Summary and Conclusions

Help Wanted? Providing and Paying for Long-Term Care

1. The growing need for long-term care has significant financing and labour-market implications

Long-term care need is growing in line with population ageing…

With population ageing, no clear signs of a reduction in disability among older people, family ties becoming looser and growing female labour-market participation, it is not surprising that the need for care for frail and disabled seniors is growing.* Growth in older age cohorts is the main driver of increased demand for long-term care across OECD countries. Indeed, policy discussion around long-term care reforms is often framed in the context of pressures arising from ageing societies. The statistics speak for themselves. In 1950, less than 1% of the global population was aged over 80 years. In OECD countries, the share of those aged 80 years and over is expected to increase from 4% in 2010 to nearly 10% in 2050.

… and this will have huge effects both on financing and labour market needs

This rapid ageing of the population and societal changes will have a significant impact on both the delivery and financing of long-term care. On the one hand, they will affect the potential supply of individuals available to provide both formal and informal long-term care. The pool of potential family carers is likely to shrink because people are having to work longer and female participation in the labour market is arising. Currently, full-time equivalent nurses and personal carers represent between 1 and 2% of the total workforce. For many countries this share could more than double by 2050.

On the other hand, LTC expenditure (excluding the value of care provided by family and friends), which currently accounts for 1.5% of GDP on average across the OECD, could at least double by 2050. But this projection could well be an underestimate once due allowance is

* The primary focus of this publication is the implications of an ageing population for the labour markets and financing of LTC services. It is important to remember that younger disabled groups also need long-term care and, in some countries, LTC systems cover both target groups. This report does not address specific questions regarding equity between these two groups (*e.g.*, available resources and support for funding the care), the labour market and social integration of younger disabled, or the adequacy of services for younger disabled people.

made for risks and uncertainties. The availability of family carers is expected to decline. This could exacerbate the expected rise in LTC spending, by about 5 to 20% by 2050. With raising real incomes, people demand more responsive and quality services. In a context of declining labour supply, higher demand for LTC workers is likely to push up real wages in the sector and, as a result, push up spending beyond the baseline projections. Taken all uncertainties into account, LTC expenditure could even triple between now and 2050.

Facing up to these challenges requires a comprehensive vision of long-term care

Addressing these future challenges will be difficult but not impossible. It will require a comprehensive approach covering both policies for *informal* (family and friends) carers, and policies on the *formal* provision of LTC services and its financing. Often, policy attention focuses excessively on paid care systems. Less attention is given to the interaction with informal and private structures.

2. Paying more attention to the needs of family carers is a win-win approach

Family carers, especially women, are the backbone of any long-term care system

Whatever the LTC system of a country, most care is provided by family carers (and friends), as part of an ongoing social relationship. Across the OECD, more than one in ten adults aged over 50 provides informal (usually unpaid) help with personal care to people with functional limitations. Much of this informal care is of low intensity: just over half of carers are involved in caring activities involving less than ten hours per week. This low intensity of caring is particularly prevalent in Northern European countries and Switzerland. In contrast, in Southern Europe, the Czech Republic and Poland, more than 30% are intensive carers supplying more than 20 hours per week), raising to over 50% in Spain and over 60% in Korea. This large variation signals not only different government policies on family obligations, but also cultural and societal attitudes.

Close to two-thirds of family carers are women, typically caring for close relatives such as their parents or their spouse, but more man become carers at older ages. One in five adults aged 50 years and above suffering from one limitation of daily activities receives informal care. This proportion doubles in the case of people with two or more limitations. These data show that family carers (and friends) are the major sustaining factor behind long-term care services.

Paying more attention to family carers is a potentially win-win-win solution

Support for family carers is often provided as recognition of the fact that they perform a socially useful and difficult task. But more than a gesture is needed. While caring responsibilities should not be forced upon families and next of kin, supporting carers is an arrangement where all parties can benefit. There are at least three potential "wins" from supporting carers:

- For the care recipient, because LTC recipients prefer to be looked after by family and friends.

- For the carer, because carers provide care out of love or duty, despite the fact that they incur economic, health and social consequences as a result.
- And for the public finances, because supporting the supply of family care can help maintain the public, formal parts of the system, affordable. The estimated economic value of informal caring exceeds by far that of formal care. According to some estimates, the economic contribution of family carers in the United States could amount to USD 375 billions in 2007 (around 2.7% of GDP). Significant reductions in family caring would put public LTC systems under financial strains.

Data suggest that there is, potentially, some scope for increasing the intensity of informal caregiving. But high-intensity caregiving is associated with a reduction in labour supply for paid work, a higher risk of poverty and increased prevalence of mental health problems among family carers. For example, on average, high-intensive caring is associated with a 20% higher prevalence of mental health problems than for non-carers, reaching even 70 or 80% higher in Australia, the United States and Korea. All these considerations suggest a role for governments in supporting family carers. This, however, immediately begs the question: What should be the policies?

Cash support is one way to support carers, but the trade-offs are difficult to manage

Financial support for carers – such as allowances paid directly to carers and cash benefits paid to the care recipient – recognise and compensate carers for their effort, but targeting of support to those facing the highest health and labour market risks, and defining appropriate compensation, remains a challenge.

Carer's allowances are cash benefits providing carers income support replacing lost wages or covering expenses incurred due to caring. In the Nordic countries, the payment to carers is akin to a remuneration, offering compensation for caring efforts while representing a relatively low wage. In some English-speaking countries (Australia, Canada – Nova Scotia, Ireland, New Zealand, and United Kingdom), allowances are targeted to carers with income below a set threshold, or carers who provide a minimum amount of hours of care.

While recognising the societal value of caring, carers' allowances raise difficult design issues, for example how to fix an appropriate compensation level, which offers carers a reasonable reward without discouraging labour market participation for working carers. Means-testing and eligibility conditions, for example, may result in disincentives to work. Eligibility criteria need to be clearly spelled out, but the definition of who is the primary carer and the measurement of carer's efforts are prone to errors. Strict eligibility requirements help to avoid abuse, but can be costly to administer and be viewed as arbitrary. There are trade-offs between how many carers can be compensated, and the amount of the compensation that can be afforded by public authorities.

Paying the recipient of care has some advantages

Cash benefits paid to the care recipient offer direct support to the person who is most in need, but are not only or necessarily used to compensate carers. Such cash benefits exist in nearly all OECD countries that have public LTC benefits, with only a few countries relying solely on an *in-kind* system (Australia, Hungary, Japan and Mexico). Many provinces and

territories in Canada have well-established self-managed care schemes, providing eligible users with cash benefits to manage care delivery, including by paying family carers and friends.

Cash benefits paid to the care recipients have some advantages, because they avoid having to define who the primary carer is. Moreover, the amount of the cash benefit can be more closely related to need. But they also leave carers dependent on the care recipient for compensation of their effort and may change family ties into a relationship where money is the driving factor. Requiring family carers to be employed under formal contracts *(e.g.,* as in the case in Germany, France for relatives other than spouses) has the advantage of clearly identifying the primary carer.

Both types of financial supports have the potential to help maintain informal caring by increasing the supply of care by family, but also involve some deadweight loss, *i.e.* the state will pay for some cases that would have been provided in the absence of any financial incentive. The extent to which cash benefits are used to reward family carers is nevertheless influenced by, among others, how flexible are the conditions for utilisation of the benefit. Here, there can be trade-offs between maintaining incentives for family caring and controlling for inappropriate use of cash benefits, or for the emergence of unregulated grey labour markets *(e.g.,* Italy, Austria).

A second trade-off regards the risk of trapping family carers into low-paid roles with few incentives for participating in the labour market. In this respect, designing financial incentives for carers might be especially delicate when care needs increase or a relatively high allowance is needed to provide sufficient financial support. As most carers are aged over 45 years, it will be important to minimise incentives for pre-retirement by avoiding offering too-high replacement rates or guaranteed pension and unemployment contributions. Policy should also not encourage women's withdrawal from the labour market for caring reasons. Last, reliance on a cash-benefit system where there is little supply of formal LTC workers can discourage the emergence of formal provider markets, unless the use of the cash is regulated to discourage black or unregulated markets.

For all the reasons mentioned, financial support should not be regarded as the sole policy option to support family carers. Services are also needed. For example, cash benefits should be seen in the context of a personalised care plan, which could include basic training for the family member, work reconciliation measures, and other forms of support to carers, including respite care.

Supporting carers also involves addressing work-life balance issues through more choice and flexiblity…

While caring does not lead to reduced work hours in case of low caring responsibilities, the impact of caring increases with care intensity. A 1% increase in hours of care is associated with a reduction in the employment rate of carers by around 10%, while a 1% increase in hours of care translates, on average, into slightly more than a 1% decrease in hours of work. Care leave and flexible work arrangements help carers address the balance between workplace obligations and caring responsibilities, and so can induce the supply of both.

Two-thirds of the OECD countries for which information is available have statutory rights to leave to care for people with chronic conditions or LTC needs. Paid leave is restricted to slightly less than half of the countries, and typically limited to less than one month or to cases of terminal illness, while the amount paid is often so low that use is limited. As in the case of parental leave, it can be difficult to set the appropriate duration of care leave. Long leave may damage the labour market position of the carers, while a short leave might not be enough and could encourage workers to withdraw from the labour force.

Care leave conditions are generally restrictive relative to parental leave to care for children, which is available widely and is paid in nearly all OECD countries. Regulations also make it easier for employers to refuse care leave than for parental leave. There are reasons for this disparity. Higher predictability – in terms of timing and duration of parental leave – makes it easier for employers to manage parental leave in a stage of the employee's working life where productivity and career opportunities are growing. Still, considering the expected future growth in LTC needs and that many carers might be caught between dual caring responsibilities (for children and for old parents), there could be advantages if caring roles were better recognised.

Flexible work conditions can reflect variation in the availability of formal care and in care needs. The United Kingdom, Australia and the United States have flexible work arrangements which appear to be effective in attenuating the risk of a reduction in working hours associated with caring. While in eight out of ten OECD countries, parents can request part-time work, rights to work part-time for carers of the frail elderly exist in fewer than two-thirds of the 25 OECD countries for which information is available.

… and offering flexible support services to carers which have to go beyond respite care

Some support services, such as respite care, training and counselling, can contribute both to ensure quality of care and to improve carers' wellbeing. Besides, such policies are of prime importance because many carers – particularly siblings and partners – are becoming older themselves and possibly frailer. Although there is a dearth of evidence on cost-effectiveness, such services can be arranged for a relatively low cost, especially if leveraging upon the widespread and invaluable contribution of the voluntary sector, as is done already in some countries.

Respite care provides carers with a break from caring duties and an opportunity to get trained to care better. Often, this is the only and most prevalent form of carers' support, although there can be shortage of services as signalled by waiting lists in some countries. Most often, families are the main funders of short-term respite care, but there can be means-tested subsidies or full financial support for respite as in Denmark. A few countries provide a legal entitlement to respite of varied duration (a few days per month in Finland, 4 weeks per year in Germany and Austria). Respite is of vital importance to reduce risk of carers' burnout. Effectiveness is the highest when services are targeted to high-intensity carers or those with the highest perceived burden, those in paid employment, and for night-care respite. Flexible services or combination of services are more likely to be appropriate to adapt to diverse carers' needs. As many carers are reluctant to seek temporary respite, financial support or geographical proximity of service facilitate access to respite.

Counselling can be effective at relieving carer's stress, and carers often lament the lack of psychological support. Sweden promotes a comprehensive and integrated counselling system. In Ireland, training for family carers is available, while the Netherlands offers preventive counselling and support services. Germany provides legal rights to individual care counsellors. In the United States, a national programme organises support groups and individual counselling. However, these services tend to be hard to access, small-scale, and often unfunded.

One-stop shops for carers and their families, or arrangements that link information on public, private, and voluntary organisations, can inform carers of available services and help to plan medical and social care. Care managers, too, can be a real asset in advising carers and helping them co-ordinate services. Assessment of carers' needs, as in Australia, Sweden and the United Kingdom, is a first important step to identify carers and advise them on appropriate services. Researchers in several countries have developed various assessment tools to this end. Nurses and General Practitioners broadly can also play a key role in identifying carers' distress early and suggest appropriate remedies.

More evidence on the relative cost-effectiveness of alternative ways to support carers is needed

While addressing carers' needs requires targeted policies, it is important to maintain a focus on the recipients' care needs when targeting support. This is a practical matter – it is easier to identify the care recipient than the carer – but it will also enable the authorities to modulate support to the needs of the care recipient. Recognition that both carers and the people they care for are heterogeneous groups with different needs calls for flexibility in designing support measures, and adapting them to the individual circumstances of both the person being cared for and the carers, and over time. Co-ordination between formal and informal care systems is desirable, too. Ultimately, however, it will be vital to strengthen the evidence-base on the cost-effectiveness of policies to support carers. As the cost of support policies will likely go up in the future, evaluation of their effectiveness in mitigating the detrimental health and labour-market effects of caring will be highly valuable.

3. All OECD countries need a system providing formal LTC services

Although family carers are the backbone, all OECD countries need well-performing formal LTC systems

While family carers provide the bulk of caring services, there are limits to what they can do, especially when dependency is very severe. Over-reliance on family carers has undesirable social, health, and labour market consequences. All OECD countries need formal LTC services, including both institutional, home-based, and community services, and good partnership between formal and informal care systems. Future demands for care will put higher pressure on governments and the private sector to deliver high-performing long-term care services. Setting the public and private financing mix and organising formal workforce supply are key elements that all governments need to address. Models and approaches vary greatly.

4. LTC workforce challenges appear manageable

Long-term care is a highly labour-intensive sector with often poor working conditions

Some workers get considerable satisfaction from working in the LTC sector. However, relatively low pay and difficult working circumstances discourage many others. Turnover is high and retention is low. As a consequence, some OECD countries struggle to match growing demand for LTC workers with available supply. Shortages of LTC workers could endanger access and quality of services.

Long-term care is a highly labour-intensive sector, but the density of LTC workers (an indicator of development of LTC supply that measures the number of LTC workers per 100 people aged over 80 years) varies widely across the OECD. While the Slovak Republic has the lowest density of LTC workers per 100 people aged 80 or over (slightly over 0.5), Norway, Sweden and the United States have the highest densities (over 3.5 per 100). Between 27% (Switzerland) and 82% (Korea) of LTC workers work in home care. Not surprisingly, density ratios are higher in institutional settings than in home care. Worker density in residential care varies from 0.1 full-time-equivalent (FTE) worker per care recipients in the Slovak Republic, to 0.8 in New Zealand.

The share of qualified nurses working in the sector varies greatly across countries. LTC workers are predominantly women (90% of all LTC workers), and many are relatively old. Typically, the required qualifications are fairly low, and lower in home care than in institutional settings. In some counties, however, qualified personnel accounts for a major part of the personnel employed in the sector, such as in Germany. There is no clear skill mix. Between 16% (Japan) and 85% (Hungary) of all LTC workers are nurses, but in most countries fewer than half the LTC workers are nurses. The average age of care workers tends to be relatively high in most OECD countries. More than half of the Australian care workers enter the LTC workforce after the age of 40, and one in ten enter after the age of 50.

For low-qualified care workers, entering an LTC job – especially in home-care settings – does not require high credentials, but difficult working conditions and low pay often generate high turnover among workers. High turnover contributes to producing a negative image of LTC, and endangers both access to, and quality of, services.

Turnover and shortages of nurses in the LTC sector are high, too, and may have negative outcomes for heath and quality of life of LTC users. Working conditions and benefits for nurses in LTC settings are generally poorer than in acute care.

Achieving an adequate supply of LTC workers is a manageable challenge

Even if the supply of family carers remains large and the economic downturn has eased labour market tightness in some countries, demand for LTC workers is growing across the OECD, and many countries are already struggling to meet the challenge. Projected declines in the working age population due to population ageing will add to the challenge. Nevertheless, an adequate supply of LTC workers is a manageable goal. This will require a

multipronged approach, as well as better evaluation of success stories and encouraging examples. Countries will need to use the following strategies:

- improving recruitment efforts, including through the migration of LTC workers, in some OECD countries, and the extension of recruitment pools of workers;
- increasing the retention of successfully recruited LTC workers, by improving the pay and working conditions of the LTC workforce; and
- seeking options to increase the productivity of LTC workers.

Migrant LTC workers reach destination countries through a variety of channels; improvements in migrant care workers' jobs quality are desirable

The presence of foreign-born workers in the LTC sector is uneven across the OECD. While Japan has very few foreign-born care workers, in the United States nearly one in every four direct care worker is foreign-born. Italy and Israel have an overrepresentation of foreign-born LTC workers compared with other low-skilled sectors in the economy. Demand keeps growing. Between 2008 and 2009, over half of the 6% increase in residential-care employment in the European Union was accounted for by foreign-born workers. In the United States, the social-assistance sectors have experienced the fourth largest growth in foreign-born workers over the period 2007-09.

Although most OECD countries have restricted managed-migration programmes for low-skilled workers, there are many immigrant low-skilled LTC workers in the OECD area. Migrant care workers reach destination countries through diverse channels. In Sweden, Spain, Portugal and Italy, some care workers may migrate under general regimes (often subject to a labour-market test). Canada, Israel, Germany, Italy, the United Kingdom and France have specific programmes, visa, regularisation measures, exemptions, or bilateral agreements targeting migrant care workers. In addition to free movements of labour across EU member states, irregular migrants in some EU countries such as Italy and Austria have entered the LTC sector via unmanaged migration channels, such as via overstay or illegal border crossing. Finally, some migrant carers arrive under family reunification schemes.

The diversity of channels and labour market conditions of migrant LTC workers makes it difficult to draw generalisations regarding the phenomenon. Nevertheless, it is possible to identify some specific challenges. First, in light of the growing inflows of LTC workers in some countries, the absence of specific reference in labour migration programmes to the labour needs of the LTC sector is conspicuous. Where irregular care migrants are numerous and growing, the question of adequacy of official migration channels to match supply with demand for care workers arises. Using agencies to match demand for workers with supply can create new problems, such as high agency rents and oversight of agency practices.

Although many LTC workers experience poor work conditions, there can be specific issues linked to job conditions for migrants. Where job quality is lower than for native-born in similar jobs, improving labour market conditions for migrants seems a priority. Training strategies, including language training, can help improving integration and labour market outcomes. Finally, over the longer term, dependence on migrant LTC workers to fill domestic "shortages" can signal inadequacy of domestic recruitment and retention policies, and raise equity concerns about the impact on sending countries.

Broadening recruitment pools can be a successful strategy but numbers reached tend to be small and evidence on outcomes poor

Measures to expand recruitments pools for LTC workers, including both existing workforce pools and new potential pools, have met with mixed success. Germany and the United States have measures seeking to encourage young people into LTC training and jobs. Economic incentives directed to LTC workers have been employed in several countries, such as financial support for re-training workers for LTC jobs in Germany, and bonuses for nurses going into LTC in Australia. Efforts to re-hire LTC workers who had exited the LTC sector exist in Germany, the Netherlands and Australia. Other countries have re-activation measures targeting long-term unemployed and those economically inactive *(e.g.,* Japan, New Zealand, Finland, the Netherlands and the United Kingdom).

There is generally little evidence on long-term cost and effects of policies aimed at increasing entry and retention from new target groups. But, where it exists, evidence suggests that such recruitment efforts have had mixed outcomes or, where successful, only concerned relatively few people. In addition, re-activation measures have often targeted work in itself, rather than work in the LTC sector, without lasting improvement in job retention in the sector.

Valuing the LTC workforce will have positive spin offs on retention and recruitment; this requires emphasis on improving working conditions

No strategy to develop new recruitment pools or make better use of existing pools will be successful if job retention and job quality is poor. Mass exit of LTC workers reduces returns on investment in recruitment and training, and depresses quality of care. Unattractive work conditions lead more workers to quit which, in turn, further increases the work burden and stress on those who remain – a vicious spiral. In the United States, turnover costs have been calculated to be at least USD 2 500 per vacancy. Measures to keep the workforce in place are therefore of utmost importance.

Investing in higher remuneration and benefits, better working conditions, training opportunities, more responsibilities on-the-job, feedback support and supervision, have all been found to be important ingredients of a successful LTC job attraction and retention strategy. Health and safety concerns are another area of paramount concern, and possibly one more difficult to manage in home-care settings, a consideration that also applies to reducing work pressure and improvement in management.

Training can be a route to upgrading the status of LTC work as a profession. Most OECD countries do not have compulsory training or qualification requirements for care workers, although many have locally organised or nationally-set training schemes for LTC workers. There is little proof of nurses in training being prepared for a potential career in LTC (*i.e.,* gerontology knowledge, managerial skills, and internships). LTC managers should be trained in leadership skills.

There is evidence of good results from measures aimed at upgrading LTC work. Dutch and German LTC-workers' retention rates, for example, are higher than in the United States and the United Kingdom, as workers in the former countries appear to be more satisfied

with their working conditions and responsibilities. Sweden, Denmark and Norway also appear to be success stories on this front. The introduction in Germany of elderly care nurses led to a redesign of tasks and responsibilities for nurses, with a positive impact on attractiveness of the sector for nurses. This suggests the importance of specific measures to improve career opportunities for nurses working in LTC and upgrade their skills.

The flip side of the coin is that by "professionalising" a still relatively easy-to-enter sector, it may raise entry barriers in the future, increasing rigidity in a sector that is regarded by workers as being highly flexible. These measures require investment of resources, too. Countries which have in place relatively good benefit packages for LTC workers, such as Denmark and Belgium, have relative high public spending on LTC. But attaching importance to LTC jobs as a "profession" brings tangible payoffs. The Netherlands and Japan, which have put emphasis on creating a "LTC profession", have been successful at creating a large LTC workforce. Public awareness initiatives to raise public perception on the image of LTC work could contribute to better recognition for the workforce, and, ultimately, better retention.

But there is still a dearth of evidence on successful productivity-enhancement measures

Unlike other service industries, evidence on productivity improvements in LTC labour markets remains sparse. A first issue regards the difficulties in defining productivity in the sector, and, particularly, the appropriate measure of outputs or outcomes with which to compare labour input indicators. Concerns about potential trade-offs between productivity and quality have delayed or hampered initiatives to substitute capital for labour or optimise the intensity of labour supply in the sector. The main avenue for improving care workers' productivity has been from reorganisation of work processes, the use of ICT to reduce bureaucracy and indirect workload, and the delegation to nursing assistants of tasks that were previously the responsibility of nurses.

5. Moving towards universal LTC benefits is desirable irrespective of financing model

There are equity and efficiency rationales for moving towards universal LTC benefits

On fairness and efficiency grounds, a majority of OECD governments have set up collectively financed schemes for personal and nursing-care costs. Many are also moving towards universal entitlement to coverage of long-term care costs.

Only a few low-income OECD countries rely entirely on family or informal arrangements for coverage of LTC costs. In the others, public LTC coverage can be grouped into three models, largely reflecting the eligibility criteria they apply. One third of the countries have *universal coverage within a single programme*, either as part of a tax-funded social-care system, as in Nordic countries (LTC spending between 2 and 3.6% of GDP), or through dedicated social insurance schemes, as in Germany, Japan, Korea, Netherlands and Luxembourg (LTC spending ranging from 0.3% of GDP in Korea to 3.5% in the Netherlands), or by arranging for LTC coverage mostly within the health system (Belgium). While not having a dedicated "LTC system", a large number of countries have *universal personal-care*

benefits, whether in cash *(e.g.,* Austria, France, Italy) or in kind *(e.g.,* Australia, New Zealand). Financing of personal care in the second group of countries is fragmented across different schemes and mechanisms. In some of these cases, only a component of the care cost is provided universally, or else care is supported only if it is received in certain settings. In most such countries, benefit levels are closely linked to ability to pay. Finally, two countries have *safety-net, means-tested schemes* for long-term care costs, namely the United Kingdom (excluding Scotland) and the United States.

Uncertainly about whether, when, and for how long an individual might need long-term care services suggests that pooling the financial risk associated with long-term care is a more efficient solution than relying solely on private out-of-pocket payments. Otherwise, the cost of long-term care services and support can rapidly become unaffordable, and not only for low-income seniors. Average LTC expenditure can represent as much as 60% of disposable income for all but those in the upper quintile of the income distribution. The oldest old and those with severest care needs are especially at risk. Hence, universal LTC benefits are better able to ensure high and equitable access to care than means-tested entitlements or social-assistance type programmes – though at a cost. Over the years, there has indeed been a convergence towards providing such a "basic universal floor" in many OECD countries (though how broad and comprehensive is the "basic floor" depends on the financial position and priorities of each country).

Even in universal systems, it is desirable to target care benefits where needs are the highest

LTC costs can be impoverishing for moderately and severely disabled LTC users, even for those who were not poor before the onset of disability. However, many low-need recipients face relatively affordable long-term care expenses, and some LTC users are income and/or asset rich. This means that universality of entitlement to LTC coverage does not exclude targeting of personal-care benefits to those with highest needs. In fact, in light of the expected growth in age-related spending, *targeted universalism* has the potential to provide fair protection in a fiscally sustainable manner. Such an approach involves some sort of collective provision of support for those with high needs, combined with support for those with low needs which reflects the individual's ability to pay.

A number of countries seem to be moving towards such "targeted universalism", albeit at very different rates and from different starting points. Such an approach requires countries to carefully balance three features of LTC coverage schemes:

- setting the need-level triggering entitlement to coverage;
- the breadth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and
- the depth of coverage, that is, setting the types of services included into the coverage.

Even within universal LTC schemes, stringent assessment criteria can be in place, as is the case in Korea and Germany, for example, relative to Japan. Some countries target LTC coverage only to the oldest segment of the population. Over the years, there have been efforts to target benefits to those with highest care needs in Sweden or the Netherlands, while Japan moved low-need users to a prevention system in 2006.

Universality of entitlements does *not* mean that all LTC should be free. In fact, all countries have user cost-sharing for LTC, although the extent varies significantly across the OECD. For example, in France a LTC cash benefit pays up to EUR 1 235 per month for a high-need/low-income user, down to EUR 27 for higher-income users, while in Sweden there is a cap for cost-sharing on home-help services of EUR 180 per month. While administratively more burdensome, paying higher benefits to low-income dependents as in France, Austria and Australia is a possible way of ensuring access to care for those who need it without excessive public expenditures. (As discussed below, there is also a strong rationale for charging care recipients for the cost of board and lodging in nursing homes.)

Targeting of the benefit package or setting a basic basket of services that all LTC users need can be trickier. On cost-control grounds, it could be argued that support for domestic care and help with so-called instrumental activities of daily living (IADL) such as shopping, cleaning or administrative tasks should not be included in a basic package. And indeed, in-kind benefits in Korea and New Zealand focus on support for daily living activities (ADL), while the Netherlands moved IADL services for people with small limitations out of LTC insurance into a separate budgeted system in 2009. In practice, however, the distinction between personal and domestic help can be difficult to make, especially where services are jointly provided to high-care-need users. Furthermore, restricting coverage to ADL services gives people an incentive to argue that they have greater needs than they actually do, so as to get access to the higher levels of support. Coverage of support for some IADL activities, as in Sweden, Denmark, Germany and Luxembourg, is reported to have helped to prevent dependent people with relatively high care needs from moving to even more expensive care settings.

Maintaining flexibility to adjust benefit coverage to changing care needs is desirable on both adequacy and quality grounds. For example, Germany and some other OECD countries extended their basket of services to include an extra benefit for those with cognitive diseases. The use of cash benefits provides users with flexibility and can recognise each individual's unique circumstances. An increasing number of OECD countries – the Netherlands, Austria, Germany, France, Italy and the United Kingdom as well as many central and eastern European countries – provide cash entitlements for care.

It is unrealistic for governments to shoulder all hotel costs of institutional care, but they can help mobilisation of cash to pay for such costs

Board and lodging (B&L) can be very expensive – twice or three times as large as personal-care and nursing costs taken together. In some Nordic countries, payments to cover B&L costs are income or asset-related, while assistance in United States, United Kingdom, Belgium, France, and Germany is targeted to low-income people through welfare or housing-subsidy programmes. Japan has flat-rate payments for this cost component, which are nevertheless lowered for low-income people.

Reasons for asking individuals to contribute towards their B&L costs go beyond governments' affordability considerations. All individuals should be required to pay at least for a minimum for their food and shelter-related expenses, regardless of their dwelling, and it can be expected that some food and shelter expenses are met by running down accumulated savings and personal wealth, regardless of where a LTC user lives. Moreover, full coverage of B&L could give incentives for LTC users to prefer institutionalisation over receiving care at home.

Including assets in the means-test used to determine individual cost-sharing (or entitlement to public support) for B&L costs better reflects the distribution of economic welfare among individuals. But it can be more cumbersome to administer and act as a disincentive to individual savings. No matter the level of B&L fees, transparency in the way fees are calculated is necessary for fairness and user acceptability.

Home ownership can provide avenues to help users mobilise cash to pay for the cost of food and shelter associated with residing in nursing homes. Possible mechanisms already used in some OECD countries are:

- Bonds/equity release and similar interest-free loan schemes *(e.g.,* Australia). They can foster a sense of ownership towards the LTC residence.
- Public measures to defer payment of nursing-home costs *(e.g.,* Ireland, some local councils in the United Kingdom), or exclude the value of houses from asset-tests *(e.g.,* United States).
- Private-sector products, such reverse-mortgage schemes and combination of life and LTC insurance policies. These facilitate decisions about having to sell the house.

Different approaches to raise finances for long-term care are possible, but to address future cost pressures, a forward-looking set of policies and innovation in financing models are desirable

OECD countries rely on different approaches to raise funds to pay for LTC coverage. These often reflect differences in how health care is financed – countries with tax-funded or social-insurance-based health coverage follow similar arrangements for financing LTC costs.

Regardless of the preferred financing model, LTC financing schemes often have too-short a time frame. Benefits or co-payments are adjusted to reflect current resource constraints, rather than making a strategic decision on the appropriate balance between collective and private responsibilities.

Issues that countries need to be considering to prepare for the increased demands for help with LTC costs in the future include:

- *Tax-broadening*, which means financing beyond revenues earned by the working-age population. Japan, the Netherlands, Belgium and Luxembourg complement payroll contributions with alternative revenues sources.
- *Better pooling across generations*, which implies avoiding unduly charging (dwindling) young population cohorts to pay for LTC costs of a growing cohort of old people. For example, in Japan LTC premia are levied on those aged 40 years and over. In Germany, not only the working-age population but also retirees are required to contribute premia to social LTC insurance, based on their pension.
- *Pre-funding elements*, which implies setting aside some funds to pay for future obligations. All social LTC insurances are financed on a pay-as-you-go basis. While a fully-funded system may not be justifiable given the uncertainty surrounding future LTC needs, demographic forecasts indicate a possible role for some pre-funding. Private compulsory LTC insurance in Germany includes some pre-funding elements. The Singapore Eldercare Programme is, in principle, fully-funded. In tax-funded LTC schemes, this would mean building a favourable fiscal position through lower debt-to-GDP ratios.

- *Innovative approaches*. New innovative schemes involving public-private partnership or voluntary funding schemes based on automatic enrolment with opting-out options are being implemented in the United States (the so-called Class Act) and have been established in Singapore. These initiatives borrow features of both public and private insurance, although the voluntary nature of enrolment remains a challenge to manage.

Private LTC insurance has a potential role to play in some countries but unless made compulsory will likely remain a niche market

The market for private long-term care insurance is small in most OECD countries. Even in the United States and France, where coverage is the broadest, less than 10% of the population aged 40 years and over holds private LTC insurance. With the exception of the United States and Germany, in most OECD countries less than 2% of total LTC expenditure is financed through private LTC insurance. The group market is large in France where it represents nearly half of the market; it is 30% of the total in the United States.

Even in countries with a relatively high share of private LTC financing, insurance market failures and consumers' lack of forward planning limit the role of private insurance in the LTC sector, regardless of whether it plays a primary or complementary role. Public initiatives to broaden access to voluntary private LTC insurance, such as preferential tax treatment, targeted regulation or public-private partnerships have met with limited success, as shown by the experience of the United States.

To broaden access, private providers have simplified insurance products (*e.g.*, move towards policies providing a fixed cash benefits) and introduced hybrid financial products such the combination of life and LTC insurance coverage. In France, for example, some 150 000 individuals (about 5% of the market) hold a long-term care insurance coverage as part of their life insurance policies.

6. With growing cost pressure, seeking better value for money in long-term care is a priority

Growth in demand for more and better care will put pressure on governments to improve value for money in long-term care

While long-term care still accounts for a relatively small share of GDP compared with other ageing-related expenditures such as pensions and health, it is projected to experience a faster relative increase over the next decades.

Efficiency discussions in long-term care have received relatively little attention compared with, for example, health care. Yet, in a context where the other large age-related spending items (pensions and health) are also expected to grow, it will be difficult to sustain expansion in long-term care services without proof that high value for money is delivered. Evidence on what works best remains scarse. There is a therefore strong need for focusing policy attention on the efficiency gaps in the sector. International research and collaboration on value for money and the development of measures or indicators of efficiency in LTC deserve much priority.

Encouraging home care is desirable for users but in certain conditions institutional care is more cost-effective

How to balance home and institutional care settings is at the core of long-term care policy initiatives in nearly all OECD countries. In 2008, institutional care accounted for 62% of total LTC costs across OECD countries, while on average only 33% of LTC users received care in institutions. Both utilisation and cost of institutional care are set to rise with growth in cases and the average severity of disability of institutional care recipients. Meanwhile, in many cases, LTC users prefer home-based solutions.

Developing alternatives to institutional care can partly compensate for cost growth, and respond to users' wishes to remain in their home. To do so, several approaches have been followed – ranging from direct expansion of home-care supply *(e.g.,* Canada, Ireland, Japan, New Zealand, Sweden, and Poland); to new legislative frameworks encouraging home care *(e.g.,* Australia, Sweden) and regulation controlling admissions to institutional care *(e.g.,* Finland and the Czech Republic); or the establishment of additional payments, cash benefits or financial incentives to encourage home care *(e.g.,* Austria, Germany, Japan, the Netherlands, Sweden, the United Kingdom and the United States).

The share of over 65-year-old LTC users receiving care at home has increased in many countries in the past few years, but several challenges remain. A market for home care providers may be missing or the supply of home care inadequate. Care organisation and co-ordination can be endangered where different home-care providers visit the same user. Information-support systems to support the choice of home-care providers by users are well-developed in, for example, Nordic countries, but less so in some other countries.

Questions about the appropriateness or cost-effectiveness of home care for high-need users requiring round-the-clock care and supervision remain, and for users residing in remote areas with limited home-care support. There is scope for government to monitor and evaluate alternative services, including incentives for use of alternative settings. LTC users can be supported to make appropriate choices and assessment of individual needs linked to available care-provider options.

Few countries have looked for ways to improve productivity in the LTC sector

Despite hopes to improve productivity in long-term care – that is producing more and better care for a given cost – the evidence gap on what works and under what conditions is still large. According to OECD projections, productivity gains could bring a decrease of about 10% in projected public LTC expenditure, relative to the pure demographic scenario. In practice, however, there is hardly any measurement of productivity in long-term care, partly becomes of difficulties in measuring outcomes. Initiatives to measure and enhance LTC productivity are still in their infancy.

Provider payments for LTC are often on the basis of salary, with fee-for-service used to pay LTC workers in home-care settings in some countries and capitation payments used in some managed-care schemes in the United States. These mechanisms are well known for rewarding *volume* instead of *outcomes* of care. Public LTC systems typically

reimburse providers on a *per diem* basis, sometimes adjusted by prospective user's risk. But where budgets are negotiated ex-ante or based on a pre-fixed share of high-need users, providers have complained about risks of budget overruns because public budgets are not adjusted over time to reflect the changes in the disability status of institutional LTC users.

There is a new emphasis in health care policy on changing incentives faced by providers to reward outcomes and performance in lieu of outputs and volumes. But pay-for-performance initiatives in long-term care are limited to a few examples in the US Medicaid Programme. Evaluations from such programmes in some US states show promising outcomes relating to resident satisfaction and employee retention rates, for example. Yet changing provider payment mechanisms is difficult, not least because there is still little assessment, comparative analysis and reporting of quality provided by home care and residential care facilities.

Encouraging competition across LTC providers can be a way to stimulate productivity enhancements. However, it can also hamper the co-ordination of care across different providers unless this is specifically encouraged. The introduction of social LTC insurance in Japan in 2000 led to the market entry of several competing LTC providers, with positive outcomes for user choice and increased incentives for cost-management. Some Nordic countries (Sweden, Denmark, and Finland) have vouchers, enabling LTC users to choose freely among accredited competing providers. Generally, LTC user satisfaction is high, although there is little evaluation of the impact on either quality or cost-effectiveness.

Increased capital intensity in the provision of LTC could improve labour productivity. Assistive devices, for example, facilitate self-care, patient centeredness, and co-ordination between health and care services. ICT can be an important source of information and emotional support to carers, carees and their families. While evidence is still sparse, some research results have shown a positive correlation between technology introduction, job satisfaction and productivity, for example in Australia and Finland. However, rather than being a substitute for labour, technology works well as a complement which enables caregivers to dedicate more time to LTC users needing further assistance. The majority of the studies remain pilot programmes, though, with need for further systematic assessment, particularly about which users could benefit the most from the use of technology.

Healthy ageing and prevention could bring high benefit, but the knowledge gap regarding the cost-effectiveness of interventions must be closed

Healthy ageing and preventing physical and mental deterioration of people with chronic care needs are potentially effective at promoting health outcomes and lowering costs. According to OECD projections, healthy ageing and productivity gains could partly compensate for future increase in LTC costs, and reduce the projected increase by about 5 to 10% by 2050.

Prevention and health-promotion efforts can influence lifestyle, help to identify risk groups and detect morbidity patterns earlier. Supporting self-management programmes encourages user centredness and is consistent with attitudes of the elderly to live active and independent lives in their homes and communities. In 2006, the Japanese government introduced in the LTC insurance system a community-based, prevention-oriented LTC

benefit targeted at low-care-needs seniors. In 2008, Germany introduced carrot-and-stick financial incentives based on sickness funds success with rehabilitation and management of users' transition from institutions to lower-care settings. However, such innovations are rare and there is still much uncertainty regarding which interventions lead to better payoffs or are cost-effective at managing LTC utilisation and preventing dependency. Filling in the evidence base would prove of significant value.

Addressing value for money in long-term care requires optimising the interface between health and care

The links between health and long-term care are significant. There is potentially scope for efficiency gains by managing the interactions. For example, in several OECD countries, LTC users are admitted or treated in acute-care facilities or settings, which are more costly and less appropriate for LTC care needs. Policy options to facilitate appropriate utilisation across health and long-term care settings can include:

- arranging for adequate *supply of services and support* outside hospitals *(e.g.,* Australia, Hungary, the United Kingdom and Sweden);
- changing *payment systems and financial incentives* to discourage acute care use for LTC *(e.g.,* pay-for-performance in Medicaid in the United States);
- creating better *rules, improving (and securing) safe care pathways and information* delivered to chronically-ill people or circulated through the system, to steer LTC users towards appropriate settings *(e.g.,* Sweden, Finland).

Another important area is better co-ordination of care pathways and along the care continuum. In several OECD countries, long-term care is fragmented across care episodes, providers, settings and services. Many OECD countries have set up co-ordination tasks or assigned responsibilities to guide users through the care process. These range from:

- *single point of access to information (e.g.,* Canada);
- the allocation of *care co-ordination responsibilities* to providers *(e.g.,* Australia, France, Sweden) or to care managers *(e.g.,* Japan, Germany, Denmark, the United Kingdom);
- dedicated *governance structures* for care co-ordination *(e.g.,* Belgium, the French *Caisse nationale de solidarité pour l'autonomie*, Japan);
- the *integration* of health and care to facilitate care co-ordination *(e.g.,* examples in the United States, Canada and Sweden).

Despite these mechanisms, problems of care co-ordination remain. The co-ordination of care *within* LTC systems and *across* health and long-term care deserves considerable policy attention in the future. An overall vision of health and long-term care could lead to gains in management.

Governance of long-term care is often complex

As the discussion on care co-ordination suggested, LTC services and settings are difficult to manage. Long-term care policies interact with other social policy issues such as health, housing, pensions and social infrastructure. The administrative and institutional-efficiency

challenges are large. Possible useful approaches that have emerged from the assessment of country practices include:

- establishing good information platforms for LTC users and providers;
- setting guidelines to steer decision-making at local level or by practising providers;
- using care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation;
- sharing data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (*e.g.* pensions), and existing social-assistance or housing subsidy programmes;
- dealing with cost-shifting incentives across health and care.