Reforming Long-term Care: Recent Lessons from Other Countries

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Chapter 1 Introduction

1.1 Background

During 2008 and 2009, the English Department of Health conducted a major review into the funding of, and future strategy for, adult social care (HMG, 2008). This review was in conducted in preparation for a Green Paper that was published in July 2009. The terms of reference for the review required that proposals for reform must:

- Promote independence, well-being and choice.
- Be consistent with principles of progressive universalism.
- Be affordable to taxpayers and those needing care.

The review was also tasked with considering whether funding and service delivery arrangements should be the same for everyone with care and support needs or should vary according to, for example, age or type of need.

Valuable lessons - both positive and negative - can be learned from the experiences of funding and service delivery arrangements in other countries. Evidence from other countries can, amongst other things:

- Open up for examination a range of different principles and assumptions on which funding and delivery arrangements could be based.
- Shed light on potential political and social factors that might constrain implementation.
- Identify additional measures that may be required to achieve desired policy objectives.

This paper reports on the experiences of a selected number of other countries in reforming their arrangements for funding and delivering long-term care.

Of course it is not always easy - or indeed possible - to transfer arrangements from one country or jurisdiction to another. Arrangements for social and long-term care, in particular, are often embedded in the distinctive historical, cultural and legal traditions of particular countries; reforms tend to be incremental rather than transformational (Karlsson *et al*., 2007). However, comparisons with other countries can help in identifying underlying principles and trajectories of change. Moreover, radical reforms that break with traditional institutional and cultural arrangements are also sometimes possible (Glendinning *et al*., 2004).

1.2 Aims of this study

This study aims to:

- Describe the key features of social care funding and service delivery in a small number of purposively-selected countries.
- Examine current debates and reforms in arrangements for funding and service delivery in these countries.
- Discuss the implications and lessons for reform in England.

In addressing these aims, three issues will be of particular interest. First, England is not alone in promoting greater consumer choice through cash payment or voucher mechanisms; consumerist approaches are being debated and implemented in other countries as well, sometimes alongside traditional service delivery mechanisms, sometimes as stand-alone provision. The study will therefore examine such developments and, in particular, their impacts on both formal care services and informal, family-based care.

A second area of interest is on the sustainability of current arrangements and the extent to which recent reforms have secured greater sustainability, particularly in the context of population ageing in developed and post-industrial societies. Sustainability has both political and economic dimensions. Economically sustainable arrangements must also be politically sustainable, relying as they do on public willingness to fund them. Thus one way of enhancing economic sustainability may be to engineer a shift in the balance of responsibilities from the state to the individual and family - but that shift must be politically and socially acceptable in order to become a viable option.

A third area of interest will be on the extent to which funding and service delivery arrangements apply equally to older and younger people with care and support needs. Much of the research published in English that analyses arrangements within individual countries, or that comprises cross-national overview studies, is driven by demographic pressures and therefore concentrates on long-term care for older people. However, the current English government review potentially encompasses younger disabled people as well as older people, so the study will pay particular attention to the age groups covered by arrangements in other countries.

1.3 Methods

The study focused on a small number of purposively selected countries. Criteria used to select countries included:

- Active debates and/or reforms to arrangements for funding and/or delivering social care support, particularly where these aim to enhance the longer-term sustainability of arrangements.

- Recent experiments with cash- or voucher-based approaches to social care, particularly where there is evidence of their sustainability and impact on the supply of formal and informal care provision.
- The availability of English speaking expert informants who could provide information on these issues.

Based on these criteria, and following consultation with DH, the following countries were included in the study: Germany, Netherlands, Denmark, Australia, Japan.

In this field of study, conventional academic publications - books and/or refereed journal articles in English tend to be scarce. Papers that document current policy debates, possible policy options and the details of very recent developments are in particularly scarce supply. Conventional sources of evidence therefore need to be supplemented. A recent literature search had already yielded a reasonably up-to-date set of publications on developments in and across European countries (Glendinning, forthcoming). As well as papers in refereed academic journals, the study was able to draw on other recently published material, including conference papers and presentations, other 'grey' literature, themed books and academic commentary.

The second major strategy for obtaining information involved collaboration with expert informants in each of the selected countries. These were academics or policy analysts with expertise in the funding and organisation of adult social care within their respective countries. Some had acted as informants in previous studies (Glendinning and McLaughlin, 1993; Glendinning, 1998; Glendinning *et al*., 2004). For each country informant, a list of key issues and questions was prepared. These questions were shaped by the overarching aims of the study, but were 'customised' for each country in order to fill in gaps in the available published material and cover the issues of particular interest for this study. Despite the fact that we were able to offer the expert informants a small honorarium for their time, some were restricted by other commitments in supplying detailed responses to the list of issues and questions.

These two sources of information were used to compile a short summary of the current arrangements, recent reforms and current debates about the funding and organisation of care in each country. The summary was then sent back to the expert informant so that facts, emphasis and omissions could be checked.[1]

Because of the purposive selection of countries, and the particular issues of interest within each country, the information collated from the published literature and from the expert informants was not comprehensive or consistent across countries. However, the involvement of the expert informants, particularly in checking draft accounts, provides a useful safeguard on the accuracy of this report.

[1] Because of other commitments, we were not able to check the summary with the Japanese informant.

1.4 Structure of the report

For each country, an outline of the main structural features of funding and service delivery arrangements is presented. This description provides the background for a more detailed account of current debates and reforms, actual and planned. The final chapter of the report draws out the implications and lessons for the reform of adult care and support in England.

Chapter 2 Germany

2.1 Background and context

Long-term care insurance was introduced in Germany in 1994-95. Previously, very limited public support for post-discharge care was available through the health insurance scheme; means-tested social assistance support, funded from taxation, was available for people with insufficient means to meet their care needs. The extensive reliance of older people on social assistance, particularly to fund institutional care, was considered to be stigmatising and incompatible with German citizenship. However, it was arguably the financial burden of social assistance expenditure on the German municipalities and regions (*Länder*), rather than pressures from disabled or older people, that shaped the insurance reforms (Schneider and Reyes, 2007). The introduction of long-term care insurance led to a substantial reduction in the numbers of people between 1994 and 2002 dependent on social assistance to fund their care.

2.2 Funding

Long-term care insurance cover is compulsory for the whole population; non-employed family members are covered by the head of household's contributions. Around ten per cent of employed people belong to private care insurance schemes; these are required to offer equivalent coverage, terms and benefits to the statutory scheme.

Until 2008, long-term care insurance was funded by adding a further 1.7 per cent of gross monthly payroll costs to existing social insurance contributions. Whereas other social insurance contributions are split 50:50 between employees and employers, employees pay a larger proportion of long-term care insurance contributions. The contributions of unemployed people are paid by their unemployment insurance. Until 2003 the contributions of retired people were split between their pension insurance and pensioners themselves, but from 2004 retired people have paid the entire 1.7 per cent contribution themselves. From 2005, a Federal Constitutional Court decision on equal treatment of people with and without children required childless people to contribute an additional 0.25 per cent of gross income.

In addition the *Länder* are responsible for subsidising the building and maintenance of nursing homes and meeting other care service infrastructure costs.

The overall distribution of funding from public and private resources is summarised in Table 2.1 below.

Table 2.1 Sources of funding for long-term care 2001

Source of funding	*As % of all spending*
Public funding:	70
Public LTCI	55
Private mandatory LTCI	3
Social assistance	8
Investment financing	5
Private payments for:	30
Nursing home care	23
Home care	7

Adapted from Rothgang, 2003.

2.3 Organisation and eligibility

Long-term care insurance funds are separate departments within the sickness insurance funds and are responsible for collecting contributions, determining eligibility and reimbursing domiciliary and institutional providers for services provided to eligible people.

Regional level associations of long-term care insurance funds (and municipalities as payers of social assistance) negotiate annually with associations of the organisations that provide professional domiciliary and institutional care services over contracts and prices. Federal law requires that private and charitable organisations are given preference over public providers in these negotiations, in order to stimulate market development and competition.

Eligibility and benefits are determined by the insurance principle that people requiring similar levels of help because of disability should receive equal treatment. People with care needs of all ages - including disabled children - are eligible. Eligibility is determined by a medical assessment of ‘care dependency’ - the duration and frequency of help regularly required with personal hygiene, eating, mobility and housekeeping.

2.4 Benefits

Eligible beneficiaries can opt for a cash payment (at a lower value); in kind professional services (worth nearly twice as much) or a combination of the two. Each option is paid at one of three Grades or levels, depending on the assessed level of 'care dependency' of the beneficiary. At each level of 'care dependency', benefits for people in institutional care are higher than the in kind service benefits for people at home. Beneficiaries opting for in kind service benefits can choose between the service provider organisations with whom their insurance fund has agreed the purchase of services; and can also choose the specific service interventions they wish to receive from their chosen provider.

Despite its significantly lower value, the cash payment option has always been much more popular, although there has been a small gradual increase in the number of beneficiaries opting for the in kind service option or for mixed awards of cash and services.

In addition some carers (who are not in full-time paid work and are providing 14 plus hours a week care to an insurance beneficiary living in the community) have their accident and pensions insurance contributions paid. Other insurance benefits include:

- The cost of four weeks a year substitute care so carers can have a break.
- Technical and nursing equipment for use at home and grants for home adaptations.
- Training courses for carers and retraining for ex-carers wishing to return to paid work.

2.5 Cost containment measures and growing funding pressures

The design of the German long-term care insurance scheme contains some powerful cost-containment measures:

- Levels of insurance benefits (and contributions) have fixed ceilings - they are not open-ended entitlements determined by needs. Moreover, both benefit and contributions levels are set by Federal law, requiring amending legislation to make increases in either. Consequently by the late 1990s it was estimated that the proportion of the benefits paid to the most severely 'care dependent' accounted for only half of their actual care costs (Schneekloth and Mueller, 1999).
- The care insurance funds had considerable influence in formulating the 'care dependency' guidelines which determine assessment and eligibility criteria in line with the anticipated level of the funds; again these must be approved by Federal Government. Moreover, there are suggestions that assessments may be

influenced by budget pressures (Schneider and Reyes, 2007). Thus an increase in the proportions of claimants assessed as eligible for only the lowest Grade 1 'care dependency' level benefits has been argued to reflect covert attempts to contain spending (Simon, 2003, cited in Schneider and Reyes, 2007).

- The continuing popularity of the much lower cash payment benefit option has helped to sustain high levels of informal family care-giving and keep down costs.

Consequently during the 1990s pressures on long-term care insurance were relatively small, compared with those on the health and pensions insurance schemes.

However, from the turn of the century pressure began to build from a number of factors:

- Continuing high levels of unemployment (particularly in the former East Germany) reduced the level of funds coming into the scheme; although the unemployment insurance funds and social assistance boards pay the long-term care insurance contributions of their beneficiaries, these were much lower than would have been paid by employed contributors.
- Continued expectations of population ageing added to these anxieties; the dependency ratio is expected to shift from 3:1 in 2008 to 1.6:1 in 2050, with a doubling of the number of 'care dependent' people eligible for long-term care insurance from 2.2 to 4.4 million (Beske and Witton, 2008).
- The proportion of LTCI beneficiaries receiving institutional care, and therefore higher benefit levels, increased between 1997 and 2001 from 27.9 per cent to 31.4 per cent (Simon, 2003).
- There has been a small but gradual increase in the proportion of care insurance recipients opting for all or part of their benefits in the form of the higher level in kind service option.

Consequently, although designed as a 'Pay as You Go' scheme, from 2000 long-term care insurance was in operational deficit; deficits totalled around €400 million in 2002 and €500 million in 2005. Some flexibility had been built into the scheme by the deliberate accumulation of a financial surplus in the first year (contributions were collected from January 1995 but the full range of benefits was only paid from July 1996). This financial reserve was expected to cover the deficit until 2006 (Schneider and Reyes, 2006).

Moreover, the real value of insurance benefits was eroded as the costs of professional care rose. Private purchase of services failed to fill the funding gap (Runde *et al.*, 2003, cited in Schneider and Reyes, 2006). Gaps in care therefore emerged; in 2002, 14 per cent of informal carers reported gaps in the personal care they gave, compared with eight per cent in 1991; the proportions reporting gaps in

help with household tasks also increased over the same time period, from seven per cent to 12 per cent (Schneekloth, 2006).

2.6 Options for reform

Two Commissions of Enquiry conducted by the main political parties reported in 2003. Both the Rürup and the Herzog enquiries concluded that there should be no major changes to the structure of long-term care insurance, particularly as any changes that increased the role of social assistance in funding long-term care would meet with resistance from the *Länder* and municipalities. Nevertheless, both reports recommended reducing the higher levels of in kind benefits paid to recipients in institutional care to the same level as the in kind benefits received by people living at home (Glendinning and Igl, 2009).

Other proposals for reform have included:

- The creation of a joint sickness, care and rehabilitation fund which would generate some savings (Beske and Witton, 2008).
- A parallel mandatory private insurance scheme, to build up resources for the old age care of current younger generations. The burden of contributing to both the current statutory and a new private scheme by current contributors would be alleviated by state subsidies and by increased contributions from current pensioners. Integrating the long-term care insurance and sickness insurance schemes was also advocated (Greiner and Bowles, 2007).
- Increasing incentives and support for home rather than institutional care, particularly through proportionately larger increases in benefit rates for people living at home and for people with dementia (Pick, 2007).

2.7 Interim reforms

Some interim reforms were introduced between 1995 and 2005.

- From 2004, retired people have been required to pay their long-term insurance contributions in full, rather than these being subsidised by their pension insurance fund.
- From the start the insurance eligibility criteria were criticised for their bias towards physical disability, so in 2002 amending legislation introduced additional benefits to support family carers of people with very intensive 24-hour care and supervision needs arising from dementia, in the form of:
  - Additional funding for each beneficiary to be spent on respite care.
  - Additional advice and support services for carers of older cognitively impaired people.

- From January 2005, contributions from childless adults aged 24 to 65 were increased by 0.25 per cent of gross income.

In addition, the incidence of social assistance boards reclaiming funds from the children of older claimants increased as long-term care insurance benefits were capped while actual costs rose (Glendinning and Igl, 2009).

2.8 Major reforms of 2008

The first major structural changes to long-term care insurance passed Federal Parliament in March 2008 and came into force on 1 July 2008.

- Contribution rates were raised from 1.7 per cent to 1.95 per cent of gross salary for people with children (of any age) and from 1.95 per cent to 2.2 per cent of gross salary for people without children.
- Benefits can be drawn after a minimum of two (down from five) contribution years.
- Benefit levels - both the in kind service option for people living at home and in institutions and the cash allowance - were increased, with the largest increases in the lower levels (Grades 1 and 2) in kind service option benefits for people living at home. Levels of other benefits, including the costs of four weeks respite care per annum were also increased.
- The add-on cash payment for people with dementia was also increased and eligibility for this add-on benefit relaxed so that it can be claimed even if someone with dementia does not meet criteria, the lowest level of ‘care dependency’ eligibility.
- Funding was allocated for new community care centres to provide care management/planning and advice.
- Funding for voluntary sector respite care services was increased.
- Staffing for people with dementia in nursing homes was increased.
- Respite care benefits can be claimed after six months (down from 12 months) care.
- New provisions for family carers were also introduced:
    - Unpaid care leave for up to six months (care insurance pays the carer’s pensions contributions).
    - Short notice unpaid care leave for up to ten consecutive days can be taken.
    - The pension insurance contributions paid for informal carers now also cover periods of respite care.

Perhaps the most significant feature of the reforms was that further increases in benefit levels are planned in 2010 and 2012 - unlike the previous 13 years when

benefit levels were frozen. Nevertheless it is widely expected that the long-term care insurance scheme will be in deficit once more by 2015.

2.9 Other issues

2.9.1 Market development

The design of long-term care insurance included a number of features intended to stimulate the development of a 'mixed economy' of provision and break the 'cartel' of a small number of traditional provider organisations that provided only a limited range of services. A traditional preference for family care, and therefore the continuing popularity of the cash benefit option, has arguably continued to restrict consumer pressures for a wider range of flexible formal services. For example, only a small minority of the 12,300 registered providers of community-based services offer basic support to people with dementia (though this proportion may increase as more people with dementia become eligible for insurance funding as a result of the recent reforms).

Overall, employment in social services occupations increased by 63.8 per cent between 1995 and 2000; long-term care insurance has been credited with the creation of over 200,000 jobs in social services. However, the highest increases appear in the numbers of registered hospital nurses, nursing aides and nurse practitioners. Increases in numbers of qualified homemakers and housekeepers (who provide mainly domestic help) are very small (Schneider and Reyes, 2006). Moreover, the proportion of 'care dependent' insurance beneficiaries receiving institutional care increased between 1995 and 2003, while the numbers of beneficiaries receiving formal domiciliary services remained more or less stable (Glendinning and Igl, 2009). All this suggests that the impact of long-term care insurance in stimulating new, flexible and acceptable community-based services may so far have been limited, although the slow small increase in beneficiaries opting for at least some of their benefits as in kind services indicates that this may gradually change.

2.9.2 Improving service co-ordination

Mechanisms to plan services at a municipal or *Länder* level remain embryonic, as do care management and care co-ordination services for individual disabled and older people. An experimental 'personal budget' project ran in seven regions between 2005 and 2008. This aimed to increase user choice and leverage on providers of domiciliary services, in order to increase the attractiveness of domiciliary care and reduce nursing home admission rates. Insurance beneficiaries were able to use the in kind service benefit (together with any private resources and/or social assistance

funding) more flexibly and purchase services from a wide range of providers, including those not registered with the care insurance funds (although they could not give regular payments to close relatives, nor employ ‘grey’ labour). Care managers employed by municipalities helped to assemble a personalised service package. The project was designed as an experiment, but suffered major recruitment problems; this may have reflected pressures from local home care providers. Those who did use the personal budget (largely very severely disabled working age people with physical or cognitive impairments) valued very highly the opportunities to personalise their support - often by employing individuals on a part-time basis - and the help of care managers to do this. However there was no evidence of any potential for improved cost-effectiveness. For former users of the in kind service benefit, the personal budget allowed the purchase of more hours per week of formal home care and could thus potentially improve outcomes. For former users of the cash benefit, there was a noticeable substitution of formal services for informal care, but without any impact on care outcomes. The potential of the personal budgets to crowd out informal care, paid for by the lower level cash benefit, raised major questions about the cost-effectiveness of the scheme, unless corresponding benefits for carers’ health and labour market participation can be established (Arntz and Thomsen, 2008).

Other experiments include opportunities for groups of long-term care insurance beneficiaries to pool their in kind benefit and create more flexible service options.

Chapter 3 Netherlands

3.1 Background and context

3.1.1 Funding

Funding for long-term care needs is generated through social insurance. The Algemene Wet Bijzondere Ziektekosten (AWBZ) insurance scheme covering long-term care was established in 1968 to cover previously uninsurable health costs such as nursing or residential care. It is administered by, but remains separate from, health insurance. The health insurance board sets the budget for AWBZ, subject to approval of the Minister of Health, Welfare and Sport. AWBZ covers the whole population, regardless of age, income or employment status and funds institutional, domiciliary nursing and personal care. People with physical, cognitive, developmental disabilities and long-term mental illness are all covered; 3.6 per cent of the population receive AWBZ benefits. Over time, more services have been brought under AWBZ, including home help and personal care services. However, there are active debates about the range of services that should be covered by AWBZ (see below).

Everyone with incomes over a minimum threshold contributes a percentage of income (13.45 per cent in 2005) to AWBZ through payroll tax systems. Contribution levels are set annually. Tax-payers not in employment pay their contributions through their tax assessments. Some revenue from general taxation is also contributed to the AWBZ budget. The average monthly contribution for someone on an average income is now €320. People receiving AWBZ benefits are also liable for income-related co-payments/charges for the institutional or home care services that they use.

3.1.2 Assessment

Up to 1997, assessments of eligibility for AWBZ-funded services were conducted by provider organisations, leading to allegations of ‘cream-skimming’ behaviours. Since then, assessments have been conducted by multi-disciplinary Needs Assessment Boards (RIOs). Initially these were administered by local municipalities but have subsequently been centralised through the creation of the Centre for Care Assessment (CIZ). The introduction of independent assessment procedures was also recognised as a potential tool in managing demand for AWBZ funding. Assessment reports are sent to one of 32 Regional Care Offices, which act as local administrative agents of the insurance companies and are responsible for deciding whether the claim for care is legally reimbursable. Once approved, the assessment is sent to an appropriate service provider.

3.1.3 Choice of benefits

AWBZ beneficiaries can choose which organisation provides their services (though there are often local monopolies). AWBZ benefits currently cover home nursing, personal care, day care, overnight care, respite care and residential care. Partly because of labour shortages that led to long waiting lists for services, cash personal budgets were introduced in 1995. These are very similar to English direct payments, being calculated according to the number of hours care needed, but with a standard 25 per cent reduction applied on the grounds that independent and informal care provision does not incur the same overheads as formal provider agencies. Income-related co-payments are also required, though most budget holders do not pay this but simply pay for less care than they are assessed as needing. Budget-holders constitute approximately ten per cent of all those receiving AWBZ funding for non-residential care.

Personal budgets can be used to fund home nursing and personal care in line with the needs identified at assessment. They can be used to employ close relatives, including spouses, as well as to purchase care from formal providers, but cannot be used for medical treatments or institutional care. In 2007, one third of budget holders relied only on care provided by relatives, one third only on care provided by care organisations and one third on a combination of the two (Da Roit and Le Bihan, 2008). Older people are more likely than younger budget-holders to employ relatives rather than use agency services.

3.2 Recent reforms and current debates

3.2.1 AWBZ budget - size, coverage and sustainability

Over the past decade the AWBZ scheme has been under considerable pressure. As both coverage and demand for care increased, so expenditure rose. In an effort to contain costs, the AWBZ budget was capped and set annually by central government. However this budget was not adjusted in line with demographically-driven increases in demand, resulting in delayed hospital discharges and waiting lists for services (Weiner *et al*., 2003). In 2000, 54,300 people had been assessed and were waiting for home care services, for an average of eight weeks.

In 1999, legal actions led to a ruling that the government was responsible for providing sufficient funds to purchase insured care; consequently capped budgets and waiting lists were ruled incompatible with insurance principles. AWBZ therefore became an open-ended scheme and both costs and premiums rose rapidly and substantially. In 2001 total AWBZ expenditure was €15.9 billion; by 2005 it had reached €22 billion. In 2001 the premium was 10.25 per cent of taxable income, up to a threshold of €27,050; in 2004 it was increased to 13.55 per cent of taxable income,

up to €29,543. There was little public protest at these increases, perhaps because premiums are collected along with income tax so their impact was partially obscured (Pijl and Ramakers, 2007).

A further strategy to meet the AWBZ funding shortfall was to increase co-payments for middle and higher income groups. Eligibility criteria used by the (then) RIO Needs Assessment Boards were also tightened.

Since their introduction in 1995, personal budgets have been used as a way of circumventing waiting lists for formal service provision. Initially expenditure on personal budgets was capped at three per cent of the total home care budget, in order to avoid destabilising existing provider organisations. However this cap was lifted in 2002 and by 2004 personal budgets constituted about 4.5 per cent of all AWBZ expenditure, serving ten per cent of all AWBZ users.

3.2.2 Specifying and extending the responsibilities of relatives and informal carers

In a further strategy for restricting expenditure from AWBZ, the CIZ Needs Assessment Boards have set out how much care family members could be expected to provide for each other free of charge. The concept of 'customary' or 'usual' care aimed to differentiate this from care needs that would be eligible for AWBZ funding.

> The AWBZ expects members of the same household to care for one another. For example, parents do it for their children; they raise them and care for them. The same applies if the child has a health problem. Parents have a parental caring duty. We call this 'usual care'. In the case of 'usual care' you are not eligible for care paid by the AWBZ. … When you need short-term care, in the first instance we assume that your partner will help you with daily care such as eating, drinking, washing and dressing. When the care lasts longer than three months, we call it family care. You are eligible for AWBZ care when family care (temporarily) withdraws. … As long as the family carer is willing to continue giving care on a voluntary basis, there is no necessity for professional AWBZ care. (Central Assessment Centre guidance, translated and cited in Tjadens, 2008)

In implementing this guidance, people living alone are not expected to have others who can take care of them, unless a neighbour or friend has been providing support prior to the assessment. In such cases this help would be regarded as 'customary care' and AWBZ funding would only cover any *additional* care needs. Where other household members are healthy, it is expected that they will do all domestic tasks, thus taking domestic care out of the scope of AWBZ. Partners are expected to provide all personal care for the first three months of sickness or disability; after that, personal care costs may be covered by AWBZ, depending on the partner's work and other commitments.

3.2.3 The new responsibilities of municipalities

In 2007 the Social Support Act (WMO) came into effect. This replaced previous legislation on the responsibilities of local municipalities for transport and housing adaptations for disabled people. Significantly, it also transferred responsibility for funding domestic help - which constituted about 42 per cent of the AWBZ budget for non-residential nursing and care - from AWBZ to municipalities. Funding for these responsibilities comes from central government through national taxation; these resources are not ring-fenced within municipality budgets.

The shift of responsibility for funding domestic help for disabled and older people from the social insurance AWBZ to municipalities involves a significant loss of entitlements; access to domestic help is now entirely dependent on discretionary municipal budgets. Moreover locally-devised and conducted assessments, previously only applicable to transport and home adaptations, have now been extended to cover access to domestic help. Thus local and regional variations in access arrangements may develop, reflecting individual municipal budgets and local political priorities. AWBZ-funded personal budget holders were also affected by these changes. In principle, the WMO legislation allows municipalities to offer personal budgets for domestic help. However most municipalities have concentrated on providing domestic help services in kind from contracted providers; only about a quarter of those receiving domestic help under the new WMO legislation receive this in the form of a personal budget (Tjadens, 2008).

In implementing the new WMO responsibilities in 2007, municipalities achieved savings of €200 million on domestic help, compared with the previous year's AWBZ expenditure. This saving was achieved by issuing competitive tenders for provider organisation contracts; and by shifting the focus of the contracted services from cleaning **and** care (which AWBZ-funded providers had offered) to domestic chores alone. Traditional providers were forced to tender at below-cost prices and many contracts were won by new cleaning companies.

Early evaluation of these new measures shows relatively little dissatisfaction on the part of users with the quality of the help they receive, the continuity of personnel, or the information they receive (Tjadens, 2008). However, these findings only relate to domestic help service users and exclude those assessed as being ineligible.

3.2.4 Care functions and care intensity - developing specified care packages

As part of developing a more unified approach to assessments of eligibility for AWBZ-funded help, since 2003 assessments have moved away from a focus on potential service inputs; support needs are now broken down into six functional domains:

- Personal care (for example showering, dressing, toileting, shaving, skin care, eating).
- Nursing care (for example wound care, medication, managing symptoms).
- Supportive guidance (for example organising daily activities, household management).
- Activating guidance (for example counselling and therapy).
- Treatment (for example rehabilitation).
- Living, services and treatment (for example sheltered housing or residential care).

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

From 2009 the calculation of payments for residential care from AWBZ is to be modernised through the introduction of ‘care intensity packages’. This will replace standardised tariffs based on the average cost of residential care, through which some users received more funding than they actually needed while others received less. A typical care intensity package will specify:

- The number and extent of disabilities.
- The domains in which help is needed (see above) and the number of hours per week for which help is needed in each domain.
- Desired outcomes.
- Accommodation-related needs (sheltered housing, night-time care).

Prices will then be calculated for each component of the package, within an overall envelope of budget-neutrality. Forty-five different model care intensity packages have been developed, aimed variously at residential and supported living settings, mental health care and support for people with physical, learning or sensory disabilities. These different funding packages seem likely to have adverse effects on residential care providers, particularly their ability to retain skilled staff and maintain quality services - they will only be able to offer those elements of the care package that are actually funded.

During 2009 there will also be changes to the financing of buildings and other capital assets of residential care providers. Residential care providers will no longer be protected by special ‘public interest’ accounting rules but will have to conform to open market conventions on issues like depreciation and reserves. There are fears that many care providers may go bankrupt as a result.

3.3 On-going debates

AWBZ contains some powerful cost-control mechanisms, including the options of:

- Reducing the coverage and scope of the scheme, as has already happened in relation to domestic help.
- Tightening the eligibility thresholds for each of the typical 'care intensity' packages.
- Reducing payments to providers for each of the care intensity packages, or freezing reimbursements to providers despite increases in costs or inflation.

Tightening the scope of AWBZ and moving the basis of funding from service inputs to the outputs specified through new assessment processes is expected to restrict the growth in AWBZ spending, although some continuing demographically-driven growth is still expected.

It is not clear what the combined impacts will be of the new municipal-level responsibilities and the care intensity packages on care providers and their ability to recruit and retain professional staff. Some instability among providers is anticipated as they are exposed to new market risks and increasing cost and workforce pressures. There is evidence to suggest that competitive tendering may have led to the recruitment of less skilled and more flexible labour (van Staveren, 2009). Similar anxieties arise as the result of the growth in personal budget holders, as home help services become deprofessionalised (Kremer, 2006). All these trends have implications for the quality of services, and for the responsibilities that unpaid family carers are expected to carry.

Chapter 4 Denmark

4.1 Background and context

Denmark adopted a policy of community and home-based care in the early 1980s, with the development of extensive services to support disabled and older people outside of institutional settings. Social and long-term care services are the responsibility of local municipalities, which have a statutory duty to provide home nursing, adapted and supported housing, nursing homes, 24-hour care for people in their own homes, preventive home visits for over-75s (Hendriksen and Vass, 2003), and other preventive, rehabilitation and independence-promoting activities (Platz and Brodhurst, 2001). These services are funded from a combination of local taxation and subsidies, block grants and equalisation grants from central government.

Domiciliary care (home help services providing practical assistance like cleaning and personal care such as bathing), meals-on-wheels services, home nursing and rehabilitation services are all free of charge, regardless of the number of hours care received or the income of the recipient. In nursing homes, user fees constitute only a very small proportion of all funding and are levied only on the types of services for which users would normally pay commercial charges, such as rent, laundry, hairdressing and meals.

Access to social and long-term care depends on assessment by the municipality. Typically, community health/nursing and social care services - the latter covering both personal care and domestic/practical help - are organised into wholly integrated teams. These integrated services also support people within sheltered housing and residential facilities, as well as people living in their own homes. Evaluations of integrated services show greater continuity of care and increased choice and autonomy for older people, both outside and within residential settings (Lund Pederson, 1998).

4.2 Current debates and reforms

Current reforms focus on the introduction of consumer-style choice into what has hitherto been a traditional Nordic welfare model of extensive, publicly-funded and publicly-provided services. While services are still publicly funded, since 2002 the Liberal-Conservative Government has introduced a reform programme to promote ‘free choice’ of service providers that challenges the traditional municipal monopoly. Municipalities are now required to invite private providers to bid for services and inform service users of their opportunities to choose between service providers.

4.2.1 Choice of provider in home care

In 2002, choice between service providers was introduced in relation to practical domestic assistance (housework, shopping and cleaning). Municipalities remain responsible for assessments, but have developed separate provider functions and must ensure that alternative service providers are also available, along with the public home help provider organisation. There was initial reluctance to introduce market mechanisms into the provision of more intimate personal care, but in 2003 the principle of free choice was extended to personal care services as well. Ideally both private and public providers should be able to offer both practical domestic help and personal care. However, many private providers offer only practical domestic help (see below).

During an assessment, a service user is given information about the available providers (including the public sector provider) and is asked to choose which provider s/he would like. The assessor must not assist in this choice. There is no evidence on what happens when the user is unable to make a choice, despite the frequency of this occurrence (Rostgaard, 2007).

4.2.2 Benefits of choice

Two arguments are frequently used in favour of greater choice. First, private providers are argued to be more likely to be able to guarantee continuity of carers, with the same carer (or very limited number of carers) visiting each user. However, people who choose private providers tend to be less severely disabled and need fewer visits, so it may be easier for providers to guarantee this. Secondly, private providers can offer extra practical services such as window cleaning, which municipal providers are now prevented from doing. However, these extra services are subject to user charges.

4.2.3 Coverage and take-up of new opportunities for choice

Annual figures on the take-up of private and public home help services show that, in 2007, 76 per cent of municipalities were able to offer a choice of provider in at least one area of home help services - personal care, domestic help or meals on wheels; only four per cent of municipalities were able to offer a choice of provider in all three areas. The proportion of municipalities offering a choice of provider has not increased since 2005.

Tables 4.1 and 4.2 show that there is little difference in the ages of people opting for private providers, but private providers are much less popular for the provision of personal care services than for practical domestic help.

Table 4.1 Use of private providers for practical home help (cleaning, shopping, laundry and so on) by age, 2005

	All users of private home help	*Users with opportunity to choose private practical home help*	*%*
All users	24,631	160,541	15.3
Under 65 years old	3,333	22,180	15.0
65-66	491	3,327	14.7
67-79	8,473	50,482	16.8
80+	12,334	84,552	14.6

Source: Statistics Denmark, 2005.

Table 4.2 Use of private providers for personal care (bathing, dressing and so on) by age, 2005

	Users of private personal care	*Users with opportunity to choose private personal care provider*	*%*
All users	2,805	99,116	2.8
Under 65 years old	462	12,882	3.6
65-66	56	2,001	2.8
67-79	836	27,868	3.0
80+	1,451	56,365	2.6

Source: Statistics Denmark, 2005.

One reason for the apparently lower popularity of private provision of personal care is that there are fewer providers offering this type of service, particularly in small or rural municipalities - many private firms actually offer only practical, domestic help. In Copenhagen and other urban municipalities, there are on average three private providers offering personal care, but rural municipalities have on average only 1.3 providers who are able to offer personal care services. Reasons reported by providers for this relatively low, and uneven, market development include:

- The extensive travelling involved in providing services in rural areas.
- The widespread obligation on providers to provide 24-hour personal care services - three-quarters of municipalities require private providers to offer personal care round the clock and this creates major organisational challenges for private providers in the provision of personal care.
- The requirement, by 60 per cent of municipalities, that staff providing personal care should have a basic care qualification. Seventeen per cent of municipalities also require staff working with people with particular conditions such as dementia or visual impairments to have additional qualifications.

- Low demand from service users, who prefer to receive personal care from municipal services.
- The requirement, by a quarter of municipalities, that private providers must use municipal IT systems.

4.2.4 Choice through personal budgets

Personal budgets were introduced for a limited trial period in a small number of municipalities. As with English direct payments, the user is allocated the cash equivalent of the services s/he is assessed as needing. Responsibilities for purchasing services, ensuring quality care and administering the budget rest with the user. The budget could be used to purchase municipal or privately provided services and could also be used to pay relatives for providing care. However, even where the personal budget option existed, take-up was low and users tended to be mentally able. There are no plans to extend this pilot scheme.

4.3 Outcomes of choice

4.3.1 User satisfaction

A 2007 survey of home help service users found that people using private home help services were significantly more likely than users of municipal home help services to express satisfaction with the number of care workers they saw; and slightly more likely to be satisfied with the reliability and punctuality of their home help service (SFI, 2007). However, these survey findings may partly reflect differences between the caseloads of public and private sector providers. People needing personal care are more likely to choose public sector provision; but they are also more severely impaired, require more frequent visits and are therefore more likely to experience multiple carers and problems with the timing of visits.

Overall, there has been a significant shift in public attitudes towards free choice of provider. In 2003, when free choice was extended to personal care, elderly people were relatively indifferent to this new opportunity. By 2007, free choice was ranked very high compared to other features of service quality (Rostgaard and Thorgaard, 2007).

4.3.2 The impact of choice on service integration

Earlier debates about privatising the practical and domestic elements of municipal home help services drew attention to the threats of disrupting well-integrated

community-based nursing and social care teams that were able to guarantee high levels of co-ordination and continuity of care (Lund Pederson, 1998). A second area of anxiety concerned the risks to flexibility and personalisation that could result when services were standardised and tightly specified in external contracts (Rostgaard, 2006).

Evidence on the actual impact of free choice on collaboration and integration between home nursing, personal care and domestic help is mixed. On the one hand, some private providers report difficulties in collaborating with municipal home nursing services because of communication problems and lack of flexibility (Rostgaard, 2007). Other private providers report excellent relationships with home nursing services. Some of these difficulties may reflect the relative inexperience of some newer private provider organisations.

4.3.3 The impact of greater choice on market development

The introduction of market mechanisms of user choice has had only limited impact in stimulating the development of new service providers, particularly providers who are able to provide personal care as well as domestic help. There is also no evidence that free choice has overcome shortages in the supply of care workers. Certainly private sector care workers report greater autonomy over the organisation of their daily work schedules, but they also carry more responsibility and have fewer opportunities for interacting with colleagues (Rostgaard, 2007). There is no research evidence on the quality of care or the cost-effectiveness of free choice and multiple providers.

Chapter 5 Australia

5.1 Background and context

Constitutionally, government in Australia is divided between the Commonwealth Government and the governments of the Australian States and Territories. The latter have responsibility for health care, but limited capacity to raise revenue through taxation. In contrast, the Commonwealth Government does not have capacity to provide services directly, but instead exerts a high level of centralised control over the generation and allocation of resources for social care for older people ('aged care'). The Commonwealth Government directly funds nursing home and residential hostel (care home) placements and shares responsibility with State/Territory governments for the funding of the community-based home and community care programme (HACC). Overall about 75 per cent of total resources for aged care expenditure comes from general taxation raised by Commonwealth and State/Territory governments, with the remainder from user contributions. Voluntary and third sector organisations are the main providers of both residential and community-based services.

The centralised Commonwealth Government responsibility for aged care policies has enabled costs to be successfully contained. A series of reforms introduced during the 1980s that came to be known as the Aged Care Reform Programme aimed to restrict the growth of spending on nursing homes and encourage the development of alternative home and community-based services. Specialised multi-disciplinary Aged Care Assessment Teams were introduced that had important gate-keeping functions. The expansion of community-based services was encouraged through the Home and Community Care Programme and the introduction of specialist care management initiatives. Paradoxically, despite its decentralised constitutional framework and strong traditions of a mixed economy of provision, 'central planning has been more successful than a market strategy in shaping the pattern of services' (Healy, 2002). Planning and efficiency measures thus used both supply-side and demand-side interventions, limiting the proportion of residential care beds to discourage the unnecessary use of relatively expensive institutional care facilities on the one hand; and, through assessment and advice, supporting older people who chose to remain at home wherever possible, directing them towards generally less expensive forms of home and community-based support. These measures also helped to protect the acute healthcare sector from some of the consequences of population ageing, while the leadership provided by the Commonwealth Government lent political legitimacy to public spending on services for older people.

Nevertheless, over the past decade, policy debate has focused on shifting the balance of responsibility for aged care from the state to the family and from the public

to the private sector, with a range of different measures being debated. This shift reflects the priorities of the Conservative administrations of 1996-2007.

5.2 Recent debates and reforms

The focus of reform measures under the Conservative administrations was on commercialisation and restructuring - on shaping demand, rather than supply-side planning.

5.2.1 'User pays' principles

A prominent discourse underpinning recent reforms in policy for older people ('aged care') has been that of 'user pays' principles - a market-based approach with an underlying assumption that economic efficiency can be improved by linking producers and consumers through the payment of fees and charges that transparently reflect the value of the services consumed. The 1997 Aged Care Act brought in a series of financial and regulatory changes to residential care that were intended to limit government commitments to financing aged care and increase the responsibilities of service users to pay for their own services (Fine and Chalmers, 2000). Initial plans required most users to contribute substantial lump sum entry payments on admission to nursing homes, to help fund renovations in the physical fabric of the premises; these lump sum entry payments would have been equivalent to the value of the family home. However, widespread public opposition led to the proposal being dropped and replaced by guidelines that enabled new residents to pay an increased daily fee rather than a lump sum entry payment. Increases in user charges for Home and Community Care services were also introduced and legislative changes made to allow the entry of for-profit community care service providers into a publicly-supported care market. Indeed, from 2004, contracts for the provision of HACC services have increasingly been subject to competitive tender.

5.2.2 Contesting the future affordability of aged care

A Commonwealth Government Treasury report in 2002 (Costello, 2002) argued that the future costs of an ageing population were unsustainable, with spending on aged care anticipated to grow from 0.7 per cent of GDP in 2001-02 to 1.8 per cent of GDP in 2041-42. A subsequent report of enquiry into the pricing of aged residential care (Hogan, 2004) estimated that the total costs of aged care would rise from A$8.3 billion in 2002-03 to A$107.9 billion in 2042-43, equivalent to 2.33 per cent of GDP, if current policies remained the same. However, the Commonwealth Government's contribution would rise only marginally, from 0.77 to 0.79 per cent of GDP while users' contributions would rise from 0.29 to 0.81 per cent of GDP, leaving a funding

shortfall of 0.67 per cent of GDP that would need to be covered either by increased user contributions or by increased government expenditure.

These estimates assumed the continuation of current policies, including the existing mix of services and the balance of provision between residential and domiciliary-based services. Given the estimated shortfall in funding, the Hogan report of enquiry advocated tighter means-testing of older people's incomes and other changes to increase the financial contribution of service users. The Australian Government's role would increasingly shift from ensuring universal coverage of aged care services to the provision of a residual safety net for those without the necessary income or assets. At the same time, the Hogan report argued for greater deregulation of residential care provision, allowing private market mechanisms - and particularly price incentives - to play a greater role in the supply and distribution of care.

5.2.3 Arrangements for younger disabled adults

The debates described above have focused on the costs and provision of services for older people only. Services for working age disabled adults are the responsibility of the States and Territories and are chronically under-funded. Appropriate support within the acute healthcare sector and in State disability services is often scarce or unsuitable. As a result, there is a high risk of younger disabled adults - particularly those with severe or complex support needs - being admitted to residential or nursing home facilities that are intended primarily for older people. In 2006 there were approximately 6,500 younger adults in nursing home care, including 1,000 people aged under 50.

The consequences of this shortage of services are a lack of specialist and rehabilitation interventions for younger disabled adults; social isolation; and the long-term use of beds that would otherwise be available for older people for shorter, end-of-life care. Moreover, because the nursing home beds occupied by younger disabled people are funded by the Commonwealth Government, there has been little incentive for States and Territories to reduce this pattern of service use.

In 2006, the Commonwealth Government and the States and Territories together agreed a funding package of A$244 million over five years, split equally between the two levels of government, aimed at:

- Moving disabled adults from residential aged care into more appropriate forms of accommodation.
- Diverting disabled adults at risk of admission to residential aged care facilities into more appropriate accommodation.
- Providing specialist disability support services to those adults who cannot be moved from aged residential care.

Following public pressure and support from opposition parties, a major public enquiry into the Commonwealth, State and Territory Disability Agreement was conducted during 2006 and 2007 by the Australian Senate (the upper House of the Australian Parliament). The final report of the enquiry called for a National Disability Strategy, highlighting the need for a coordinated, high level, strategic policy to address the needs of working age disabled people, their families and carers.

The new Labour government elected in November 2007 responded to this recommendation by making reform of disability services a national funding priority. Early in 2008 it ratified the UN Convention on the Rights of Disabled People and shortly afterwards promised a significant expansion of Commonwealth funding to State and Territory governments to increase support services for disabled people. The A$1.8 billion announced as the initial funding for the initiative in 2008 was intended deliver more than 24,500 additional disability places including:

- Approximately 2,300 in-home support services
- 2,300 supported accommodation places
- 9,900 individual support packages; and
- 10,000 respite places in a range of forms across Australia.

These measures constituted the first steps towards the development of a National Disability Strategy. Preliminary proposals for this were set out in a consultation paper published in 2008 (http://www.fahcsia.gov.au/disability/nds_discussion_paper/why.htm).

Chapter 6 Japan

6.1 Background and context

The pressures that lead to the introduction of a compulsory long-term care insurance programme are similar to many western countries, but may have been experienced more acutely in Japan (Campbell and Ikegami, 2003). These were:

- Population ageing - Japan is the most rapidly ageing society in the world (Izuhara, 2003); the proportion of the population aged 80-plus is expected to grow more rapidly than other industrialised countries over coming decades.
- A decline in traditional patterns of three-generation households and in family care, as women enter the workforce; the traditional responsibilities of daughters-in-law for providing care have also declined.
- Growing strains on the acute healthcare sector because of the heavy use of hospital beds to provide long-term institutional care; this care was fully funded by health insurance.

In addition, existing arrangements (based on the Gold Plans for long-term care published during the 1990s) were proving expensive and unsuitable for an anticipated major expansion in demand. Access to services was controlled by municipal welfare bureaucrats without relevant professional training who were believed to rely heavily on discretionary judgements; access was means-tested; provision varied between municipalities; and individuals had no choice of service provider (Ikegami, 2007).

In April 2000 Japan introduced a compulsory, public long-term care insurance programme (*Kaigo Hoken*). Everyone aged 40-plus pays premiums; everyone aged 65-plus is eligible for benefits, as are people aged 40-plus with age-related conditions, based on a standard assessment of disability and care needs.

6.2 Structure and funding

Municipalities are the insurers, responsible for setting premiums, overseeing services and managing finances, including responsibility for determining levels of expenditure on insurance benefits for their eligible residents. Eligibility criteria are set nationally but administered locally.

Public funding for long-term care insurance is split 50:50 between taxes (national, regional and local); and income-related premiums, which are paid by everyone aged 40-plus. The contributions of older people are deducted from their public pensions.

Those aged 40 to 64 pay a supplement to their health insurance premium; the supplementary premium is split 50:50 between employees and their employers. In addition, all those using long-term care insurance pay a standard co-payment of ten per cent of the cost of their services (excluding care management), regardless of their income level.

Setting the budget for long-term care insurance took the following factors into account:

- Prices of services remained the same.
- Widely varying levels of provision were taken into account, with higher levels of services (including domestic help) protected rather than benefits being set at a national average.
- Existing institutional care beds in nursing homes and hospitals were assumed to be available for long-term care.
- Surveys and local government figures were used to estimate the numbers likely to be eligible for long-term care insurance and actual take-up rates (Ikegami, 2007).

6.3 Eligibility and assessment

Everyone aged 65-plus is eligible, as are people aged 40-plus suffering from age-related disabilities such as stroke or Parkinson's Disease (Campbell and Ikegami, 2003). Because of concerns about variable and discretionary local decision-making under previous arrangements, the design of long-term care insurance attached great importance to the creation of transparent, uniform eligibility criteria. Factors such as income, assets or access to family care are not taken into account.

Municipal officials administer a 79-item questionnaire focusing primarily on activities of daily living; the answers are scored using a computer-based algorithm to create seven categories differentiated according to the amount of care needed. The result is reviewed by a local expert committee, alongside a report from the assessor and a doctor's report, and the final level of eligibility is confirmed. In about one-fifth of cases the computer-calculated level is altered (usually upwards) (Ikegami, 2007).

Older people receive 96 per cent of total expenditure from the long-term care insurance scheme; people aged 40-64 suffering from age-related disabilities receive only four per cent. Funding for other disabled people aged 40-65 and those under age 40 comes from workers' compensation schemes, disability pensions and universal health insurance. Services for these groups are funded from 'assistance funds', under which local government case managers calculate an individual budget and the individual can choose between providers to spend the budget.

6.4 Benefits

Long-term care insurance covers institutional care, domiciliary home help, nursing and bathing services; day care and respite care for people living at home; home equipment and adaptations; and other services such as group homes for people with dementia.

Benefits are all in the form of services, not cash. Debates prior to the introduction of long-term care insurance focused on the respective benefits and drawbacks of cash or in kind service benefits and their impact on traditional patterns of family care-giving, particularly the traditional responsibilities of daughters-in-law. Advocates of in kind service benefits argued that cash payments would inhibit demand for services and therefore the supply of services; prolong oppressive care obligations and poor quality family care; and cost more because demand for cash payments would be higher. Opposing arguments for in kind service benefits focused on the need to reduce the burden on unpaid family care givers, particularly daughters-in-law; these arguments prevailed.

The level of benefit depends on the level of assessed care need. For non-residential care, the level of benefit at each level is determined by the cost of model care plans/service packages judged appropriate for that level of care need. New for-profit and non-profit providers of community services were encouraged as a means of promoting the ‘marketisation of social care’ (Ogawa, 2001).

Almost all long-term care insurance beneficiaries have a care manager to advise on service options, draw up care plans and manage costs within the framework of the entitled benefit level. Eligible individuals can choose between any certified care management agency; these were created specifically to support the long-term care insurance scheme. Care managers receive minimal training; care manager agencies commonly also provide services - at the time long-term care insurance was implemented, there was no appropriate infrastructure for training and employing independent professional care managers.

Eligible insurance beneficiaries have a choice of service providers, but the extent of this choice varies, particularly between rural and urban localities. It is believed that greater choice has had an impact on service quality. Older people are reported to try several providers before they find one they are satisfied with and community-based providers actively compete for users; as prices are fixed by the insurance scheme, their marketing materials focus on quality. Certainly the volume of community-based services - home help and day care - has increased substantially following implementation of the scheme, and more markedly than the growth in institutional care provision.

6.5 Subsequent developments and reforms

As noted above, the budget for the long-term care insurance was calculated using estimates of eligibility and take-up. However, in the first year of operation, only half the estimated number of hospital beds were transferred to long-term care insurance, so the insurance fund had a net surplus (only ¥3.6 trillion instead of an estimated ¥4.3 trillion was spent). Expenditure was expected to increase in subsequent years to ¥5.5 trillion, as demand increased and the supply of services expanded. In fact spending rose to ¥6.8 trillion by 2005 because more people than expected were eligible for long-term care insurance - some 16 per cent of the 65-plus population against an original estimate of 12 per cent.

The design and early implementation of long-term care insurance was not accompanied by any major concerns about the longer-term cost of the scheme; little initial increase in expenditure was anticipated, over and above that already planned for through the Gold Plans. Moreover, the new insurance premium contributions immediately reduced the burden on general public expenditure. During the insurance scheme's first two years of operation, concerns focused on two issues:

- The computer algorithm used to determine the level of insurance benefit had been developed using nursing home data for people with higher levels of need; some minor revisions were made using data from community-based pilot schemes.
- Additional adjustments to the algorithm were made in response to criticisms that people with cognitive impairments were assessed as needing less care than people with physical impairments.

By the third year of the scheme, however, concerns about rising costs and anticipated increases in contribution levels came to predominate, as demand continued to increase as more people became aware of their entitlement. This concern was despite the fact that a majority of people entitled to community-based services did not take up their full entitlement. Two studies in 2002 showed that beneficiaries were using less than half the maximum amount of community-based services that they were eligible for, possibly because of the disincentive effect of the standard ten per cent copayment and/or because of cultural legacies of preferring family-based care. However, this underutilisation was not expected to continue, with beneficiaries expected to use up to 80 per cent of their entitlements by 2010 (Hiraoka, 2006).

The following measures were therefore instituted:

- Small cuts were made in 2003 and 2006 in the prices paid for services by the long-term insurance scheme.
- From October 2005, most hotel costs in nursing homes were removed from long-term care insurance coverage, leading to an increase in out-of-pocket expenses for residents. Hotel costs were originally only covered by long-term care

insurance because they had been included in the previous hospital-based, health insurance-funded provision. The new out-of-pocket charges for hotel costs were income-related, with the poorest paying no increases; and also varied according to the level of facilities (particularly single versus multi-bedded rooms).

Between 2006 and 2008, a number of changes to community-based benefits were also phased in:

- Benefits for those in the two lowest eligibility categories (those with the lowest level care needs) were restricted and replaced by preventive health promotion interventions, mainly diet and exercise programmes delivered in day centres that also offered social activities.
- Care planning was supervised and the availability of services was restricted to Local Comprehensive Care Centres run by or on behalf of municipalities.
- For people at the two lowest levels of eligibility who receive only domestic help and other support with instrumental activities of daily living, there is a new, reablement-focused emphasis on the active involvement of the user.

Together these measures have allowed only limited increases in contributions up to 2012.

6.6 Outstanding issues and debates

Long-term care insurance has been popular. While costs have increased, it has been possible to contain expenditure by restricting benefits for those at the lowest two eligibility levels. It is arguable that such restrictions would have been far more difficult to deliver within a taxation-funded system. Moreover, long-term care insurance has also helped to reduce pressures on the acute healthcare budget (Ikegami, 2008).

There is continuing pressure on available institutional care provision; waiting lists for nursing homes are growing. This is partly because criteria for admission to nursing homes for older people were loosened by the long-term care insurance - access is no longer restricted by the gatekeeping role of local government welfare offices; and partly because the availability of other types of institutional provision is also restricted by a new regional long-term care insurance planning system. Attempts have been made to meet the shortfall in institutional care through increased use of group and extra care housing, where residents must pay the full hotel costs. This has introduced new problems of equity because of the different levels of hotel costs payable for different types of facilities in different types of institutional care.

There is also continuing debate on whether domestic and other help with non-personal care should be covered by long-term care insurance. The insurance scheme algorithm was designed to ensure that people who only needed help with

instrumental activities of daily living would be included in the scheme, in order not to exclude poorer older people living alone who had previously received this lower level help. The new emphasis on reablement for people at the two lowest levels of eligibility who receive only domestic help is intended to help contain expenditure, although there is continuing uncertainty about the effectiveness of this measure in the shorter and longer terms.

A third area of debate is on the current age restrictions on eligibility for long-term care insurance and the inequity that results from these:

- People aged 40-65 with non-age-related disabilities (for example as the result of an accident) pay insurance contributions but are not eligible for benefits until they reach 65.
- Because people aged 40 to 64 are in work, they contribute double the level of premiums as those aged 65-plus but only receive four per cent of benefits. However, they are argued to benefit substantially from the increase in services and the corresponding reduction in demand for informal, family care for their older relatives.
- People aged under 40 pay taxes that fund half the long-term care insurance scheme but are not eligible for benefits.

As an increase in premiums was not a politically feasible option, in 2005 the Government attempted to extend the scheme - both contributions and benefits - to younger age groups. However this was opposed by employers because of the increased labour costs that would result from their increased contributions. Working age disabled people also expressed some anxieties about possible reductions in their current levels of services. Moreover, the logistical problems of devising equitable eligibility criteria across a very range of ages and disabling conditions are considered formidable, as would be the challenges of devising appropriate service benefits for working age as well as older people. The age restrictions on the scheme are due to be reviewed again in 2009. In any case, any changes to the current age criteria would require a major overhaul of the computer algorithm that calculates eligibility levels, which is not appropriate for younger people or people living in the community; it is possible that several different algorithms may be required, for people of different ages and living in different settings.

The role of care managers has been a continuing concern. In order to rapidly increase supply, given their crucial role in helping insurance beneficiaries manage their care, entry qualifications are low - five years experience in a related field, an exam and about four days of training. However, both the quality and morale of care managers are relatively low; vocational motivations have been eroded by a job that is dominated by accounting for service usage and calculating co-payments, and by high case loads. Programmes of training and peer support have attempted to improve

both performance and morale, although the potential conflict of interest on the part of care managers employed by service provider organisations remains.

Other debates reflect concerns about the marketisation of care - the increased opportunities for for-profit as well as non-profit agencies to provide care insurance-funded services. There is suspicion of profit motives and the introduction of what is seen as US-style marketisation policy (Ogawa, 2001).

Chapter 7 Summary and Discussion

7.1 Aims and scope of the study

This small study aimed to:

- Describe the key features of social care funding and service delivery in a small number of purposively-selected countries.
- Examine current debates and reforms in funding and service delivery.
- Discuss the implications and lessons for reform in England.

Three issues were of particular interest. First, to what extent are questions of economic and political sustainability important drivers in reforms to the social and long-term care arrangements in other countries? How are other countries addressing these pressures? To what extent do there appear to be tensions between the economic and political dimensions of sustainability?

A second area of interest was the development of market mechanisms within social and long-term care systems - in particular, the development of opportunities for users to exercise greater choice. What mechanisms - including cash payments and vouchers - are being used? What effects do they appear to have on the range, quality and costs of services and on satisfaction for users and their families?

A third area of interest was the extent to which recent reforms and debates apply equally to older and younger people with care and support needs. Given the acute demographic pressures of population ageing experienced and/or anticipated in all developed and post-industrial societies, it could be expected that funding and service delivery arrangements for older people would be prioritised in any reform programme. However, this leaves unanswered (and often unasked) the question of equity in the levels and range of publicly-funded care and support between older and younger disabled people. In contrast, the English review of care and support arrangements covers arrangements for both older and younger disabled people and this is reflected in the scope of this report.

This study has documented some of the very recent developments and on-going debates in the funding and organisation of long-term care in five very different countries. It therefore complements other published accounts, which tend to focus on major, system-wide changes.

It is not always easy obtaining up-to-date information on current developments and debates in other countries without access to policy documents and analytic commentaries in the languages of those countries. This small study has been carried out in collaboration with well-known researchers and policy analysts in the selected

countries, first to provide translated summaries of original documents; and secondly to comment on early drafts of the accounts presented here. The latter safeguard is particularly important, as it is easy in comparative research to make errors in interpretation and emphasis; a measure which may appear relatively minor within an English context, for example, may be much more significant in the arrangements of other countries.

As noted above, many analyses of policy developments in long-term care focus primarily or exclusively on older people. They also often have a regional focus, such as selected European countries or welfare regimes (for example Österle, 2001; Bettio and Plantenga, 2004; Da Roit *et al*., 2007; Pavolini and Constanzo, 2008; Glendinning, forthcoming). Within the European region in particular, the European Union has the potential to facilitate policy transfer between countries in policy areas such as health and long-term care, so this regional focus of interest is therefore understandable. In contrast, this study has included two advanced welfare systems outside Europe - Japan and Australia - where similar pressures can be detected and recent developments in funding and care provision have also taken place.

7.2 Summary of main recent developments

- **Germany** has seen the first major structural reforms of its long-term care insurance scheme since it was introduced in 1994. A growing gap between the capped insurance benefits and the actual costs of care, and deficits in the insurance funds themselves have together led to increases in both contribution and benefit levels. Measures to support family carers have also been strengthened. Further increases in benefit levels are planned; however, the insurance scheme is expected to be in deficit again by 2015.
- The **Netherlands**' social insurance scheme has also faced growing financial pressures. Contributions to the scheme and co-payments for services have been increased. Moreover, the coverage of the scheme has also been restricted, with responsibility for providing domestic help transferred to the municipalities and the responsibilities of families to support sick and disabled relatives spelt out. Changes in assessment practices and in methods of calculating payments to providers for more individually tailored service packages have also been made in an attempt to increase sustainability.
- Home help and nursing services in **Denmark** remain funded from taxation and provided by municipalities. However quasi-markets have recently been introduced; since 2002 'free choice' of service provider has been promoted, first in relation to domestic help and subsequently for personal care too. Despite initial scepticism, choice of provider has become more highly valued by users, particularly for domestic help; municipal services remain more popular for personal care.

- **Australian** reforms over the last decade have aimed to transfer substantial responsibility for funding residential care for older people from the government to individual users. Debates continue about further shifts in Commonwealth government responsibilities from universal coverage to a residual safety-net. User charges for community-based services have increased and for-profit providers have been allowed to enter a publicly-supported quasi-market. Current policy priorities focus on improving the levels and quality of support for younger disabled people, for whom services have been seriously under-funded and for whom much provision is inappropriate.
- **Japan's** long-term care insurance scheme, primarily covering older people, provides benefits only in the form of services, but with opportunities for choice between providers. Levels of demand on the scheme have increased as more eligible people apply and take up their full entitlement. Since 2000 there have been some cuts in the levels and range of benefits; these have helped to limit the size of any increases in contributions up to 2012. Current debates include whether insurance should cover domestic help; and the inequalities caused by the exclusion of most disabled under-65s from insurance benefits.

None of the countries studied has, or is considering developing for the future, private sector long-term care insurance, either as a stand-alone model or in partnership with state support to manage risks associated with longevity. Moreover, in none of the countries included in this study are individuals' assets or housing equity used to fund long-term care; Australian plans to draw on the housing equity of older people to fund nursing home care were dropped after major political opposition.

7.3 Discussion

Given the purposive selection of countries in line with interest in the unique features of established care arrangements and recent reforms in each country, it is not easy to identify common themes or trends. The following discussion therefore highlights issues which may characterise developments in only one or two countries but which are nevertheless of interest and relevance for reform in England.

7.3.1 Managing increasing demand and cost constraints

Despite major differences in institutional traditions and cultures between the five countries, all are involved in negotiating an on-going balance between the growing demand for care - primarily from growing numbers of older and very elderly people - and political and economic constraints on welfare spending. Only Australia has significantly reduced the coverage of state-funded support to medium and higher income older people through its 'user pays' policy, although this policy has attracted

widespread criticism. In contrast, the other countries included in this study have retained clear principles of universal coverage to everyone with needs for support above a given threshold, whether through social insurance schemes (Germany, Netherlands and Japan) or taxation-funded provision (Denmark). In these countries, it is the range of publicly-funded provision that has been adjusted, with practical domestic help being most likely to be removed from otherwise universal long-term care coverage. The clearest example of this strategy is the removal of domestic help and the 'customary care' expected from relatives from coverage under the Netherlands AWBZ social insurance scheme. Similarly, when faced with funding pressures Japan did not exclude less disabled older people from eligibility for its social insurance scheme. Instead it introduced a new focus on preventively-oriented reablement and health promotion interventions, particularly for community-dwelling beneficiaries opting for domestic help and also removed nursing home hotel costs from social insurance coverage.

This approach is not necessarily uncontroversial. For example, there is no evidence of the longer-term cost-effectiveness of the preventive interventions for less severely disabled Japanese social insurance beneficiaries; and the application of guidelines in the Dutch AWBZ insurance scheme on the 'customary care' provided by relatives has prompted appeals and political debate (Pijl and Ramakers, 2007). However, the approach of restricting the range of funded services has enabled both countries to maintain universal schemes in which access depends on the level of disability or need for help, rather than inability to pay. Continuing universality also characterises the Danish and German reforms - no one is excluded because of income or asset levels or, indeed, age.

A prerequisite for such strategies is a clear lead role for central government in managing overall budgets and funding for care. This strong central government role is particularly striking in Australia, where the Commonwealth Government has long been responsible for managing a single integrated funding stream, expenditure and benchmark levels of service provision for 'aged care', despite the strong traditions of State and Territory autonomy within a federal system. In other countries too, central governments or their agencies have overall control over the generation and spending of resources for care. In Germany, the recent increases in contributions and benefit levels have required Federal government legislation, while the Dutch government also exercises control over the AWBZ budget. Indeed, the marked discrepancies in the levels and quality of services for older and younger disabled people in Australia arguably reflect the long-standing control exercised by the Commonwealth Government over levels of spending and the efficiency and equity of service provision for older people; services for younger disabled people have remained the responsibility of the States and Territories. It should be noted that this strong central government role can be combined with complementary responsibilities on the part of local and regional authorities in administering assessments and regulating provision (and, in the case of Japan, actually being the insurers).

Managing expenditure in all these countries is also helped by a clear separation between the long-term care and acute health budgets, whether these are insurance or taxation-funded. Indeed, pressures on health budgets to fund long-term residential and nursing home care for older people have constituted major pressures for reform in many countries, as illustrated by the creation of separate long-term care insurance schemes in Japan and Germany. With separate funding streams, health budgets and access to health care are protected from at least some of the pressures of population ageing, while a separate long-term care budget can be managed in the ways illustrated in this study. Overall, there is strong evidence on the sustainability of a single, integrated funding stream for long-term care (Karlsson *et al*., 2004).

Of course, it is not always possible to cap the costs of long-term care systems. Population ageing is a major factor driving demand. Moreover, there is a growing disparity between the growth in productivity that is achievable in the manufacturing and consumption of physical commodities and the limited productivity gains that are achievable in human services without major compromises to quality (Baumol, 1993). Germany and Japan, in particular, have increased contributions to their respective long-term care insurance schemes; the contributions to the Dutch AWBZ scheme are already high, as is taxation in Denmark. It is possible that the political feasibility of obtaining relatively high levels of contributions from tax-payers or insurance contributors is enhanced by the principles of universality and entitlement that underpin the schemes they are paying for. Moreover, principles of progressivity can nevertheless be built into income-related contributions and into co-payments for services received. It is also arguable that the leadership role played by central governments can help to champion and legitimate high levels of spending on care and support for older and disabled people and thus secure increases in taxation or insurance contributions which might otherwise be politically unacceptable.

7.3.2 Markets and consumerism

All five countries make greater or lesser use of a range of quasi-market mechanisms within their long-term care systems. These approaches have two main objectives: to introduce competition between providers in order to drive down price and improve the quality, range and responsiveness of services; and to offer older and disabled people consumer-related choices over who provides their services and what particular mix of support they receive. Quasi-markets involve the separation of purchasers and providers, as well as measures to allow or encourage the entry of new, for-profit and non-profit organisations to compete on equal (or sometimes advantageous) terms alongside traditional service providers.

The histories of these policies vary. Australia, for example, has a long tradition of voluntary and charitable provision; recent debates have argued for yet further deregulation of residential care markets. In contrast, the introduction of ‘free choice’

has been a recent, and to some extent contentious, development in Denmark. The impacts of these initiatives also vary. It has not always been easy to stimulate new service providers, particularly in rural areas; in Japan and Denmark, users in different parts of the country experience variations in the extent to which they have a choice of service providers. Traditional preferences for family care, as in Germany, also restrict demand-side pressures for a wider range of service options. In Japan, however, there has been a marked increase in the volume of community-based services compared with institutional care, although funding incentives and the activities of care managers in advising on service options and drawing up care plans may provide additional pressures to market development.

Experiences of social care markets in which individuals receive cash to purchase their own services (as with direct payments, personal budgets and individual budgets in England) are very limited. Even in the Netherlands, cash Personal Budgets are still only used by a minority of AWBZ beneficiaries. In Germany, the insurance cash benefit option is usually used to pay informal carers; the insurance funds remain the purchasers of the in kind service benefit option, although this option has been described as a '"voucher" for approved services' (Evans Cuellar and Wiener, 2000). In all five countries included in this study, municipalities or insurance funds are the major purchasers of services and are therefore in a position to exercise considerable control over the costs and quality of the services available within local or regional markets. However, the effectiveness of these major purchasers in stimulating new, flexible and high quality service provision is not always guaranteed; formal service providers in Germany, for example have been relatively slow to respond, whereas the volume of community-based services has increased markedly following the introduction of long-term care insurance in Japan.

Care management (as in Japan) and funding based on detailed assessment of functional domains (as in Netherlands) are alternative mechanisms for creating flexible, personalised support packages. However, the care management 'personal budget' experiment in Germany was neither popular nor cost-effective.

Only in Germany and Netherlands can funding be used to pay for informal care. In Germany the continuing popularity of the cash benefit option reflects the traditional value attached to family-based care (and perhaps also the continuing unattractiveness of some formal service provision). The Dutch Personal Budget can be used to pay informal carers or purchase formal services. In both countries at least some people mix some formal service provision with some informal care and this mixed option appears to be increasing in popularity in Germany. The availability of long-term care provision in the form of cash payments also has implications for the care-giving workforce, in particular the risk of deprofessionalising existing qualified care workers (Kremer, 2006) combined with the expansion of opportunities for very low paid employment. Significantly in the German personal budget experiment, care workers who were not recruited from registered providers had to be offered

conditions of work consistent with standard part-time employment. Non-agency carers employed by Dutch Personal Budget holders must also be given basic employment rights. The use of cash payments to create more flexible, personalised support through less formal employment arrangements has major implications for the quality of care.

7.3.3 Older people or all ages?

Inevitably many of the developments reported in this study have been prompted by demographic pressures and the need to develop sustainable arrangements for funding and delivering support to growing numbers of older people. However, this does not necessarily mean that reforms are restricted to older people. The experiences of the countries included in this study indicate that it is not just feasible, but may actually be desirable, for reforms in funding and service organisation to cover both working age and older people.

Both Germany and the Netherlands' social insurance schemes cover people of all ages, including disabled children, as does municipal home help provision in Denmark. In all three countries, the principle of universality applies equally to younger and older disabled people. In contrast, the experiences of Australia and Japan suggest that difficulties may arise from the creation of long-term care funding arrangements specifically for older people. In Australia, until very recently there has been no policy leadership or funding incentives to develop appropriate services for younger people with severe disabilities. In Japan, there are questions about intergenerational equity in respect of an insurance scheme substantially funded by working age people through contributions and taxation. Younger generation contributors are argued to benefit from a reduction in the unpaid family care they would otherwise have been required to provide; moreover, challenges are anticipated in ensuring that both eligibility criteria and insurance benefits are across a wide age range. Arguably, arrangements that apply equally to younger and older disabled people may be preferable; these of course also avoid transitions for people ageing with a disability.

However, there are lessons to be learned from the experiences of Germany and Japan in designing assessments and criteria for eligibility for universal provision. In both countries, eligibility criteria based primarily on measurement of ability to perform activities of daily living have inadvertently discriminated against people with cognitive impairments who needed very extensive help and supervision but who were not physically impaired. In both countries adjustments have had to be made to eligibility criteria to ensure they are applicable to people with physical and mental impairments.

7.3.4 The role of informal care within wider long-term care policies

Sustaining informal and family care is widely regarded as essential for the overall economic sustainability of long-term care arrangements (although the role of family care in relation to some groups of younger disabled people is more contentious). The approaches of the countries included in this study vary. Japan has explicitly reduced the burdens on traditional family carers by offering services rather than cash benefits through its long-term care insurance scheme. The Netherlands has formalised - and indeed possibly increased - the responsibilities of relatives during the early months of illness or disability. Relatives are major providers of care in Germany; the long-term care insurance scheme offers respite care, leave entitlements and other social protection measures for informal carers and these have recently been increased.

Despite these variations, they nevertheless all indicate that explicit attention has been given to the roles of family carers in developing policies and practice to support older and disabled people. Only in Denmark are municipal personal care and domestic services still so extensive that few relatives are or expect to be involved in providing this care. In all countries the dual demands of sustaining informal care and maximising labour market participation are likely to become increasingly challenging.

7.4 Lessons for the reform of care and support in England

Drawing on the above discussion, the following principles for the reform of care and support in England can be suggested:

- A single, integrated funding stream for long-term care is easier to manage and sustain than multiple, fragmented funding streams. Separate funding streams for health services and long-term care also help the sustainability of both.
- Central government has a major role to play in generating and managing resources for care; setting clear eligibility criteria; and sustaining political support for an area of public spending that will come under increasing pressure over coming decades. Local government has important roles to play in conducting assessments and ensuring an appropriate range of services is available.
- Income-related insurance contributions (or hypothecated taxation) may be an acceptable, and progressive, way of raising revenue. Additional revenue can be generated from income-related co-payments. Political acceptability may be enhanced by the inclusiveness of universal schemes in which all contributors have a stake as potential beneficiaries.
- It is feasible to design systems in which older and younger disabled people enjoy the same entitlements and benefits. Age-related inequalities may be difficult to resolve subsequently. However, universal eligibility criteria need to reflect appropriately the help needed by people with cognitive impairments.

- The impact of service users as purchasers of services may have only limited effectiveness in increasing the range, volume and quality of services. Additional financial incentives such as differential reimbursement packages, voucher arrangements and the widespread involvement of proxy-purchasers such as care managers may also be needed.
- Benefits in the form of cash payments are likely to encourage or support informal care-giving, but additional social protection measures for carers are also required. Benefits in the form of cash payments may also create new difficulties in guaranteeing quality employment for carers and quality care for those who need it.

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