to provide health care, which was not practicable for the small municipalities. About a third of the municipal tax goes to the landsting, which runs hospitals and primary care. Both municipality and landsting are politically governed and financed from below: municipal tax averages 31 percent of one’s income. Only persons with quite high incomes pay national, progressive tax. Most (about two-thirds) of individual income tax paid in Sweden never leaves the local arena, being a tax to the municipality and the landsting.

The national government is comparatively weak, and the long arm of the government, the county office (län, corresponds to Japanese ken) with its governor and rather small office does not have capacity to monitor all municipalities and their doings. Following a scandal in old age care, they were equipped in 2005 with inspectors who act on complaints but also on own initiative. (The county office previously handled complaints, but they were even more understaffed for the task.) The län does not always cover the same area as the landsting. The relationship between the local authorities (municipality and landsting) and the national government was and is to some degree a negotiated one: the national authorities could not and cannot have their way in all matters. Conflicts between center and periphery are part of the history of Sweden, as well as of other European countries. Many aspects of public old-age care today can be understood in the light of this tension. The preference in Swedish administrations is for consensus, and that social policy "filters down." Changes are often enacted piecemeal and by "muddling through," rather than through heavy-handed government decrees.

New taxes and other burdens levied from "above" were, and still are, often fought in different ways, and at least some understanding of local needs was expected. The last major uprising against the state was in 1743, when many rebels were massacred by the military. There was also unrest during World War I, with hunger riots, and until the 1930s Sweden had the world's highest strike rates. Authorities in the 1600s responded to popular discontent by creating an administrative court system, paralleling the civil and criminal one, to which anyone affected by an administrative decision in the previous poor relief (with some interruption in the 1800s) or today's social services can appeal at no cost. It is rare for applicants for or users of services to do so, but appeals are increasing.

In an international perspective, Nordic municipalities enjoy a remarkable autonomy in administrative and financial matters. They set their own tax levels to finance their programs. An intermunicipal tax equalization scheme enforced by the parliament ensures that the capacities of municipalities to provide services are about equal, a scheme little liked by more affluent municipalities. The tax rate was some 6 percent in the 1920s, remained low till the 1960s, and rose to 20 percent in the early 1970s; at some 31 percent today it is now considered impossible to raise further. The administration of these communal affairs was and is rather transparent. All public records have been publicly available by law since 1762, except for classified military documents and records on individual clients of the social security, health care, and social services. Individual income and tax records, for example, are public documents. After all, people may be willing to pay tax—opinion polls show an astonishing inclination to do that in Sweden—but they want to have the chance to see that other people also pay their dues.

In the 1700s and 1800s, population growth and shortage of land increased poverty in Sweden. It became necessary to regulate the responsibility for paupers more explicitly, as parishes often fought over which one was responsible for a certain pauper. In 1788 local responsibility was clearly stipulated: everybody had a "home right" (hemortsrätt) in his or her parish (municipality), which was by law responsible for providing for him or her.

Another important aspect of Swedish life and mentality is the quite recent urbanization: over 90 percent of all Swedes lived in sparsely populated rural areas up to the 1900s, and half of them still did so in 1945 (about
5 percent in 2000). In 1749 Sweden had 1.8 million inhabitants, that is, on average, some 700 persons per parish. Overseers of poor relief knew all their fellow parishioners and vice versa, a practical but maybe not always enviable situation for recipients of relief. Many municipalities are still quite small, averaging roughly 30,000 inhabitants. Older people made up the majority of poor-relief recipients up to the late 1940s, when pensions were raised substantially and many municipalities introduced housing allowances. In 1950 there were still nearly 2,500 municipalities, usually geographically synonymous with the parish, most of them quite small and each with their own administration, public elections, and the like. Bigger municipalities and towns had subdivisions of local units to monitor people and poor relief, somewhat like traditional Japanese and Chinese systems. Reforms reduced the number of municipalities to around 1,000 in 1952 and 290 in 1975.

Notwithstanding these changes in Swedish administrations, local welfare workers and health care staff usually know their catchment area and (potential) clients quite well. A number of studies illustrate this fact, both in urban and more rural areas. This transparency may seem reassuring to some observers, like the author, and be interpreted as continuing traditional links between citizens and authorities. To others it may appear a suspicious feature of a society with too little privacy, reminiscent of totalitarian systems.

Filial obligation—introduced in law in the early 1800s—disappeared in Sweden with the poor law itself in 1956 and was removed from the Civil Code in 1978: it was argued that public old-age care was now so extensive that the law was obsolete (obligations still apply, however, for spouses). In poor-relief-era records there are many cases of overlapping responsibility, where the municipality paid family members in kind or in cash to care for parents, siblings, or more distant kin. Sometimes the outspoken motive was to avoid burdening the municipality, which might happen if the family was overburdened; sometimes the reason was explicitly humanistic.

Reliance on kin was often insecure, and many people organized mutual aid societies in the 1800s and early 1900s. The local, voluntary health care insurance associations were gradually incorporated with the state and made compulsory in 1953. Locally elected representatives were on the regional boards until 2006. It is typical of the Nordic, reformist approach to social welfare that the private arena and the state gradually overlap and interpenetrate each other. An important part was also played by large organizations of the popular culture: the temperance movement, the labor movement (still administering unemployment benefits), dissenting religious and political movements, unions, and various self-help organizations (such as the cooperative consumer and housing movement), all of which contributed to the “social capital” of Swedish society.

3. Demographic Aspects

3.1 Population Aging

When Swedish population data were collected for the first time in 1749—the world’s oldest—the results were immediately classified as state secrets because they were considered politically sensitive. These early records show that 6 percent of the population was 65 or older at that time. During the later 1700s and the 1800s, as the Nordic countries underwent demographic transition, there was rapid population increase and proletarianization. The proportion of older people in the populations of Nordic countries rose slowly in the nineteenth century, reaching 8 percent in Sweden in 1900 (out of a quite youthful total population of about 5 million), and 18 percent today, out of 9 million inhabitants (5 percent are 80 or older). In absolute terms, the number of old Swedes doubled in the four decades following 1860. A century ago demographers predicted further increases in the elderly population. The main concern at that time was the drastic decline of fertility, but Sweden was also among the first to set up a near-universal, although very meager and means-tested, pension system in 1914.

Historical changes in marital patterns contributed to population aging by their effects on fertility. The increasing proportions of the never-married in the Nordic populations during the 1700s and 1800s mirrored
young adults’ increasing difficulties in establishing independent lives, despite of substantial emigration to the United States and other destinations. By the 1920s, 19 percent of the women and 12 percent of the men were still single as they approached old age (60-64 years). The very low marriage rates that continued up to World War II meant that singlehood and childlessness was common among older cohorts well past the 1950s. (At age 60-64 in 1950, 14 percent of the men and 21 percent of women were still single.) The Nordic countries were among the first to experience population aging due increasing longevity and declining fertility. After a temporary plateau, there will be another growth in aging around 2020-30.

3.2 The Family Situation of Older People

In contrast to popular stereotypes about waning family solidarity, a number of studies now conclude that the Western and Nordic family is doing fine, and in some ways better than before. Swedish studies show that older persons in just a few decades have seen their family networks expand and contacts, support, help, and care in the family are stable or even increasing.

The marital status of the elderly is important in this context because it tells us something about the availability of an immediate source of support and care, the spouse. The rising proportion of the population that has a spouse or partner is noteworthy. Further, the time lived with a spouse is much longer than in the past, as evidenced by the large number of golden weddings. Marriages dissolved by death on average lasted about 15 years during the 1700s, about 25 years in the early 1900s, 36 years in 1952, 42 years in 1981, about 49 years in 2000, and 50 years in 2006. About 14 percent of Swedish marriages contracted in 1906-10 were intact 50 years later, compared to 24 percent of those contracted in 1946-50.

It should also be mentioned that many people—young and old—live in relationships outside conventional marriages. Beyond rising rates of marriage among older persons, about 5 percent live in common-law relationships, and some 4-7 percent have a LAT relationship (living-apart-together) (Sundström 2009). The rising marriage rates of the past imply that an increasing proportion of old people will have offspring. Childlessness has decreased in the Nordic countries and seems to have leveled off at about 10-15 percent of older people. It cannot be expected to decrease much further, as a rather high fraction of middle-aged cohorts report that they have never lived in a relationship (e.g., 9 percent of Danish men and 6 percent of Danish women ages 45-49 years in 2002-3 [Leeson 2004]). Similar figures are reported from Swedish fertility surveys. Having just a single child has not become more common and is maybe less common than before.

3.3 Kinship Patterns of Older People

It is well known that kinship networks of old people in some ways are more extensive today than in the recent past. For example, more generations are alive at the same time, a trend that is noticeable among Nordic elderly. In Sweden in 1994, 65 percent of older people had grandchildren (Sundström and Malmberg 2006). Analysis of data in SHARE indicates that a higher fraction of persons 50 and older in Denmark and Sweden (the two Nordic countries participating in SHARE) have grandchildren than in other European countries. They also provide care for their grandchildren just as often (below). Having one or more siblings is also more common now than previously. Having both partner and children seems to be increasing as well; in the case of Sweden from 47 percent (in 1994) to 51 percent (in 2000) and the proportion having neither decreased from 14 percent to 9 percent. Availability of all near family—defined as partner, children, and siblings—was stable at 39 percent of old people. Conversely, a small and shrinking group of old people have none of these family ties.

There are indications that more older people in the past lacked close family. Thus 14 percent of elderly Finns in 1950 had neither spouse nor children. In Sweden in 1954 the figure was 17 percent: in Denmark it was 13 percent in 1962, 11 percent in 1977 (Statistics Finland 1953; SOU 1956; Platz 1981). Family relations beyond these close ones have been assessed in more global terms in a few studies, but are harder to compare. In a representative population survey of Swedes 75 and older in year 2000, no one reported that they lacked
relatives altogether, though the exact meaning of this remains unclear (Johansson and Sundström 2004).

3.4 The Geography of Family Ties of Older People

To these purely demographic aspects of the kinship panorama we may add the geographic availability of kin, which provides a somewhat different picture. Generally speaking, we would expect relatively high local density of kin networks, because most Swedes live where they grew up or quite near. Geographic mobility has been remarkably stable since 1749 with about 8 percent of adult Swedes moving across a parish border annually. (Many moves take place inside a parish, as most are short-distance.) Most people live in the county where they were born: 81 percent of the population in Scania (Malmö), 68 percent of those who live in Stockholm county (Statistics Sweden 2006b, table 1.3.2; my computations). Nevertheless, access to close kin does vary locally, with potential consequences for frail older persons.

Data in Figure 1 show the percentage of persons 80 or older in each of the 290 municipalities who lack a partner (nearly all live alone) and have no child within a 200 kilometer radius. The source of this information is the unique Swedish multigenerational registry, established in 1947 and covering the whole population. On average 15 percent of those 80 and older have neither partner nor child reasonably near, but local variations are big, with much higher rates in many northern municipalities (Alm Stenflo 2006). These variations have obvious implications for the public services, as we shall see below. There is thus a good deal of geographic closeness, with important local variations, but also many old people who have relatively thin family networks around them, even though this group, as we have seen, may be proportionally smaller today than, say, 50 years ago. In Sweden in 1954, 2 percent were categorized as "isolated" (SOU 1956); in Denmark in 1962 "between 2 percent

![Figure 1](https://example.com/image.png)

Figure 1. Availability of close kin (partner or children) for elderly Swedes (65 and older) in 2004 (percentages). No partner and no child within 200 km. Only biological offspring are considered. The fractions in border municipalities are somewhat overestimated as children living in neighboring countries are not registered. Source: courtesy data provided by Gun Alm Stenflo, formerly at Statistics Sweden, now at Statisticon, Uppsala.
and 3 percent” lived in "extreme isolation" (Shanas et al. 1968, 262). The Norwegian survey in 1953 reported that 5 percent had no contact at all with family, though after contacts with friends were taken into account few were considered to be completely isolated (Ström 1956).

Children are perhaps the most significant social tie for old people beyond a partner, and it is now well known that distance to closest child is small in most European countries including the Nordic ones. Nor has this distance grown substantially, judging from Danish and Swedish evidence, whether measured in travel time or geographic distance. Almost all offspring move out of their parents’ home in the Nordic countries but do not move far away. Still, about a tenth of elderly Swedes have their closest child at a distance that rules out frequent physical contact (Johansson and Sundström 2004). The perspective of offspring naturally provides a more diversified picture, and a sizable number live rather far away from their parents. For example, in Sweden in 1984 just 2 percent of 30-49-year-olds lived with parents, but 6 percent lived in the same house or the immediate neighborhood, and in total 37 percent lived within 15 kilometers (after Sundström 1984).

Frequency of contacts with relatives is a staple in surveys of old people, and without going into detail it is obvious that interaction remains high though more social life took place inside households in the past, when coresidence with children and others was more common. It is illustrative that between 1962 and 1975, coresidence declined in Denmark but temporary stays in each other’s homes increased vastly (Platz 1981). There is regrettably no later information on this finding, except that studies of vacation patterns find visits to relatives to be one of the most common “tourist” activities.

To some extent geographic and social mobility go together. There are longer distances between old people and their offspring when the latter are upwardly mobile, with less chance of physical contact between them. Failing to observe this correlation may lead to premature conclusions about old parents’ being neglected by children who have "made it” socially. If the distance factor is accounted for, variations in social contacts between generations of different social status vanish (Sundström 1986).

### 3.5 Living Arrangements and Housing of Older People

As censuses are no longer undertaken in Denmark and Sweden, census data in the Nordic countries are rarely relevant to describe the household structure of older people in any detail. We may however gain some evidence from surveys and historical studies. The stereotypical image of old people historically mostly living with offspring in complex households of three generations and or similar constellations has some support in demographic studies, but variations between local areas were often great (Moring 2003).

From a demographic perspective, the rural three-generation household stereotype is problematic, not only because it assumes that members of all three generations were alive at the same time—which they often were not—but also because it often assumes that at least one generation was propertied. Notwithstanding these objections to simplified views of historical family patterns, it remains that coresidence was much more common in the recent past. In 1954, for example, 30 percent of old Swedes lived with one or more adult children, although only 9 percent lived with a grandchild in the household. In 1975 these arrangements had shrunk to 9 and 1 percent, respectively. And even if fewer old people than expected lived permanently with their offspring in the past, they commonly spent their last years in coresidence (Gaunt 1983).

Of particular significance for issues of services and care is how common it is for old people to live alone. This pattern may signify a situation of vulnerability but is also is consistent with preferences of old people who cherish their independence, often seen as a central feature of Nordic mentality. It was common that older people who shared house with children tried to establish independent "sub-households," with kitchens of their own, for example. In the records they may have appeared to be living together.

Living arrangements are conditioned by norms and by material factors such as availability of affordable housing and access to family. Generally speaking, the availability of family influenced whether older people lived alone or with family (or others) and whom they lived with. This conclusion was also drawn in the well-known three-country study in 1962, where it emerges that it was especially the never-married and childless who lived
with siblings and that persons without close relatives also were more likely to live alone (Shanas et al. 1968, table VI-18a). As we shall see below, kin availability also helps to determine patterns of care. Living alone has been on the increase in many countries—and it has already climaxed in the Nordic countries—while coresidence with children is declining.

In spite of so many older people living alone in the Nordic countries, there is no indication that loneliness and isolation is high or has increased among them. If anything, the opposite conclusion can be drawn from available data. Indeed, older people in the Southern European countries report (much) higher rates of loneliness and feelings of being abandoned (Walker 1993; et al. 2007).

3.6 Interaction between Generations: The Contents of Exchange and Caregiving

Less is known about the content of interaction across Nordic generations than about the frequency of contacts and distances, but in general terms it can be stated that older people in the 1950s were still mainly receivers of housing, help, and financial support. Yet a Swedish survey in the early 1950s and a 1962 Danish study observed that some older people were *givers* of help and money rather than receivers (Elmer 1960; Shanas et al. 1968). Two percent of the Swedish elderly in 1954 were "substantial" givers of help to somebody in another household (SOU 1956), in 2002-03 about 5 percent were givers of extensive informal care outside their own households and another 17 percent gave less extensive help. Another 5 percent gave mostly intensive help inside their household, typically to a partner, in absolute numbers equally many men and women (Sundström and Malmberg 2006). Today older people are often givers of informal care and financial support to younger generations. In 1962, 29 percent of old Danes gave some kind of help to children and 14 percent to grandchildren; in 1977 the percentages had risen to 49 and 52, respectively (Platz 1981). Only a minor fraction of these numbers is attributable to more old people having these ties. In 1980, 50 percent of Swedes ages 55-64 reported "regular" child-minding (SØU 1981). This number is supported by more recent data in the SHARE survey, which also indicate that caring for grandchildren is as common among people 50 and older in Denmark and Sweden as in southern Europe.

A common stereotype holds that the contemporary family is typically burdened by both small children and aging parents who need care. This is rarely the case, but data in SHARE for all European countries including Denmark and Sweden support a looser version: those 50 and older do play a pivotal role for exchanges in both directions in these constellations (Attias-Donfut, Ogg, and Wolff 2005). Danish studies in 1987, 1997, and 2002 assessed exchanges from the perspective of middle-aged cohorts: reports of socializing, vacationing, caring for grandchildren, maintenance of housing, and the like, were simply massive, but financial help was marginal (Leeson, Spöhr, Matthiessen 1988; Leeson 2004). The large majority also expected to get help from their children, should the need arise, and most reported that they were prepared to help their parents (in future). As to their values in life, the family and what it stands for emerged as paramount (Leeson et al. 1988; Leeson 2004). It has been suggested that when resources were directed to old people by the welfare state, it was possible even for aging parents to remain givers, and not only to adult children in trouble. It also freed younger generations to seek jobs and advancement (Sundström 1983, 1987).

In this context, it should also be observed that these cross-sectional rates of caregiving greatly underestimate the lifelong risk of ever being a caregiver, which is roughly two to three times greater. Many stop, and many begin, a caregiving episode every year (Hirst 2002; Leeson 2004). Data on this are very scarce, but in Sweden about 40 percent of elderly women and 20 percent of the men report having ever been carers, mostly for parents or spouses (Sundström and Malmberg 2006). In Sweden and the other Nordic countries (and elsewhere) caregiving typically climaxes around age 45-54. After that, care for parents and other family declines, though caring for a partner remains high and even increases somewhat. Most of the caring is infrequent, with 5 percent of both men and women providing daily care, and the absolute number of spouse-carers are the same for men and women. Daily care is usually for a partner or, less often, other close family and usually in one’s own household (Sundström and Malmberg 2006).
The intermittent nature of caregiving also implies that many or maybe even most people will eventually become caregivers, depending on how strict is our definition of care. In a national survey in 2000, 34 percent of people 70 and older living in the community reported one or more incidents of caregiving during their lifetime, higher for women (41 percent) than for men (24 percent) (Sundström and Malmberg 2006). The recipients were almost all parents or partners (12 percent in either case) or other close family (9 percent). There is no evidence of decreasing caregiving (Lingsom 1997) and, as mentioned above, some recent data indicate increased caregiving, and especially for daughters and other female kin during the 1990s. It seems that this increase has to do both with wider social ties (above) and with cutbacks in social services for older people in Sweden (Johansson, Sundström, and Hassing 2002; Olsson, Svedberg, and Jeppsson Grassman 2005).

4. Public Services for Older People

4.1 Beginnings

Until the late 1940s public old-age care remained poor relief and institutional care. The caring bureaucracies were often averse to new ideas. Older people with little or no need were institutionalized—sometimes forcibly—because of poor housing, lack of family, or sheer poverty, the municipalities confiscating their possessions, if any. Contemporary photographs graphically depict the conditions of institutions and their residents, often without teeth, subject to rules of order nailed to the wall. Troublemakers were threatened with the workhouse. Most old-age homes had tasks of work that residents were expected to perform, such as chopping wood and laundry. (Some also had pigs or other forms of husbandry.) A certain improvement were the pensions introduced in 1914, and extended in 1937 to all people 67 and older, except those who were institutionalized. In those cases the authorities kept their income, but sometimes paid them pocket money. The system ended in 1948.

The poor law of 1918 gave access to the old-age homes also for "ordinary" residents, who paid for their stays in full. By the 1940s, they made up about a tenth of all residents, and the fact that institutions began to house "ordinary" citizens may have something to do with the ensuing scandal. During World War II, pensioners began to organize themselves in a pressure group, on initiatives by syndicalists and communists. They fought for housing allowances and higher pensions. (Today these organizations—but now nonpartisan—recruit about 40 percent of the 65-plus population.) They convinced a well-known author, Ivar Lo-Johansson, to embark on a trip through "old age Sweden," visiting many old-age homes and odd quarters of old people on his way. His grandmother was one of the first to receive a pension in 1914, one dollar a month, the first money she ever possessed of her own. He described what he saw in the most widely circulated weekly, in a series of reports with horrifying photographs (also published as a book), and in radio programs in 1949.

The time was ripe: earlier proposals and attempts by voluntary organizations to establish home care had been ignored by the authorities or seen as valuable but "too expensive" and impracticable on a larger scale. The old-age home was seen as the solution. Yet, after the scandals, community care was suddenly not only humane but also proclaimed the cheapest way to provide for old people. Home Help, a public service that provides help with household tasks or personal care in the community, became the new strategy in old-age care. In 1950, 6 percent of older people were institutionalized, and in 1954 already 1 percent had Home Help, mostly used by poor working-class women. In 1954, 3 percent still had a maidservant living with them, and many more purchased temporary help with cleaning, laundry, and other chores. This form of help disappeared rapidly with better work opportunities for women and competition from inexpensive or free Home Help.

To stimulate municipalities to establish Home Help services, the government for many years provided heavy, earmarked subsidies for these services. Governing in Sweden is more often done by manipulating economic incentives than by commands or legal procedures. Thus, in the 1970s, when the government wanted municipalities to upgrade their institutional care from old-age and nursing homes to so-called service houses,
subsidies for Home Help were officially said to apply also for residents in service houses. Residents could also get government housing allowances, which the municipalities could reclaim through the "back-door" by raising the rents of the service houses. This tactic made investment in traditional institutions (where Home Help was not applicable and no housing allowance could be paid) comparatively very expensive for municipalities.

4.2 Transitions

Despite the new emphasis on community care in the 1950s and 1960s, institutional care also expanded, built by ambitious and resourceful municipalities for older people whose needs were often small or nonexistent. Up to that time, institutional care was often an alternative for older people who lived in poor housing, or they might go into care for "causa socialis." Today it is primarily a matter of seeking nursing care.

Older people's use of service since the early 1950s is shown in Figure 2. The lowest band in the diagram shows institutional care of all kinds, its growth and decline, returning to the "traditional" level of 6 percent in 2006/7. (A rate of 5-6 percent was not unusual in the poor-relief era.) Home Help, in the upper band, grew from nothing to 16 percent in 1975 and after that declined to about 9 percent in 2009. In hindsight it appears that there was overconsumption not only of institutional care but also of Home Help in the 1970s and 1980s. Many used these services—frequently free or very inexpensive—for many years. Home Helpers also cooked, baked bread and cookies, cleaned windows, took out the dog, and even milked cows in more exceptional cases. In that era, social service departments sometimes had no fixed budget and were more or less free to spend money at their own discretion.

Nevertheless, in the 1970s some older people still lived in substandard housing, there were no "meals on wheels," and gender roles were even more inflexible than today. A close reading of survey questionnaires for

![Figure 2. Simplified representation of public services for older people, 1950-2009. Source: my own computations of service statistics and government investigations.](image-url)
older people in Stockholm in 1954 and 1978/79 discloses that married men did nothing (or next to nothing) in
the household in 1954, but did contribute or help out more just 25 years later (Skoglund 1992); and a recent
study finds that older men and women equally often care for their partners (Sundström 2000; Malmberg
and Sundström 2004).

4.3 Contemporary Trends

An interesting trend in recent years is the growing demand for private retirement lifestyle housing, usually
special apartment houses (often owner-occupied condominiums or cooperatives) that require residents to be 55
or older. This is mostly a choice for those who like this lifestyle and have the money. These places are not
institutions and seldom provide many or any services, although that is likely to change as residents age. They
are entitled to public services like everybody else living in the community. Approximately 2 percent of older
Swedes live in these settings. Very few older people want to move to institutional care; interest in retirement
communities is bigger and also appears to be increasing. It should also be mentioned that many older people
have a second home, and some live permanently or temporarily in resort communities in southern countries, so
far primarily in Spain.

There are other signs of privatization, such as the increase in privately paid help with household chores. Of
course, the big privatization is the growing significance of the family in providing care for older people. Indeed,
when we speak of "family," it is spouses (men and women) and daughters who increasingly provide this care
(see below). Coverage rates of services have shifted somewhat over time, but the greatest worry of older people
and their families today is the perceived lack of institutional care. Today's residents in institutional care are very
frail and often dementia sufferers when they enter; about two-thirds of the residents are deemed to be in this
predicament. A special kind of residence for dementia sufferers, the group home, was established in the 1990s,
but most live in ordinary institutional settings. Programs such as day care have had a slow start, and uptake is
only a fraction of potential users.

It is misleading to compare contemporary Home Help with the service provided in, say, the 1970s. Today's
users can get help many times a day, during evenings, at night, and on weekends, features unavailable just a
couple of decades ago. Yet Home Help now tries to minimize household chores (e.g., offering meals on wheels
instead) and concentrate on providing personal care. Needs assessments have become stricter, and municipalities
tend to reinterpret the letter of the law. On average clients use about 30 hours per month, but the
distribution is very skewed, with most using many fewer and a few using 200 hours or more. In practice
those will often be the minority that are mentally alert but with severe physical dysfunctions and with a family
that knows their rights.

Although the amount of support—from the Home Help and from family—typically increases with rising need,
longitudinal studies show that most users die or are institutionalized before they attain very high amounts of
community care. Social services for older people are usually handled by the same agency and by the same needs
assessor, the "gatekeeper." Services are charged according to income, and Home Help fees are sometimes
structured so as to make "small" needs quite costly, whereas the very frail find it relatively less expensive. The
incentive in this is not always felicitous. A cap on fees protect users against being impoverished. Capital and real
estate does not count in calculating the fees, although income from capital does. (Capital does however reduce
or hinder housing allowances.)

Cutbacks in services in the 1990s and after coincided with improved functional capacity of older people. In
1988/89, 30 percent of those 65 and older living in the community needed help with one or more activities of
daily life (ADLs). In 2002/03 only 21 percent needed such help and local outreach to nonusers of services
(persons not using any service) rarely finds people with unmet needs. During the same period fewer people on
average used Home Help; and now they must wait longer before asking for it. Their frailty is greater and they
increasingly need help with personal care when they become Home Help clients. They will also get fewer hours
of help relative to their needs today than previously (Sundström 2000).
Social administrations in the municipalities often attempt to change the image of the Home Help service by emphasizing personal care—not housekeeping—and often symbolically change the name to Home Care. For staff, this means a job where many clients display frailty and illnesses, and not infrequently loneliness, depression, and dementia. The only group of older people frequently using Home Help who have benefited from a rise in service provision are the childless living alone. This group, incidentally, constituted a large proportion of the traditional poor-relief clients about half a century ago. Yet, public services today have a different social profile—they are now for everybody, regardless of social class, although utilization rates may differ because of the better health of higher social classes.

4.4 Averages and the Longitudinal Risk of Public Service Use

A problem with all cross-sectional information, including the coverage rates for services, is that they cannot tell us the historical (longitudinal) risk of becoming a user of a certain service. We must follow persons from the day of retirement until their death to find out how the state (and the family) eventually attend to their needs. If coverage rates are high, but represent use by the same people for a very long time, the services will still reach just a small segment of the needy, whereas shorter use will allow for more rapid turnover and seeing to the needs of more people, even if coverage rates are low. Basically it is the problem of rationing: if it works well, everyone will get the desired goods, although a little less or less frequently. It is important to note that a high longitudinal risk does not necessarily imply high prevalence rates, or vice versa. Indeed, the little evidence there is on these aspects in the Nordic countries indicates rising long-term risks (chances) of using public services before death, at the same time cross-sectional user data indicate declining rates of use. The explanation seems to be that these services are now used for much shorter time than before. It is noteworthy that most old people will have used public Home Help before they move to an institution or before they die.

Data for Sweden indicate that the historical chance of getting public support has risen dramatically (Fig. 2). Around 1950, some 15 percent of older persons eventually ended up in institutional care; nothing else existed in the way of care. The rest died at home or in hospitals that did not at all provide dignified care of the kind these persons needed. A study in the 1970s found that 30 percent eventually ended up in an institution; another 20 percent used Home Help, but died elsewhere. Analysis of an urban sample of 70-year-olds followed from 1970 (H70 in Gothenburg) found that 50 percent ended their lives in institutional settings (personal communication from Marie Ernsth Bravell). Contemporary evidence indicates that about 90 percent of those 80 and older eventually use Home Help or institutional care.

In the historical past, older people who used poor relief were short on (functional) family or lived alone or were poor. It was exceptional that, in the poorhouse in Mulseyrd (near Jönköping), the widow of the previous county governor languished in the 1840s and 1850s. Her aristocratic husband had lost his job for mismanaging public funds and abandoned his family. To some extent it is still true that the less well off and persons short on social networks more often use public services in the Nordic countries, particularly institutional care, where, for example, the never-married (and often childless) still are overrepresented. In the Nordic countries institutionalization rates were somewhat higher than in most other Western countries—about 5-6 percent of the elderly in the 1950s, typically rising in the following decades retreating more recently. Rates at this level were not unusual in earlier centuries but varied a good deal locally. Swedish regions with many large estates and proletarianized farmworkers had more poorhouses to accommodate them in their old age. Again, averages give an incomplete image of institutionalization, as the cumulative risk of institutionalization varied locally and has shifted historically (Gaunt 1987; Sundström 1995).

Institutions are permanent residences for old people, excluding acute health care facilities. The Home Help services that expanded rapidly in the 1960s were an alternative. They had and have a much less visible class bias. Older workers use Home Help services more often than middle- and upper-class persons, but analyses indicate that this is mostly due to class differences in functional capacity and living arrangements. Persons who used Home Help were often helped by their family as well and vice versa (Sundström 2000; Sundström...
and Malmberg 2006). These patterns will be dealt with in more detail below.

It seems that class gradients may have become attenuated, with public services focusing on the oldest and frailest, often those suffering from dementia. Older people now manage longer at home, thanks to better housing, informal care provided by family and others, and the public services. In particular, as we have seen, older people stay married longer and marriage protects against institutionalization and use of other services: few husbands or wives send their partners to institutional care. This goes a long way to explaining risks of institutionalization, but usually we have access only to "snapshots" of marital status for institutionalized persons. It is rare to find the trajectory from onset of retirement or thereabout to the end of life that describes geographical moves, institutionalization, and other events.

4.5 Family Care and the Public Services: Symbiosis, Collaboration or Coexistence?

An important aspect of old-age care in Sweden is the high degree of overlap between family care and public services, which as we have seen also occurred in poor relief. Many older people who are helped by their families also receive public support. This is a significant feature of Nordic welfare and also the arrangement preferred both by older people and by their families: they don't want total dependence on the family or on public services. With a combination of the two, there is room for choice and maneuvering. International research shows this to be the preferred pattern also in continental and southern European countries (Daatland and Lowenstein 2005). Yet, for example, in Spain, there is much less overlap in care provision between family and state than in northern Europe (Walker 1993; Sundström et al. 2007).

Everything else equal, we may expect family ties in general and informal care in particular to be at least partly determined by the size of the family, acknowledging that access to a partner and offspring may be of primary importance. Of course, access to family means not only that one may receive help but also that one may have to provide it. If networks expand or contract, one might find a corresponding change in these risks (chances). These dynamic aspects are hard to assess, but some evidence of the effects of network character and size can be deduced from survey data. There is thus a clear social profile to the pattern of help old people receive when they live alone in the community and need help, as shown for Sweden with two different data sets in Tables 1 and 2.

In Table 1 we highlight the division of labor between family and state. In Table 2 we take a closer look at who the helpers are. It emerges from Table 1 that older people who need help, but who are married and have children, mostly rely on family only (80 percent). Those who lack both of these cardinal relations tend to rely exclusively on the state.

It is not surprising that older people who live alone and have offspring often use public Home Help; but they rarely use it exclusively: It is common for them to have a combination of family support and public help. As mentioned, adult children of older people often live in the vicinity, and in this group we have seen the greatest increase in family care in the 1990s, paralleling cutbacks in public Home Help (Johansson et al. 2002).

Access to a partner or child and its consequence for who the carers are can be gleaned in some detail from Table 1, which describes various combinations of informal and formal (public Home Help) care in Sweden for older people in need of help. It verifies that public services (Home Help) are used mostly by older persons lacking close family, but in Table 2 we also see a characteristic pattern of whom in the family is relied on.

Those who have a partner rarely rely on help from others; evidence indicates that outside help is used primarily when the partner also is frail or otherwise not able to give the support needed, regardless of whether they have offspring. (Also, when public help is given to these persons, relatively few hours of help are granted.) Partnered persons who do not have children use Home Help somewhat more often than when a child is demographically available. As mentioned, geographic proximity of offspring is a deterrent to use of public support in old age.

For unpartnered older persons, having a child or not thus makes a big difference. Unmarried persons with children tend to receive help from them, alone or in combination with Home Help, though 21 percent are helped
Table 1. Persons 65 and Older Living in the Community, by Family Situation, Need for Help, and Source of Help, Sweden 2002-3 (%)

<table>
<thead>
<tr>
<th>Source of help:</th>
<th>Married/Cohabitating</th>
<th>Living Alone</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Has Child</td>
<td>No Child</td>
<td>Has Child</td>
</tr>
<tr>
<td>Needs help¹</td>
<td>16</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>Source of help:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family only²</td>
<td>80</td>
<td>69</td>
<td>42</td>
</tr>
<tr>
<td>Home-help only</td>
<td>5</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Both</td>
<td>14</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>Neither³</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Sum</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Sample sizes</td>
<td>(1,711)</td>
<td>(194)</td>
<td>(1,078)</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden (2006a); my computations.
¹About 97 percent lived with spouse only, but includes those also living with children, siblings, and others.
²Needs help with one or more ADL; help received refers to the same ADLs.
³Or other informal care.
⁴But may have had other sources of support.

Table 2. Support Patterns for Swedes 75 and Older in Need of Help,¹ by Family Situation and Help Constellation, 2000 (%)

<table>
<thead>
<tr>
<th>Has Spouse or Partner</th>
<th>No Spouse or Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has Offspring</td>
<td>No Offspring</td>
</tr>
<tr>
<td>(N=313)</td>
<td>(N=37)</td>
</tr>
</tbody>
</table>

| Women (% of all helpers) | 22 | 24 | 66 | 69 |
| Spouse/partner only      | 70 | 70 | –  | –  |
| Children¹                | 3  | 3  | 30 | –  |
| Other kin                | –  | 3  | 4  | 13 |
| Other household member   | –  | –  | 2  | –  |
| Friend/neighbor          | 1  | 3  | 6  | 14 |
| Home Help                | 5  | 3  | 21 | 34 |
| Combinations of Spouse+child¹ | 6 | –  | –  | –  |
| Spouse+Home Help         | 5  | 11 | –  | –  |
| Spouse+other(s)¹         | 1  | 5  | –  | –  |
| Child+Home Help¹         | 1  | –  | 19 | –  |
| Child+other(s)¹          | 1  | –  | 4  | –  |
| Home Help+other(s)       | –  | –  | 3  | 19 |
| No one                  | 6  | 5  | 12 | 19 |
| Total                   | 100| 100| 100| 100|

Source: Own computations on HPAD survey 2000 (Sundström 2000).
¹In need of help with one or more ADLs.
²Children include potential in-laws.
by public services alone. The small category that has neither partner nor children (a tenth of this age group) receives help from more distant kin or neighbors or others. They also more often rely on the public Home Help (53 percent), though we note that even among them a minority is dependent solely on the public service (34 percent).

Access to kin clearly also influences the chance of giving care. In Swedish national data for those 55 and older, 45 percent are caregivers (to any person, regardless of relation and location) if they have a partner, a parent, and a siblings living, in contrast to 24 percent of those who have two of the three, 20 percent of those having only one, and 16 percent of those who lack any of these near relations. Of course, the biggest difference is the presence of a parent. It is rare to have all three of these relations: only 12 percent have them all, 47 percent have two, 33 percent just one, and 8 percent none of them. There is a good deal of care being exchanged inside the family, but there is also substantial care being given to more distant kin and to non-kin (Sundström and Malmberg 2006).

The degree of division of labor between family and Home Help is typically nebulous, though some countries report that there may indeed be agreements between family carers and the public services about who does what, producing a significant overlap between these providers. In the Nordic countries the issue has surfaced in recent years of cutbacks in public services. A systematic comparison of care patterns for the 75 plus in the international OASIS project found—consistent with our analysis—that the overlap between formal and informal care was largest for frail persons in Norway and England and rather small in Germany, Israel, and Spain, where more people had help either from their family or from the state. In Israel and Spain proportionally many used relatively inexpensive, privately paid help (Daatland and Lowenstein 2005), which is rarely available in the Nordic countries.

4.6 Financial and Administrative Aspects

As we have seen, Swedish public old-age care rests on a long tradition but is also shaped by political and financial factors. As early as 1912 a Swedish government commission on pensions pointed to the significance of (supposedly) weakened informal care necessitating public spending (in 1914 we got the first general pension program). This idea has remained an ingredient of most Nordic white books on pensions and old-age care. Even if they make no assumption about a decrease in care, they consider the availability of family care. The latest examples are an econometric analyses of the consequences of increased need for old-age care in Norway of 2050 (Holmøy, Langset, and Lerskau 2006) and a similar Swedish analysis with a rather "optimistic" perspective on future needs for care (Lagergren and Batljan 2000; Statistics Sweden 2006a). In contrast to at least one officious European Community inquiry (Council of Europe 1998), official Nordic publications do not propose that families should shoulder bigger commitments in old-age care.

A 1977 Swedish government commission on old-age care outlined a plan for high service rates to expand even further, but financial problems of the municipalities soon led to stagnation and decrease in coverage rates. In 1950 and 1960 Sweden spent about 5 percent of its GDP on older people, 6 percent in 1965, 7 percent in 1970, and a dramatic 10 percent in 1975. The expenses per retired person trebled in fixed prices (SOU 1977, table 7.12). It was used mostly to raise the quality of the services, but also to bolster salaries and working conditions of staff. In the early 1990s the rate had reached about 14 percent. It has not risen since, notwithstanding repeated government efforts to raise spending on older people, and budget forecasts do not indicate any future rise. About three-quarters of these expenses are on pensions and housing allowances. The latter benefit enabled nearly 40 percent of older persons to demand modern and adequate housing. A recent overhaul of the pension programs means that they will be less generous in the future, safeguarding actuarial soundness but limiting pensioners' purchasing power, as some 85 percent of their incomes derive from pensions. It is noteworthy that the high coverage rates of services in the early 1970s were attained at relatively low tax levels.

Any further rise in standard of living or services may have to be financed by older people themselves, or by their families. This probability has been hinted in government publications but has not been well received. It is
likely that we have reached the limit of what the welfare state can allocate to older people. Henceforth the problem for the service providers will be how best to use these resources, in other words, a more efficient use of them. Efficiency is often the explicit motive of reforms of the services. We will try below to assess how authorities allocate the armory of services available to them.

4.7 Administrative Reforms, Quality Indicators

The stagnation in resource allocation on older persons coincided with a general trend in the 1980s and 1990s of rehabilitation and care in the community, such as deinstitutionalization of the mentally sick and developmentally impaired. So-called bed-blockers that plagued hospital wards in the past were made away with through a reform in 1992: when a hospital can do no more for patients and wants to discharge them, the municipality must provide care or foot the hospital bill. This move quickly solved one problem, but has made burning issues of unsatisfactory rehabilitation and gaps in the chain of health care after discharge from hospital. Sweden, like many other countries, strives to bridge the gap between social services and health care, but has not been wholly successful.

It can be noted that the law does not prescribe the right of the needy citizens for support, only the duty of municipalities to provide a service, but not how much or what kind, or in what manner. The Social Service Act that is supposed to steer municipal provision dictates only that there must be Home Help services and institutional care, without specifying their levels. The whole law is a “framework.” The intention was that the vague formulations should allow for local solutions and initiatives, and potential conflicts should be solved through prejudications created after appeals to the administrative courts (see above). This law has not always worked the way legislators expected when they formulated it in the affluent 1970s (the act is from 1982) and a number of revisions have been necessary.

One such amendment—the prescription that municipalities "ought" to support family carers when feasible (1998)—reflects increased awareness of the significance of family care, which was made mandatory for municipalities in 2009. There are no uniform procedures for needs assessments in Sweden; each municipality has its own routines. By contrast, Germany (Pflegeversicherung), France (allocation personnalisée d'autonomie—APA), Spain (Ley de dependencia), and Japan (Kaigo Hoken) have mainstreamed procedures. Proposals in Sweden to introduce better assessment or even a care insurance have so far met with little interest.

Several European countries are now experimenting with various ways to give the public some indicators of the quality of services. The Swedish Association of Regions and Municipalities publishes "Open Comparisons" reports, with many indicators of the quantity and quality of local services. Another somewhat different type of report (the "Ageing Guide") is published by the National Board of Social Welfare. The intention is that service users or their families may assess the quality of services and put pressure on local authorities through the publicity. There is great variation among the quality indicators in these reports, from standard indicators of residences, to aspects of staff training, to whether people die alone and whether people in terminal care were told that they were going to die. Since 2008, questionnaires have been sent out nationwide to nearly all users of institutional care and Home Help. A first report of findings shows that most users are relatively satisfied, which has been found also by previous, smaller studies.

In January 2009 Sweden adopted the Law of Freedom of Choice (Lagen om valfrihet—LOV) requiring municipalities to institute a legal tender process for choosing providers of services. Reimbursements to providers are fixed, and they are invited to compete on quality.

4.8 Family Care and Responsibility

One reason for Nordic reserve as to family care is the official wish to keep labor force participation high; another is traditional views of gender. Provision of informal care is seen as a mostly female undertaking, and it is often assumed that this is hard to combine with paid work. It is estimated that two-thirds of all care for older Swedes
is provided by family, of which two-thirds again is provided by women (Szebehely 2005). Analyses of both cross-sectional and longitudinal data fail to find any major effects of informal caregiving on gainful employment of either men or women in general, except in the less common cases of very heavy informal care (Sundström and Malmberg 2006). Indeed, analysis of a period in the 1990s of shrinking public services for older people and a simultaneous increase in family care coincided with an era of consistently high labor force participation. Surveys indicate that few of these family carers wish any specific support for themselves; what they ask for is good services at a reasonable level for the person they care for (Sundström and Malmberg 2006).

The increase in care, we have noticed, fell nearly all on daughters and other female family members (Sundström, Johansson, and Hassing 2003). They help more in general, and especially if the live near their parents. Yet common assumptions about (female) employment and capacity to provide help and care for aging family members (parents) may be overly mechanistic. There is no rational link between high coresidence—and presumably more informal caregiving—of older people and their children in Finland and Norway, on the one hand, and high labor force participation in full-time jobs for men and women in Finland and low rates for women in Norway, on the other hand. Denmark and Sweden have little coresidence and high employment rates, with many women in part-time jobs, but the reason for the part-time choice is rarely provision of care to aging family members (Sundström and Malmberg 2006).

Interestingly, these patterns contrast with what is observed in southern Europe in the SHARE database, where many carers of old family members report that they have had to refrain from work or stop working (Sundström and Malmberg 2006). A plausible explanation for these divergent patterns is the access to relatively abundant and affordable public services for older people in the Nordic countries, both community services and institutional care. This is also what carers asked for in a large representative Spanish study of carers in 2004 (IMSERSO 2005) and in international comparative studies such as the OASIS project, which covered Norway, Germany, Britain, Spain, and Israel (Daatland and Herlofson 2004; Daatland and Lowenstein 2005).

Families in general and carers in particular do not ask for the state to "take over" altogether, but desire a shared commitment, where both parties contribute (Daatland and Herlofson 2004; Johansson and Sundström 2004; Daatland and Lowenstein 2005).

Norms about responsibility for older people have been probed in a few international studies. In the OASIS project, older persons in Norway, Germany, Britain, Spain, and Israel differed somewhat in their definitions of responsibility, but everywhere the large majority wanted responsibility to be shared between family and state. Preferences vary, as may be expected, by actual availability of government support. Half or more were for "mainly state" responsibility for financial support, domestic help, and personal care in Israel and Norway. Much the same held for opinions on who should be responsible for increasing, future needs (Daatland and Herlofson 2004). Another international study found similar patterns, shown in Table 3.

In Sweden a quarter of carers endorse the family’s having the main responsibility, as against three-quarters or more in the other countries. Only in Poland does a large fraction (36 percent) accept the family’s total

<table>
<thead>
<tr>
<th>Desired responsibility</th>
<th>Sweden</th>
<th>England</th>
<th>Poland</th>
<th>Germany</th>
<th>Italy</th>
<th>Greece</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainly family, state contributes</td>
<td>22</td>
<td>65</td>
<td>57</td>
<td>71</td>
<td>77</td>
<td>78</td>
</tr>
<tr>
<td>Mainly state, family contributes</td>
<td>57</td>
<td>12</td>
<td>5</td>
<td>11</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>State all</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know, No answer</td>
<td>12</td>
<td>18</td>
<td>1</td>
<td>14</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Sum</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>N</td>
<td>581</td>
<td>320</td>
<td>875</td>
<td>451</td>
<td>863</td>
<td>290</td>
</tr>
</tbody>
</table>

Source: EUROFAMCARE (http://www.uke.de/extern/eurofamcare), by permission.
responsibility. (A couple of national studies confirm the pattern; see the concluding comparison of Spain and Sweden.) The OASIS study is nearly exceptional in considering both family and state support simultaneously (Daatland and Lowenstein 2005). It is very unusual to find a conscious discourse on this in official publications. A rare exception is a French analysis of the APA, with systematic consideration of network configurations of old people at different levels of need and the interaction of family and public support (Jeger 2005). These aspects are likely to be more important in coming years.

A survey in Flanders (Belgium) found that most people 55 and older are negative toward legal filial responsibility for residential care (Vanden Boer and Vanderleyden 2003). A recent opinion poll in Denmark by the pensioner organization Aeldre Sagen revealed the same pattern (Leeson 2004). Still, we rarely encounter discussions of the ambivalence and conflicts that may be inherent for both provider and recipient in obligatory care for a dependent old relative. Without entering a discussion of the complexities of these aspects, it appears that strict application of legal responsibility may not guarantee adequate care for dependent (old) persons. The individual family history, with emotional ties but also conflicts, may lead to abuse in situations of enforced care, as is documented both scientifically and in fiction.

As care of older people is a public responsibility in Sweden there are no legal filial obligations for family, but also no rights. If a family prefers to care for a family member, they often get little recognition and support. The underlying philosophy has been to promote maximum independence from the family and next of kin, even when support for daily living is needed. For example, if a person wants information about a spouse's illness, treatment, and prognosis, informed consent from the sick person is required. In Swedish civil law, expectations of family support exist only for spouses, although officially do not include "heavy" personal care. Persons who take care of a terminally ill family member can receive payment from the Social Insurance under the program Care Leave, which grants persons in gainful employment (under 67 years of age) the right to time off work, with compensation for up to a total of 100 days per person cared for. The compensation is about 80 percent of the income before taxes. (There is no general right to take time off work to care for family members.)

In the 1990s Sweden "rediscovered" the importance of the family in supporting older people. First was the realization that the success of a policy of home-based community care depended largely on extensive family input. Second, as a result of economic recession, there was a growing interest in the informal care sector and its potential to substitute for costly formal service provision. Third, there was increasing research evidence pointing to the crucial role of families, their care burdens, and their need for support. And, in the 1990s there was a growth of carer organizations, lobbying the authorities and seeking public recognition and support.

Cutbacks in public services have had negative repercussions on carers and have driven the "carers' movement" to increase their lobbying of local and national governments to provide easily accessible, flexible, and tailored support for carers. Policy initiatives to meet demands of carers also reflects an ambition to make support of carers an integrated part of the "aging-in-place" policy in Sweden. After several decades of neglect, of family care slowly changes.

**4.9 Local Variations in Public Services: A Threat to Equity?**

As we have seen, countries can vary as much within themselves as between one another. The same holds true for care needs and services for older people meant to address those needs. There are substantial local variations in public services (Home Help) for the elderly in all the Nordic countries. Lack of uniformity is not a new feature of public provisions for the needy. It could be seen in the 1829 inventory of poor relief (Skoglund 1992) and was recognized by the first modern government white papers on social services (SOU 1932). A failure to analyze local variations in needs and services can partly be excused by a serious shortage of the kind of data needed.

The problem has been to connect public services with needs, information on which is typically derived from surveys. A couple of Swedish studies have analyzed service variations, although using other types of data. Studies that used macro only level indicators of demography, economy, and political structure failed to explain variations (Berg et al. 1993; Trydegård 2000). When these analyses failed to find any "rational" demographical,
political, or financial explanation (at the macro level) of these local variations, it was tempting to conclude that the reason behind the local differences was local incompetence and ignorance.

Yet a recent study that used individual data disclosed that the patterns may indeed be more rational—and equitable—than previously thought. It was previously unknown that needs differ considerably between the municipalities in Sweden, needs defined as living alone and needing help. When survey data on individuals are connected with local coverage statistics it was shown that variations in service coverage vanish when local differences in needs are accounted for (Sundström and Malmberg 2005). Frail older people who live alone all receive Home Help to about the same extent (about 54 percent) wherever they live. This implies a surprising degree of equity, which cannot be inferred from "raw" variations in service coverage, as seen in a study by the author and colleagues (Davey et al. 2006). The pattern is shown in Table 4.

Municipalities providing fewer services have on average proportionally fewer old people who are frail and live alone: high-providing ones have many more old people in this predicament. The latter are typically rural municipalities with many working-class elderly in poor health. If we focus on persons in need, as in Table 4, these influences tend to vanish. Interestingly, informal care varies in the same manner as public services in these regional analyses, that is, the higher the need, the more help both from family and from the public services (Davey et al. 2006). In other words, for coverage rates to be equitable, they have to be unequal, as needs are unequally distributed in the country.

It is likely that the single-point-of-entry system of welfare in Sweden and the ancient tradition from the poor-relief era explain why social workers manage relatively well to target needy older people in their catchment areas, as they receive Home Help equally often, regardless of where they live. The rest are usually receiving the help they need from their families. As mentioned above, surveys or local outreach activities find very few older people who need help but do not get it, in general and in comparison with, for example, the United States (Shea et al. 2003).

Older people in regions with low coverage rates of public services more often are helped by their families, implying not only parallelisms but also a degree of substitutability between these sources of support. In municipalities that have low coverage of Home Help, 25 percent of older people in need have both family and Home Help to support them; in high coverage areas 36 percent (national average 30 percent). But there is also less overlap between family care and public services in these regions, probably because of stricter needs assessments that allocate support primarily to persons without family. The greater overlap of family and state in regions with greater coverage suggests that Home Help is an indirect support to carers in these regions, as more frail old people enjoy support from both; in regions with low coverage the choice is often family or state.

| Table 4. Patterns of Family and Public Support for Frail Persons 65 and Older by Coverage Rate of Public Home Help, Sweden, 2002-3 |
|---|---|---|---|---|
| Level of Municipal Support (Home Help) | Low | Moderate | High | Total |
| In need of care (%) | 21 | 27 | 31 | 27 |
| Type of care received (%) | | | | |
| Informal only | 37 | 44 | 35 | 39 |
| Home Help only | 29 | 24 | 20 | 24 |
| Both | 25 | 28 | 36 | 30 |
| Neither | 9 | 5 | 9 | 8 |
| N | 97 | 136 | 159 | 392 |

Source: after Sundström and Malmberg 2006.
* Defined as living alone and having one or more ADL impairments.
Another important aspect is the efficiency of services; are they allocated in a way that will target older people in need, or at least as many of them as possible? Most countries with reasonable rates of publicly financed services tend to provide different services for different needs, with more or less superimposition (overlap) between them. The degree of overlap affects how large a proportion of all older people are covered. A degree of substitution was already seen above in the analyses that used data at the national level.

4.10 How Efficient Is Service Allocation?

Many countries strive to make their services more efficient. Efficiency seems usually to mean not providing unnecessary help and avoiding duplication: giving the right kind of input for a specific need, but no more, and the right amount, for example, the number of Home Help hours. A general conclusion, then, is that the more different services we have, the better. The reason is of course that needs differ and also change over time. To add some crude insight into this issue, we can draw on scattered data on public service use. Efficiency here obviously is not the strict economic term but a more loosely conceived concept.

Swedish data on the overlap (superimposition) of different services capture two important aspects of efficiency, that is, how the arsenal of services is used and whether the whole panorama of services target more older people than the individual services themselves.

The most common Swedish service beyond Home Help for older persons, and often their first contact with the helping bureaucracy, is transportation services. In total some 18 percent of older people use these services, which are very extensive in Sweden. Eligible persons just call an ordinary taxi and pay the same fee as if they were taking the local bus or tram. If they are severely handicapped, there are also special vehicles that take wheelchairs. Somewhat less common are meals on wheels, alarm systems, and the like. None of these services were available in the 1970s. As sketchily indicated in Figure 2, there was no or little decline in overall coverage, if the whole panorama of services is considered. Since the culmination of Home Help and institutionalization in the 1970s, there has been a diversification of public services, in a sense responding to the diversity of needs among older people.

Regrettably there is no routine monitoring of all services, but service statistics for a single municipality—Jönköping (122,000 inhabitants)—shed some light on the issue, as shown in Table 5. We find both concrete changes and overall continuity, in the provision of different kinds of services. As it becomes very complicated to account for all variations, data are simplified into a few categories.

Targeting at large showed remarkable stability in this municipality between 1999 and 2008, but shifts took place in the kinds of services provided. The trend over time is that the heavier and more expensive services were replaced by lighter and less costly ones: institutional care by Home Help and Home Help, in turn, by transportation services, meals on wheels, alarm systems and the like. Up to about age 75-79 these "other" services are the most common ones in total, and they are more common than either Home Help or institutional care to about age 85-89. This is not to say that these services are inferior; they may even be more adequate. It may for example be better for some older persons suffering from (mainly) insecurity or dizziness to have an inexpensive alarm system than to get an infrequent visit by a Home Helper. It emerges from Table 5 that "other" support indeed is more common than Home Help and institutional care together up to about age 80, and more common than each of the latter to about age 90.

The issue of the quality of the services cannot be answered with these data, but analyses of survey data show that persons who only use these "other" services mostly have quite small needs for help and rarely express needing more (Sundström 2000). It is also worth noting that small services that reach out to many older people may be better than targeting fewer people with heavy support and giving the rest nothing (Clark, Dyer, and Horwood 1998). A small service can still be important.

Another noteworthy aspect, already mentioned, is that statistics on Home Help and institutional care—the only ones routinely available in Sweden—give a very limited representation of public support to older people. Services reach out to about double the number of recipients that we can deduce from the official statistics. It is
Table 5. Use of Public Services for Older People in the Municipality of Jönköping, November 1999 and 2008, by Age (%)

<table>
<thead>
<tr>
<th>Age</th>
<th>Any Kind Of Service</th>
<th>Home Help</th>
<th>Institutional Care</th>
<th>Only &quot;Other&quot; Service</th>
<th>No Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>65−74</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>93</td>
</tr>
<tr>
<td>75−79</td>
<td>18</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>82</td>
</tr>
<tr>
<td>80−84</td>
<td>37</td>
<td>12</td>
<td>9</td>
<td>16</td>
<td>63</td>
</tr>
<tr>
<td>85−89</td>
<td>62</td>
<td>23</td>
<td>17</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>90−94</td>
<td>80</td>
<td>27</td>
<td>34</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>95+</td>
<td>82</td>
<td>24</td>
<td>47</td>
<td>11</td>
<td>18</td>
</tr>
</tbody>
</table>

2008

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65+</td>
<td>23</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>77</td>
</tr>
<tr>
<td>80+</td>
<td>53</td>
<td>18</td>
<td>17</td>
<td>19</td>
<td>47</td>
</tr>
</tbody>
</table>

1999

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65+</td>
<td>24</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>76</td>
</tr>
<tr>
<td>80+</td>
<td>54</td>
<td>16</td>
<td>22</td>
<td>16</td>
<td>46</td>
</tr>
</tbody>
</table>

Source: Calculated on information provided in November 2008 by Pia Kopp, Jönköping municipality and in November 1999 by Anette Elver, Jönköping municipality.

Note: "Any Kind of Care" includes Institutional care, Home Help, day care, alarm system, transportation, meals on wheels, or other public service provided under the Social Service Act.

It is hard to say whether this is representative, but results from a few other Swedish municipalities and national survey data on use of these services indicate that that these patterns may be rather typical, at least for the years around 2000 (Sundström 2000).

At the national level, the only and most representative data we have for Sweden are shown in Table 6, from which it can be deduced that most users of Home Help also use transportation services, but that the opposite is not the case. The majority of persons using transportation services do not use Home Help, confirming that many of them have (so far) rather small need of support. Many, of course, have a combination of the two. In middle- and high-coverage municipalities, older people get more of both kinds of services and there is a bigger overlap of the two.

In Table 4 we saw that difference between areas with unlike regimes of coverage disappeared when we looked at family/Home Help interactions for older people in need. For the panorama in Table 6 of Home Help and transportation services, the two largest services in Sweden for older people, a good deal of the variations remain even when we look at older persons in need. Medium- and high-coverage areas do provide a higher fraction of needy older people with some kind of service than low-coverage areas, but the differences are not dramatic.

There is also a tendency to provide more older people with both services when coverage rates are higher. Transportation services are typically allocated as a first service to persons in the early stages of frailty. Therefore many of them do not use Home Help. In later stages, when they use Home Help, many of them will also have transportation services. In other words, it seems that more services do meet needs better than a few, but also that some administrations are better at discriminating between users with specific needs, implying some variations in efficiency of resource allocation.

Regions with lower coverage rates use their diversified services differently. They seem to try to target more older persons by spreading services in a more discriminating way, but still cannot reach as many. Regions with higher coverage rates tend to allocate more of their more abundant services on the same clients.

As already indicated, these analyses have touched only on quantities of services, not their quality, although
Table 6. Substitution and Complementarity in Public Services for People 65 and Older in Sweden, by Coverage Rate of Municipality, 2002-3

<table>
<thead>
<tr>
<th>Coverage Rate of Home Help Services</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>All</th>
<th>Population (1000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No service use*</td>
<td>86</td>
<td>85</td>
<td>80</td>
<td>84</td>
<td>1,190</td>
</tr>
<tr>
<td>Only Home Help</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>31</td>
</tr>
<tr>
<td>Only Transportation</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>9</td>
<td>124</td>
</tr>
<tr>
<td>Both</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>6</td>
<td>80</td>
</tr>
<tr>
<td>Sum</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>(N)</td>
<td>1,023</td>
<td>1,085</td>
<td>1,118</td>
<td>3,226</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Older Persons Who Live Alone and Need Help</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>All</th>
<th>Population (1000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No service</td>
<td>29</td>
<td>24</td>
<td>19</td>
<td>23</td>
<td>36</td>
</tr>
<tr>
<td>Only Home Help</td>
<td>16</td>
<td>12</td>
<td>14</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>Only Transportation</td>
<td>18</td>
<td>25</td>
<td>24</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>Both</td>
<td>38</td>
<td>39</td>
<td>42</td>
<td>40</td>
<td>62</td>
</tr>
<tr>
<td>Sum</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>(N)</td>
<td>97</td>
<td>136</td>
<td>159</td>
<td></td>
<td>392</td>
</tr>
</tbody>
</table>

*Neither Home Help or transportation services, but may use other services.

Some observers might feel that a large quantity (high coverage rates) is a quality in itself. We may superficially assess how well these more or less overlapping services target persons in need. As shown for a national average of older Swedes in Table 7, older persons with no kind of public help tend to be in very good health ADL-wise, and the more services they receive, the poorer their health. Closer scrutiny of the data also reveals that persons who use Home Help get more hours of help, the lower their ADL (analyses not shown). Yet about a fifth of the users found the Home Help insufficient.

5. Discussion

We are at risk of painting an overly rosy picture of Swedish social services if we are satisfied with the empirical data above. Public services need to be critically assessed as to their quality and meaning to the users and their families. The fact is that Swedish old-age care has been haunted by scandals throughout the postwar era. Many people, young and old, are quite critical of these services, although persons with parents in institutional care are less negative than others, and most old people who use them find little to complain of. It is possible that some of the critique should be seen as a sign of the health of the system. If it keeps a critical vein alive that is a good thing; in a less generous system users may have to keep silent and show gratitude, although they did not always do that even in the poor relief era, as we have seen. Still, there are few exit options in Swedish old-age care, beyond the family. In this context it should be noted that public services in Sweden are used to the same extent by citizens of all social classes, when they are in need. Less use by the upper classes is due mainly to their better health.

After stagnating public finances and continuous cutbacks of the two major services (Home Help and
Table 7. Older Persons (75 and Over) by Support and ADL Index, Sweden 2000 (%)

<table>
<thead>
<tr>
<th>Type of public support for older persons living in the community</th>
<th>ADL-Index (Average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No support</td>
<td>8.3</td>
</tr>
<tr>
<td>Only transportation service</td>
<td>7.5</td>
</tr>
<tr>
<td>Only alarm system</td>
<td>7.5</td>
</tr>
<tr>
<td>Transportation service and alarm system</td>
<td>7.2</td>
</tr>
<tr>
<td>Home Help only</td>
<td>6.9</td>
</tr>
<tr>
<td>Home Help and transportation service</td>
<td>5.8</td>
</tr>
<tr>
<td>Home Help, transportation service, and alarm system</td>
<td>5.5</td>
</tr>
<tr>
<td>Home Help, transportation service, alarm system and meals on wheels</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Note: ADL index is here defined as number of activities of daily life (ADL) a person can do without help: shopping, cooking, cleaning, laundry, dressing and undressing, getting in or out of bed, showering or bathing, toileting, going outdoors. The index can thus vary from 0 to 9. It may be mentioned that 51 percent managed all nine activities without problems.

Institutional care) in the 1990s and after, family care increased. This increase is to be expected in part because more old people today have close family, and more adults have aging parents. But increased support for aging family members is likely also to be a response to the shortage of public services. As mentioned, more old people are married and more also have children or other relatives than before. In the early 1900s nearly a quarter of the elderly had never been married and childlessness was high. Even with an unchanged propensity of caregiving this would entail more family help, everything else being equal, although we know little about the implications of increased caregiving for the carers.

There has been a diversification of services through the expansion of other services for older people. The growth in transportation services, alarm systems, and the like, has in a way offset cutbacks in Home Help and institutional care and can be interpreted as a means to save resources and raise efficiency. But other services, when used in the right way for the right clients, can also be more adequate than the rigid choice among nothing, Home Help, and institutional care. We may indeed already see early evidence of the future sketched in micro simulations of the prospects for older people in Sweden.

Rising numbers of older people in need of care, some but not all of them well off, may require reallocation of public expenditures, raised taxes, or fees for services, alone or in combination with fewer public services, more private commercial care, and more family care (Klevmarken and Lindgren 2008). Raising taxes is not a likely alternative, as the general tax level is on its way down. Although it has been as high as 55 percent of GDP, tax revenue was 48 percent of GDP in 2003, 46 percent of GDP in 2010 (OECD). Further rationing and diversification is a likelier option. Significantly, the vast expansion of services up to the mid-1970s took place with only small tax rises: high service coverage may be possible at reasonable costs.

We have in this vein observed that regions with lower coverage rates of their services use their diversified services differently and more sparingly, attempting to cover more older people with what they have. They target more older persons by spreading their graces in a more discriminating way. Regions with higher coverage rates tend to allocate more of their more abundant services on the same clients. Spreading the jam thinner also holds for overlap between family care and public services. Areas with higher coverage rates of public services have more older people who benefit from both. In the less covered regions, older people have to choose between family or state.

Swedish authorities attempt to ration services by eligibility criteria, restrictive needs assessment, or raised fees (Sundström and Tortosa Chulia 1999). This has led to a postponement of institutional care. Older people
use Home Help instead., and those who previously used Home Help make do with less costly "other" services. Paradoxically, 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.

Some local authorities in Sweden are experimenting with voucher systems that allow users—still needs-assessed by the municipality—to choose between different providers, who will all be paid for by the taxpayers (municipality, various private firms, cooperatives, etc.). Similar arrangements have been mandated since 2009 for all municipalities. It also seems that raised fees for services have kept some people from using them altogether; they find better value for money in the private market. This may often be so-called black work, untaxed work that provides no protection either for user or provider (e.g., social security benefit). Contrasting with practices on the continent, the Nordic tradition has been to support clients primarily in kind. Hence many old people receive services but very few family carers are remunerated in cash. In other words, support to carers is indirect, through some relief from what has to be done by the family or not at all. As mentioned, public services tend to provide personal care, leaving household chores to the family or others. The ancient fear that state support would lead to impoverished relations within the family seems groundless. Although family ties may appear weak at times, they have proved more viable than government programs.

An important feature of Nordic societies is the far-reaching overlap of what is done informally, mostly in the family, and what is done by public bodies. Public support is mostly seen in positive terms, although there is a constant risk of more or less benign paternalism. Opinion polls continue to show that the large majority wants the state to shoulder the responsibility in one's own old age and for one's frail parents, and indeed not just in Sweden and the other Nordic countries (Daatland and Lowenstein 2005). The administration of poor relief in the parishes created a mentality and routines for the management of care for older people, and other frail, sick, or destitute persons. This generated local identity and social cohesion. Later affluence made for a vast and important difference: today's social services provide for everybody (in principle), not just for the poor.

Acknowledgements

This manuscript is an abbreviated version of a presentation at the workshop at Hosei Institute, Tokyo January 2009. Professor Seiritsu Ogura, Hosei Institute of Aging, made my participation at the seminar in Tokyo possible, for this I am grateful. My research has been supported by a research grant to Hitotsubashi University from the Ministry of Education of Japan (grant number 18002001). Thanks also to Dolores Puga and Antonio Abellan Garcia, CSIC, Madrid; Anette Elver and Pia Kopp, municipality of Jonkoping; Svein-Olav Daatland and Katharina Herlofson, NOVA, Oslo.

Notes

1 I have used data from the early release 1 of SHARE 2004. This release is preliminary and may contain errors that will be corrected in later releases. The SHARE (Survey of Health, Aging, and Retirement in Europe) data collection has been primarily funded by the European Commission through the fifth framework program (project QLK6-CT-2001-00360 in the thematic program Quality of Life). Additional funding came from the US National Institute on Aging (U01 AG09740-13S2, P01 AG005842, P01 AG08291, P30 AG12815, Y1-A9-4553-01 and OGHA 04-064). Data collection in Austria (through the Austrian Science Fund, FWF), Belgium (through the Belgian Science Policy Office) and Switzerland (through BBW/OFES/UFES) was nationally funded. The SHARE data set is introduced in Börsch-Supan et al. (2005); methodological details are contained in Börsch-Supan and Jürges (2005). See www.share-project.org/.

2 The H70 Gerontological and Geriatric Studies in Gothenburg began in 1971. A unique population-based study of normative aging in 70-year-old populations, H70 looks at medical and cognitive measures in five birth cohorts. A
number of secular trends in mental and physical health have been described across cohorts. In addition, some cohorts have been followed longitudinally over three decades. The H70 study is coordinated by several research groups at the University of Gothenburg, including Geriatrics, Primary Health Care, Psychiatry, and Epidemiology.

References


http://www.ssb.no/emner/12/01/rapp_200621/rapp_200621.pdf.


Ministère de la Santé et des Solidarités (DREES).


Japanese Journal of Health Economics and Policy: Instructions to Authors

The Japanese Journal of Health Economics and Policy accepts articles from the subject areas of health economics and health care policy. Articles that are submitted to the Editorial Committee of the journal have to be original and, as such, should not have been published elsewhere, either in whole or in part, and should not be submitted to other journals while a decision on publication by the Editorial Committee is pending. Contributing authors should be mindful of, and strictly follow, the Guidelines set below.

1. The purposes of the journal are as follows:
   1) The development of research in the area of health economics and health care policy, with a view to this forming an academic basis for policy design and its evaluation.
   2) The provision of opportunities for scholars and other interested parties to present research results in the area of health economics and policy.
   3) The promotion of free exchange and the discussion of views, ideas, and opinions among all persons concerned with the various dimensions of health economics and health care policy.

2. Primarily, the following types of articles are accepted for publication:
   1) Research Papers: These are articles presenting detailed, original, empirical and/or theoretical research, and providing a clear statement and explanation of the objectives, method, and result of the research in question.
   2) Research Notes: These comprise small and concise notes on the original research, or articles containing new views and opinions of academic value that do not meet the standards of a research paper.
   3) Research Reports: These include reports on particular data, surveys, experiments, and other such matters, along with reports on improvements in research methodologies that can provide useful information for future research activities.
   4) Other articles that are approved by the Editorial Committee may be published.

3. Authors are subject to no restrictions with regard to their areas of research interest and expertise. The authors are not required to be members of the Institute for Health Economics and Policy and/or the Japan Health Economics Association.

4. Authors should email the main text of their articles along with the figures/tables and the abstract, and should, in addition, send a hard copy of the articles through regular mail. Articles once submitted will not be returned. Authors may express a preference as to whether their articles are to be published as a research paper, as research notes, or a research report, although author preferences regarding article type will not be binding upon the Editorial Committee.

5. Authors should follow the Writing Guidelines attached with the Authors’ Guidelines. When asked by the Editorial Committee to make revisions, authors are expected to revise their articles in full accordance with the requirements of the Committee and to resubmit their completed and revised articles. If a resubmission is not made within 90 days from the date of notification, the submission will be considered as withdrawn. However, the 90-day limit will not apply in cases where the Editorial Committee decides that there is a valid reason for the delay.

6. In the case of articles based on research that has been supported by grants, fellowships, or other such funding, authors are required to provide the names of the awarding institutions or organizations concerned, the research title, the year the grant/fellowship was received, and all other relevant information in their acknowledgements.

7. The authors must clearly indicate that all research involving human subjects was conducted in accordance with the standards set out in the Ethical Guidelines for Epidemiological Studies and Ethical Guidelines for Clinical Research.

8. In the case of research concerning the assessment of health care technology, authors are advised that the Editorial Committee may, if necessary, request information regarding possible conflicts of interest prior to the evaluation of the articles concerned.

9. Decisions regarding the acceptance of articles for publication and the designation of the type of article will be made by the Editorial Committee on the basis of the referees’ reports. Submissions that do not meet the standards for research papers may be published as research notes or research reports.

10. The Editorial Committee can comment on the papers accepted for publication if points related to research designs of the papers are made and/or opinions on paper reviews are divided. In that case, the authors will be notified of such comments.

11. Authors are advised that the Institute for Health Economics and Policy will retain the copyrights for all the works accepted for publication. The authors of the papers accepted for publication will be requested to sign a consent form for copyrights transfer.

12. There is no publication fee for the published papers. Extra copies of published papers will be provided at actual cost price upon the authors’ request.

13. Articles accepted and published as research papers will be eligible for being considered for "Association’s Paper Award" for the most valuable article of the year and the award-winning author(s) will be honored with an award certificate by Japan Health Economics Association and with an extra award by Institute for Health Economics and Policy.

14. Authors should assume principal responsibility for proofreading of the paper for language (English) related issues. Therefore, when the level of English does not meet the standard, authors may be requested to bear reasonable expenses for additional proofreading done by the Editorial Committee.

15. Articles should be sent to the following address:
   Editorial Office of the Japanese Journal of Health Economics and Policy:
   Institute for Health Economics and Policy
   No. 11 Toyo Kaiji Building 2F, 1-5-11 Nishi-shinbash, Minato-ku
   Tokyo 105-0003 Japan
   Telephone: (+81) 3-3506-8529; Fax: (+81) 3-3506-8528
   E-mail: kikanshi@ihep.jp

Revised as of April 1, 2011
"Japanese Journal of Health Economics and Policy"
Manuscript Submission and Specifications

1. Format of articles
Articles are to be submitted in the format of an A4-size Microsoft Word document file with 36 lines per page. As referee reading will be conducted anonymously, the following four items should be included on the cover page (first page), while the main text should appear from the body page (second page) onward and acknowledgements should not be included from that page onward. (1) The title of articles, the name, title and institutional affiliation of authors, acknowledgements, and the date of submission must be entered clearly on the cover page. (2) The name, title, institutional affiliation, address, telephone number, fax number and email address of authors should also be provided separately for contact purposes. (3) In the case of co-authored articles, the email address of all the authors concerned must be supplied in full. (4) Where articles are based on research that has been supported by grants, fellowships or other such funding, authors are to give the name of the awarding institutions or organizations concerned, the year of the award and all other relevant information in their acknowledgements.

2. Articles in Japanese should be no longer than 12 pages, with 40 characters per line. Articles in English should be no longer than 6,000 words, excluding the cover-page, figures/tables and abstract.

3. An abstract of about 1,000 characters in Japanese or about 400 words (double-spaced) in English should be prepared and attached to the article. Up to 10 Japanese and 10 English keywords are to be selected for article searches and listed at the end of the abstract. Keywords in English should as a rule be in lower case letters.

4. Endnotes (e.g., 'Note 1') should be placed together at the end of the main text of the article in numerical order.

5. Bibliographical references should be numbered by superscript next to the citations in the main text of articles, and the full references should be listed at the end of the main text in numerical order with all numbers clearly indicated. Up to three authors for individual works may be listed in bibliographical references, but for works with four or more authors the name of the first author only should be given and followed by 'et al.' The following specimen examples are to be taken as standard for contributing authors:

Journal articles:

Books:

Translations:

6. Figures and tables are to be numbered sequentially, with captions added and sources clearly indicated. Figures should not be entered into the main text of articles, but should rather be placed individually in separate attachments with the places for insertion indicated in the right margin of the main text.

7. Roman and Arabic numerals and letters used for outlines should as a rule be set out in the order as follows: 1. (1) a) ... .

Effective on and from 31 March 2008
## Editorial Committee

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Editor</td>
<td>Hideki Hashimoto</td>
<td>Professor, Health Economics and Epidemiology Research School of Public Health, University of Tokyo</td>
</tr>
<tr>
<td>Editorial Advisor</td>
<td>Naoki Ikekami</td>
<td>Professor and Chair, Department of Health Policy and Management, School of Medicine, Keio University</td>
</tr>
<tr>
<td>Editorial Advisor</td>
<td>Shuzo Nishimura</td>
<td>Director-General, National Institute of Population and Social Security Research</td>
</tr>
<tr>
<td>Editorial Board</td>
<td>Masako I</td>
<td>Professor, School of International and Public Policy, Hitotsubashi University</td>
</tr>
<tr>
<td>Editorial Board</td>
<td>Kohei Komamura</td>
<td>Professor, Faculty of Economics, Keio University</td>
</tr>
<tr>
<td>Editorial Board</td>
<td>Takuma Sugahara</td>
<td>Professor, Faculty of Economics, Hosei University</td>
</tr>
<tr>
<td>Editorial Board</td>
<td>Wataru Suzuki</td>
<td>Professor, Faculty of Economics, Gakushuin University</td>
</tr>
<tr>
<td>Editorial Board</td>
<td>Haruko Noguchi</td>
<td>Professor, Faculty of Political Science and Economics, Waseda University</td>
</tr>
<tr>
<td>Editorial Board</td>
<td>Chisato Hamashima</td>
<td>Section Head, Research Center for Cancer Prevention and Screening, Cancer Screening and Management Division, Cancer Screening Assessment Section, National Cancer Center</td>
</tr>
<tr>
<td>Editorial Board</td>
<td>Takashi Fukuda</td>
<td>Chief Senior Researcher, Center for Public Health Informatics National Institute of Public Health</td>
</tr>
<tr>
<td>Editorial Board</td>
<td>Fumiaki Yasukawa</td>
<td>Professor, Graduate School of Social and Cultural Science Kumamoto University</td>
</tr>
</tbody>
</table>


January 28, 2013

Editorial Office of the Japanese Journal of Health Economics and Policy:
Institute for Health Economics and Policy
No.11 Toyo-kaiji Bldg, 1-5-11, Nishi-Shinbashi, Minato-ku, Tokyo, 105-0003 Japan
Phone:+81 3-3506-8529 Facsimile:+81 3-3506-8528
URL:http://www.ihep.jp/jhea/ E-mail:kikanshi@ihep.jp

Shobnsha Co.,Ltd.
2-35-1, Eitai Koto-ku, Tokyo 135-0034, Japan
Phone:+81 3-3642-1281 Facsimile:+81 3-3643-3774
E-mail:info@shobnsha.co.jp