Chapter 1

Long-term Care: Growing Sector, Multifaceted Systems

Long-term care (LTC) is a growing, but relatively small sector in the economy. People older than 65 years of age, especially those aged over 80 years, have the highest probability of receiving LTC services, while women are the main recipients of services. LTC is a labour intensive sector, which is mostly publicly funded. On average, LTC expenditure accounts for 1.5% of GDP across the OECD. Most care is provided by family carers. The LTC workforce (mostly women working part-time in a majority of countries) is about 1.3% of the total OECD workforce. Over the last ten years, new long-term care programmes have been implemented in a number of countries, including cash-for-care programmes in European countries and the United States, aiming at providing consumers with more choice and control over LTC services. Due to the variety in target groups, governance, provision and workforce, LTC services are often fragmented. The connection with health systems is sometimes poor. The size, benefits, target groups, use, provision, governance and financing of long-term care differ markedly across countries. This chapter provides an overview of the sector in OECD countries. It begins by defining long-term care. In the following sections, it offers a snapshot of who uses, provides, and pays for long-term care services. Another section describes available services, with a focus on cash-for-care programmes, while the final section offers a short overview of recent policy developments in the sector.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

1.1. Scope of this report: How do OECD societies address the growing need for long-term care?

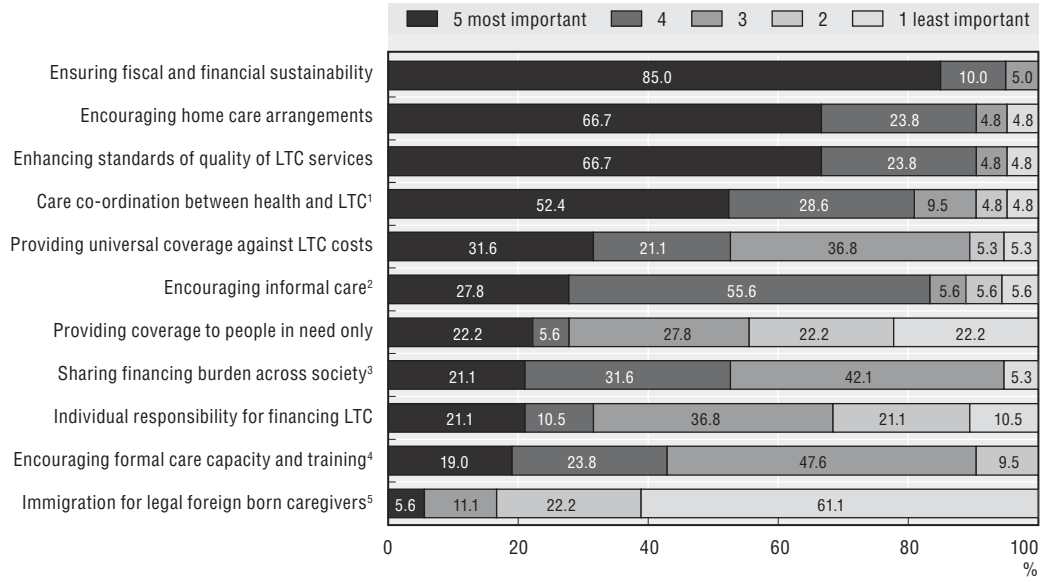
How societies address the issue of long-term care (LTC) – that is care for people needing daily living support over a prolonged period of time – is linked to social, moral and ethical norms, government policy and other country-specific circumstances (Ngai and Pissarides, 2009). For some, LTC is part of the private sphere, where family and friends are mainly responsible for providing unpaid care, while others consider long-term care as a collective responsibility. Furthermore, societies interpret the concept of collective – often state – responsibility for long-term care differently, in terms for example of financing, provision, and regulatory roles of governments.

These differences have implications for the development of formal long-term care systems, which can differ significantly even in societies with similar demographic profiles, or with a similar share of the population needing care. Yet formal LTC systems are just the tip of a largely submerged iceberg. In all countries, the major share of long-term care remains "hidden", in the shape of informal – mainly family and friends – care.

In the future, pressures on long-term care are expected to grow, for at least four reasons. *First*, although the speed at which populations are ageing varies considerably across countries, and despite uncertainties about future trends in disability among the population, demographic transformations will increase demand for LTC services in all societies. *Second*, changing societal models – such as declining family size, changes in residential patterns of people with disabilities and rising female participation in the formal labour market – are likely to contribute to a decline in the availability of informal caregivers, leading to an increase in the need for paid care. *Third*, as societies become wealthier, individuals demand better quality and more responsive social-care systems. People want care systems that are patient-oriented and that can supply well co-ordinated care services. *Fourth*, technological change enhances possibilities for long-term care services at home but may require different organisation of care. This raises pressures for improving the provision of care services, their performance, and, therefore, will drive cost up.

These changes will create upward pressure on the demand for long-term care services and, as a consequence, the human and financial resources necessary to provide LTC services. This report discusses such future demands on long-term care services and systems, in terms of human resources and financial sustainability. While both elderly and younger disabled people, including those with physical and cognitive handicaps, may need LTC, the report focuses mainly on older population groups. Financing appears especially at the top of policy priorities towards long-term care in OECD countries (Figure 1.1).

Figure 1.1. **Financial sustainability is the most important policy priority for LTC systems in the OECD, 2009-10**



Note: Includes responses from 28 OECD countries. Four countries identified other policies and reforms than the ones listed above, including: improving functional needs assessments and international co-operation.

1. Harmonising LTC and health systems, support care co-ordination.
2. Encouraging informal care and support for informal carers (including family members).
3. Sharing the burden of LTC financing across society as a whole, including seniors or retired high-income individuals.
4. Encouraging formal care capacity and training to caregivers, for example in order to reduce the burden on informal caregivers.
5. Encouraging or facilitating the immigration of legal foreign-born caregivers.

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

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1.2. What is long-term care?

Long-term care is the care for people needing support in many facets of living over a prolonged period of time. Typically, this refers to help with so-called activities of daily living (ADL), such as bathing, dressing, and getting in and out of bed, which are often performed by family, friends and lower-skilled caregivers or nurses.

As the costs of formal LTC may quickly become high for those in need of care, many countries have set in place public risk-coverage systems. Coverage may be restricted to specific low-income target groups or be universal. Benefits may imply services in kind or in cash and services can be provided in different settings, usually depending on the status of the care recipient. Care workers may have different qualifications depending on the care recipient's status and a country institutional arrangements, as does the intensity of care provision. Long-term care can be provided in home, institutional or day-care settings, from public, not-for-profit or for-profit providers, with services varying from alarm systems to 24h/7 days personal care. Service users may be required to pay a share of the cost for the use of such provisions.

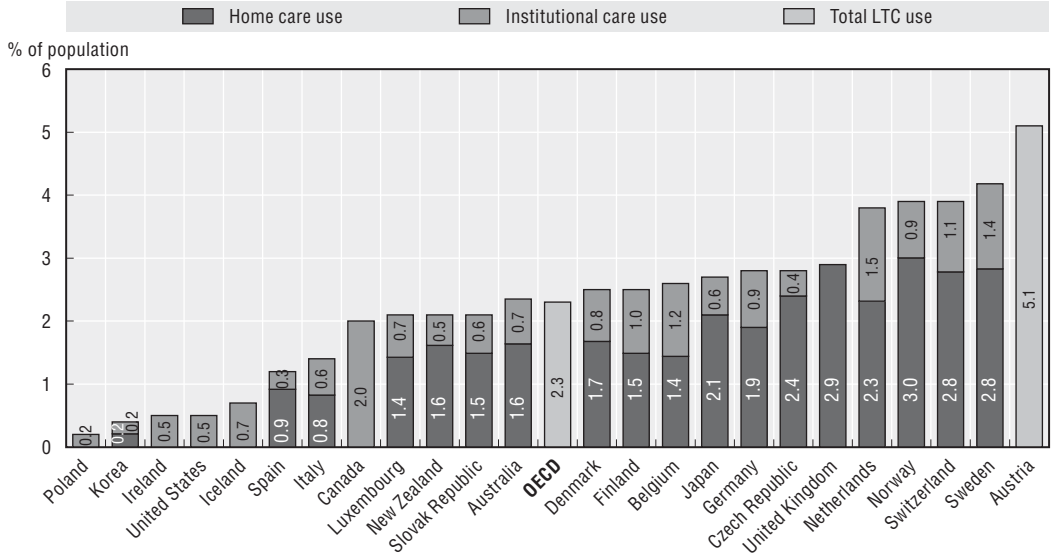
Responsibilities for – and expenditure on – formal long-term systems care can be centralised at one ministry or agency, typically the Health Ministry or the Social Affairs Ministry, or be a shared responsibility, although often lower-level authorities have authority over the provision of services and, in some cases, over funding. Almost a third of

OECD countries have decentralised governance of LTC to state, regional or local level (*e.g.* Canada, Finland, Korea, Mexico, Slovenia, Sweden, Switzerland, the United Kingdom and the United States).

1.3. Who uses formal LTC services?

The use of formal LTC services – measured in terms of LTC recipients – is low in Poland (0.2%), and the United States and Ireland (0.5%) (institutional recipients only), while high use is seen in Austria (5.1%, all in the form of cash benefits), Sweden (4.2%), Norway and Switzerland (3.9%), and the Netherlands (3.8%). On average, 2.3% of the population uses formal LTC services across OECD countries (2008) (Figure 1.2). For the 23 countries for which data are available, around 70% of all LTC users receive services at home, ranging from 55% in Belgium to over 80% in the Czech Republic.

Figure 1.2. **More LTC users receive care at home than in institutions**
LTC users as share of the population in OECD countries, 2008



Note: Data for Canada, Luxembourg, Denmark, Belgium and the Netherlands refer to 2007; data for Spain refer to 2009. Data for Japan refer to 2006. Data for Japan underestimate the number of recipients in institutions because many elderly people receive long-term care in hospitals. According to Campbell *et al.* (2009), Japan provides public benefits to 13.5% of its population aged over 65 years. Czech home-care users include 300 000 recipients of the attendance allowance. Polish data underestimate total LTC users. Austrian data represent recipients of cash allowances.

Source: OECD Health Data 2010, the Korean computerised administrative network and additional Australian and Swedish data.

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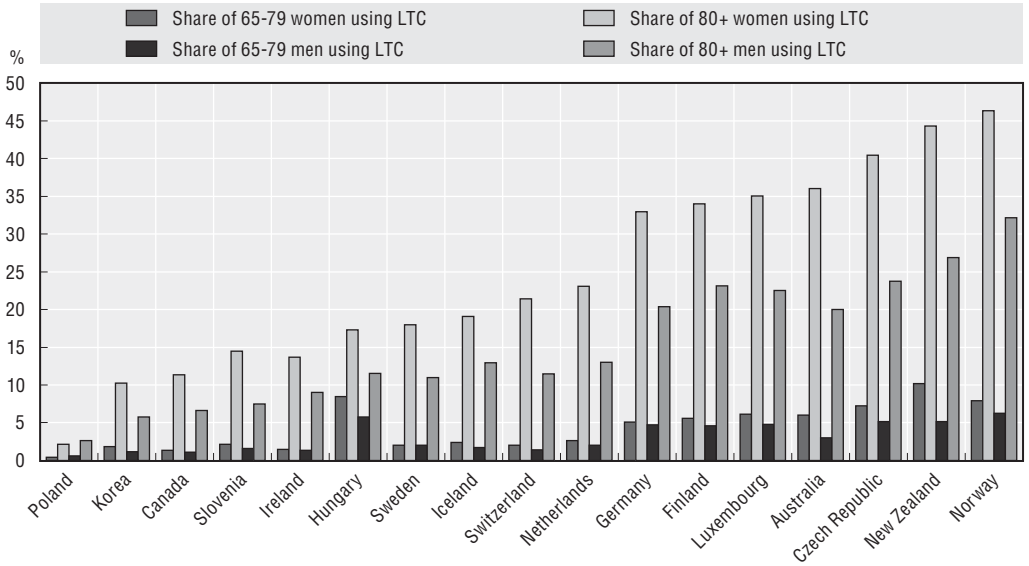
Demand for LTC is highly age-related (Figure 1.3), even though elderly people are not the only target group. Less than 1% of those younger than 65 years use LTC, while after the age of 65 years, the probability of LTC use increases fast. Between 2% (Poland) and 46% (Norway) of the women aged 80 years old or over use LTC services, while the correspondent male proportion ranges from 2.6% in Poland to 32% in Norway. These data reflect higher female life expectancy and survival rates. Still, in most countries, one in five LTC users is younger than 65 years, while around half of all users are aged over 80 years (Figure 1.4).

Figure 1.3. **Most LTC users are women aged over 80 years**

LTC users by age and gender, as a share of respective population group, 2008



Note: Data for Austria, Belgium, France and Poland refer to 60 years instead of 65; data for the Slovak Republic refer to 62 years; for Norway, data refer to 67 years and over. For home-care users in Poland, the age breakdown refers to 60-74 years and those aged over 75, instead of 65-79 and those over 80. Data for Sweden refer to institutional care only. Data for Canada, the Netherlands, Australia and Luxembourg refer to 2007. Austrian data represent recipients of cash allowances.

Source: OECD Health Data 2010 and additional Australian and Swedish data.

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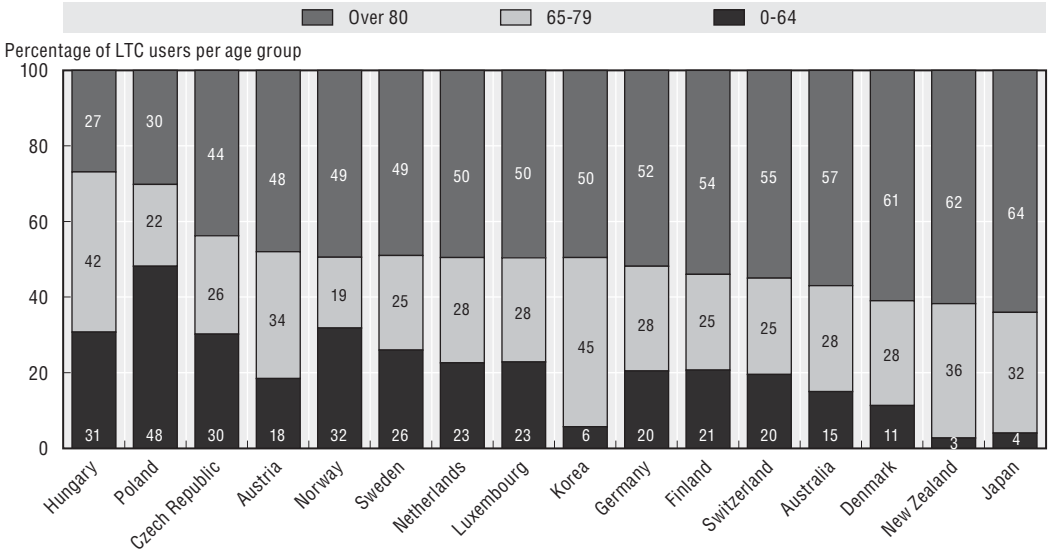
Figure 1.4. **Approximately half of all LTC users are aged over 80 years**

Share of LTC users by age, 2008



Note: Data refer to different age breakdown for the following countries. For the 65-80 age group: recipients are aged over 60 in Austria, Belgium and Poland; LTC users are over 62 in the Slovak Republic; home-care recipients are aged over 60 and institution recipients are aged over 65 in France; recipients are aged over 67 in Norway). The age breakdown for home-care users in Poland refers to 60-74 and those aged over 75 instead of 65-79 and those aged over 80; Polish data underestimate LTC use. Data for Canada, the Netherlands, Australia and Luxembourg refer to 2007. Data for Japan are for 2006. Austrian data represent recipients of cash allowances.

Source: OECD Health Data 2010 and additional Australian and Swedish data.

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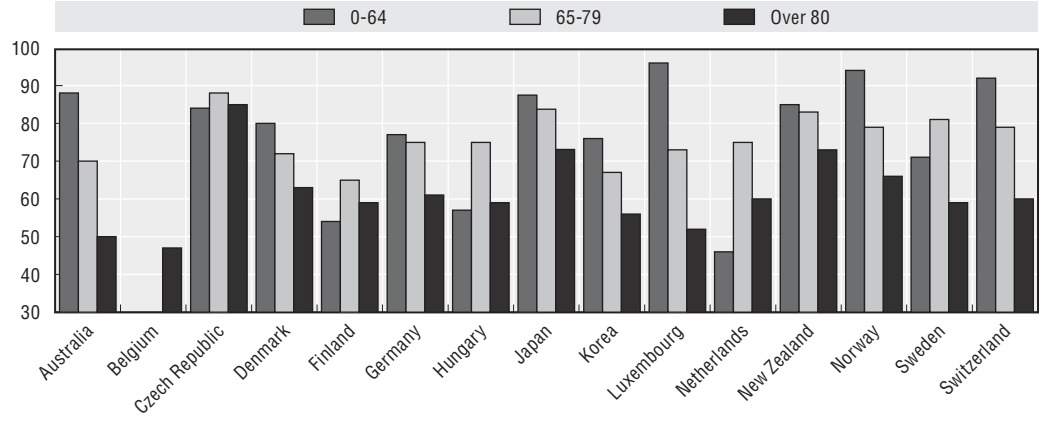
In nearly all OECD countries, between half and three quarters of all formal LTC is provided in home-care settings. In all countries, very old users are less likely to receive home care than younger ones (Figure 1.5). Nevertheless, more than half of the care recipients aged 80 years or over receives care at home in most countries. A substantial share of the old LTC recipients suffers from dementia-related problems (see Box 1.1).

Figure 1.5. **Younger LTC users receive higher amounts of home care than the very old ones**

Home-care users as a share of total LTC users by age, 2008



Note: Data for the following countries refer to different age breakdowns. For the 65-80 age group: recipients aged 60 years and over (Belgium); recipients aged 62 years and over (Slovak Republic); recipients aged 67 years and over (Norway). For Poland, the age breakdown for home-care users is 65-74 instead of 65-79 and over 75 instead of over 80. For Norway, the over 80 years age group may be underestimated. Czech home-care users include 300 000 recipients of attendance allowance. Polish data underestimate total LTC users. Data for Japan refer to 2006.

Source: OECD Health Data 2010, additional Australian, Japan and Swedish data.

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Box 1.1. **Dementia, Alzheimer's disease and LTC**

Psycho-geriatric conditions lead to reduced cognitive functioning and (increasingly) require other people not only to support the care recipient in performing ADL and/or IADL, but also to take over other aspects of the life, including day-to-day supervision, decision making and legal guardianship. For many carers, this is a long-term, physically, mentally and emotionally intense task, which becomes more burdensome, the further the illness progresses. Furthermore, although medical options supporting prevention of vascular dementia are available, for other types of dementia preventive measures are still unknown and medical treatment can, when in early stages, only ameliorate some effects of the disease (Groth *et al.*, 2009).

Recent analysis linked the prevalence of dementia to age groups (Ferri *et al.*, 2005, as reported in Alzheimer Europe, 2006). According to these calculations, some 12% of those aged between 80 and 84 years, and almost one in four of those aged over 85 years, suffer from dementia. With ageing populations, strong increases in the prevalence of dementia may be expected across the world (Brookmeyera *et al.*, 2007), while current global expenditure on dementia-related costs already amounts to 1% of GDP worldwide and 1.24% of GDP in high-income countries (Wimo and Prince, 2010).

Box 1.1. **Dementia, Alzheimer's disease and LTC** *(cont.)*

Improved diagnostics may lead to earlier recognition, which, if not accompanied by better preventive and treatment options, suggests that a higher than proportional growth of those in need of LTC will have a recognised form of dementia. Earlier detection may lead to increased quality of life, but will possibly be associated with higher treatment costs. The expected drop in the availability of family care and the increase in dementia-related problems – in many cases combined with other health problems – could pose financial and human-resource challenges to LTC systems. Pressures due to increasing dementia prevalence will be especially high in rural areas and for (mainly elderly) family carers, as younger and better educated people tend to move away from these areas, while access to health and care services is often poorer in rural areas.

Several countries pay special attention to dementia-related problems in long-term care, for instance by developing an integral Alzheimer Plan (France, the United Kingdom), or by improving or creating special benefits for dementia-related care needs, which may fall outside the realm of ADL and IADL (Germany, Australia, Austria, Finland).

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

Between 1998 and 2008, the share of the population aged 65 years or older increased by 12% across the OECD, while the share of those aged 80 years and over increased by 32%. In most countries this also led to an increase in LTC use except in the Netherlands (2004-07) and in Switzerland (1998-2008) where the share of the population using LTC decreased somewhat. For the OECD countries for which data are available, only in Norway (2001-07), Switzerland (2000-07) and the United States (2000-08), institutional care use remained stable, at the level of the earliest year. In Sweden, institutional care use as share of the population decreased by 19% (1998-2008) accompanied by a steady increase of the share of home-care users, while in 12 other countries the share of the population using institutional care increased over the past five to ten years. The share of the population using home care saw a 15% decrease in the Netherlands (2004-07), was stable in Switzerland (2000-08) and grew in most other countries. The share of the population using home care increased by more than 70% in Hungary, and by around 50% in Japan, Luxembourg, and the Slovak Republic, with smaller increase in Sweden. Japan show sharp increases in total LTC use.

1.4. Who provides long-term care?

Family carers

Definitions of family carers vary, from wide to narrow, depending on variables such as the minimum number of hours per week spent caring, the minimum period spent caring, or wider or narrower inclusion of caring tasks. There can be limitations in the share of the population investigated (people in working age, adults or people of a certain age), and the pre-existing relationship of the care recipient with the family carer (spouse, a parent).

Chapter 3 analyses family carers considering the population aged over 50 years providing personal care support. However, different definitions lead to major differentiations in calculations. For instance, a wide definition led to the count of 100 million carers in the EU25 (Alber and Kohler, 2005), whereas a stricter definition (at least 20 hours care per week)

counted 19 million (Grammenos, 2005), of which 9.6 million caring at least 35 hours care per week. According to *OECD Health Data 2010*, in the United Kingdom, only 0.7% of the population and in Luxembourg and the Slovak Republic around 1% of the population are family carers (2006), whereas in the United States 15% (2004) and in the Netherlands 21% of the population between 18-65 years of age (2008) are family carers.[1] These figures may suggest differences in the provision of family care across countries, reflecting different cultures, but data limitations and uneven definitions are a factor explaining these differences.

Crucially, however, even in estimates using narrow definitions, the size of the family care "workforce" is at least double that of the formal care workforce *(e.g.,* in Denmark), and in some cases it is estimated to be more than ten times the size of the formal-care workforce *(e.g.,* Canada, New Zealand, United States, the Netherlands). On average, around 70 to 90% of those who provide care are family carers (Fujisawa and Colombo, 2009).

Family carers are mostly women, especially spouses or adult daughters or daughter in-law. The more intense the care becomes, the more likely it is that women are the family carers, except in a spousal care situation (Glendinning *et al*., 2009; NAC and AARP, 2005; ABS, 2008). On average, a family carer of frail adults is above 45 years of age. The most intense care is usually provided within a household.

Estimates for the United States suggest that family carers delivered care for an economic value[2] of USD 375 billion in 2007 (Houser and Gibson, 2008), higher than the estimated cost of USD 230 billion of paid LTC services in 2007 (Gleckman, 2009). For Europe, it has recently been calculated that the economic contribution of (unpaid) family work ranges – depending on the method used – between 20.1 and 36.8% of European GDP (Gianelli *et al*., 2010). These and other studies point to the high economic value of family care.

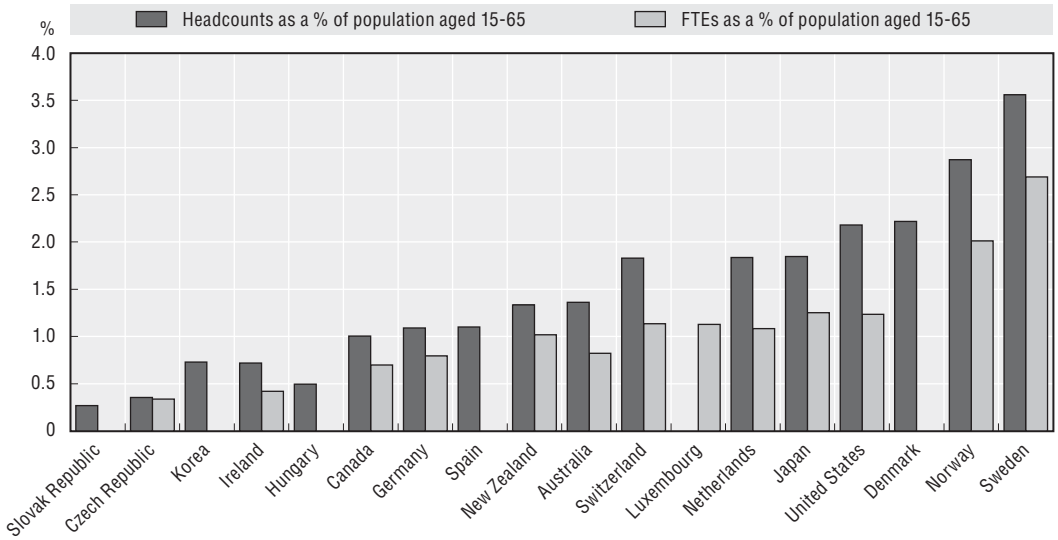
However, providing care as a family member can lead to costs, for instance related to lost working days and foregone career opportunities. An Australia study estimates the opportunity cost of income forgone as a result of unpaid family caring at AUD 4.9 billion – equivalent to nearly 10% of the total expenditure on formal health care in Australia (Manaaki, 2009). Other costs may be related to the (mental) health of the carer (see Chapter 3). In some countries, family members may be legally required to contribute to the cost of formal care when care recipients are poor (Germany, Slovak Republic, France), while the family caring process may also lead to increased household expenditures, such as heating, medication, telephone costs, medical aids, and transport. This picture led many governments to support family carers (see Chapter 4).

Paid care workers

LTC workers (nurses and personal carers) account – in headcount – for 1.5% of the working-age population in selected OECD countries (Figure 1.6).[3] The lowest shares are found in countries where the formal LTC sector is still small, for example the Czech Republic and the Slovak Republic (0.3%). The highest share (3.6%) is found in Sweden, followed by Norway (2.9%) and Denmark (2.9%).

The size of the LTC workforce does not necessarily relate to the number of those in need. A proxy is the density per 100 people aged over 80 years, which varies from about five in the Slovak Republic to more than forty in Sweden and Norway (Figure 1.7). With a demand for care that may outgrow the size of the LTC workforce (Martin and King, 2008), some countries report shortages of workers in the sector, for example Spain, Austria,

Figure 1.6. **LTC workers represent a small share of the working-age population, 2008**



Note: FTE stands for Full Time Equivalent. The definition of full-time equivalents varies across countries. LTC workers include both nurses and personal caregivers. Data for Hungary, Canada, New Zealand, Luxembourg and the United States refer to 2006. Data for the Slovak Republic, Germany, Australia and Denmark refer 2007. Data for the Netherlands, Spain and Sweden refer to 2009. Data for Korea refer to 2010 (National Statistical Office). Data for Germany exclude 170 000 elderly care nurses (2007). Data for the Netherlands refer to ADL workers and nurses in employment only.

Source: OECD Health Data 2010 and Korea National Statistical Office.

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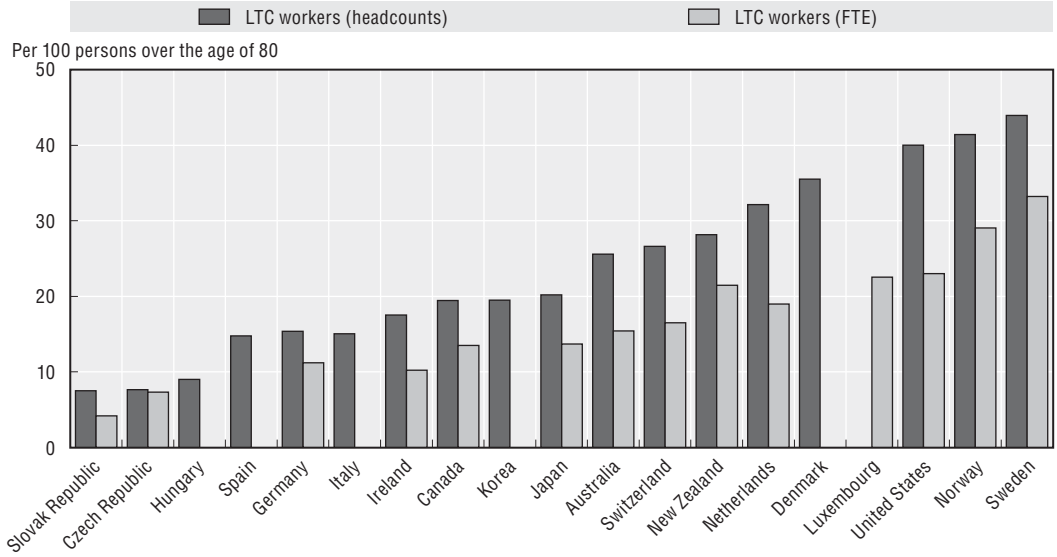
Figure 1.7. **The size of the LTC workforce is limited compared to the number of those in need**

LTC-worker density per 100 persons over 80 years across OECD countries, 2008 or latest available year



Note: The definition of full-time equivalent (FTE) varies across countries. Data Italy are from 2003; data for New Zealand and the United States are from 2006; data for the Slovak Republic, Germany, Australia, Denmark, Canada, Hungary and Luxembourg are from 2007; data for Spain, Korea, the Netherlands and Sweden are from 2009. Data from Germany exclude elderly care nurses (*circa* 170 000, 2007); data for the Netherlands are limited to nurses and ADL assistants in employment.

Source: OECD Health Data 2010 and Korea National Statistical Office.

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Canada, Finland and Italy (Fujisawa and Colombo, 2009; OECD, 2008), while almost all countries struggle with recruitment and retention (Chapter 6).

In some OECD countries, for example in Southern Europe, demand has been met by an increasing inflow of migrant care workers. In Italy, the share of foreign-born care workers increased rapidly, to reach an estimated 72% of all home-care workers in 2005 (Lamura *et al.*, 2010), a substantial share of which work in an *informal context* (that is, without formally contracted services). In other OECD countries foreign-born care workers shape a substantial share of the *formal* LTC workforce (Fujisawa and Colombo, 2009), for instance up to 23% of the direct-care workers in the United States are migrants (PHI, 2010).

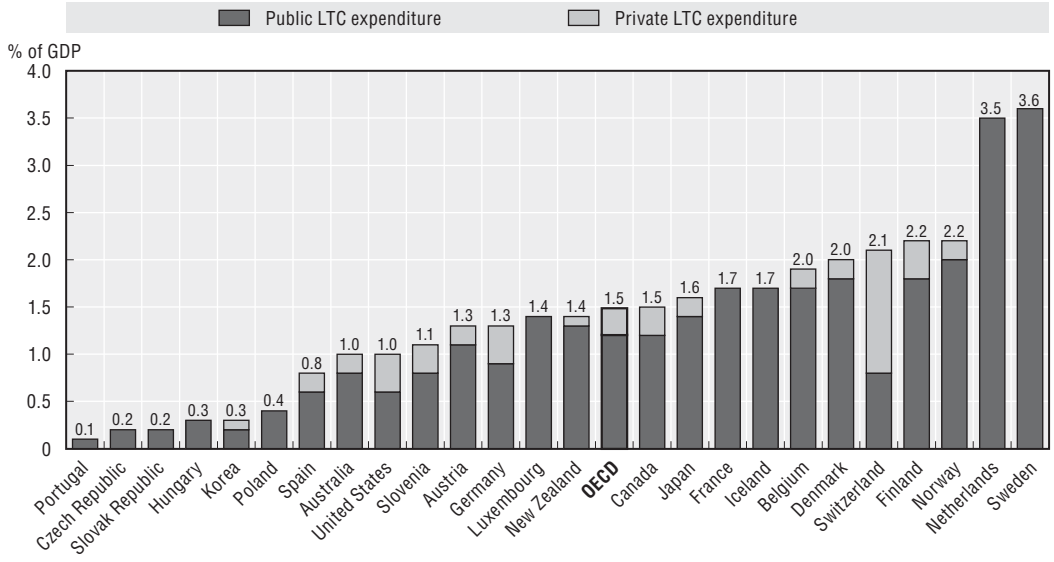
1.5. Who pays for long-term care, in what settings and at what cost?

Public funding plays a major role

Total spending on LTC[4] accounted for 1.5% of GDP on average across 25 OECD countries in 2008 (Figure 1.8). There is significant cross-country variation in the resources allocated to LTC, in line with observed differences in utilisation. This variation reflects differences in care needs, in the structure, and comprehensiveness, of formal LTC systems, as well as in family roles and caring cultures. There is also variation in the extent to which countries report both the health (so-called "nursing") and the social-care spending components of long-term care (Box 1.2).

Figure 1.8. **The share of public LTC expenditure is higher than that of private LTC expenditure in OECD countries**

Percentage of GDP, 2008



Note: Data for Austria, Belgium, Canada, the Czech Republic, Denmark, Hungary, Iceland, Norway, Portugal, Switzerland and the United States refer only to health-related long-term care expenditure. In other cases, expenditure relates to both health-related (nursing) and social long-term care expenditure. Social expenditures on LTC in the Czech Republic are estimated at 1% of GDP (*Source*: Czech Ministry of Health, 2009). Data for Iceland and the United States refer only to nursing long-term care in institutions. Data for the United States underestimate expenditure on fully private LTC arrangements. Data for Poland exclude infrastructure expenditure, amounting to about 0.25% of GDP in 2007. Data for the Netherlands do not reflect user co-payments, estimated at 8% of total AWBZ expenditure in 2007. Data for Australia refer to 2005; data for the Slovak Republic and Portugal refer to 2006; data for Denmark, Japan and Switzerland refer to 2007.

Source: OECD Health Data 2010.

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Box 1.2. **Is LTC health or social spending?**

Long-term care includes both health and social-care services. Clear definitions and harmonisation of the boundaries between health spending and social LTC spending help to ensure comprehensive and internationally comparable data on total expenditure on health. However, it is not always straightforward to separate the two components of LTC. Different countries may report the same spending item under health or under social services, sometimes following country practices or the division of responsibilities for long-term care across government authorities. Such variation in the treatment of long-term care spending reduces the comparability of some key indicators, such as the share of health expenditure to GDP.

Total long-term care spending is calculated as the sum of *services of long-term health care* and *social services of long-term care*. The former, which represent health-related long-term care spending, include palliative care, long-term nursing care, personal care services, and health services in support of family care. The second, social services of LTC, include home help *(e.g.,* domestic services) and care assistance, residential care services, and other social services. In other words, the health component of LTC spending includes episodes of care where the main need is either medical or personal care services (ADL support), while services whose dominant feature is help with IADL are considered outside the health-spending boundaries. The WHO, OECD and Eurostat are reviewing definitions of these spending items and providing more guidance to countries on how to separate them; this is part of the process of revision of the System of Health Accounts manual.

Source: Long-term care Guidelines under the Joint Eurostat, OECD and WHO Health Accounts data collection.

Sweden and the Netherlands allocate the highest share of their GDP to LTC, around 3.5%. Other Nordic countries (Norway, Finland, and Denmark), as well as Switzerland, similarly spend more than 2% of their GDP on LTC. France, Iceland and Japan allocate about 1.6-1.7%, while Canada is around the OECD average. At the opposite end of the spectrum, southern and eastern European countries, together with lower-income OECD members such as Mexico and Korea, spend relatively little on long-term care. In the case of Korea, which implemented a universal LTC insurance system in 2008 and whose population is rapidly ageing, spending is low but expected to grow in the future.

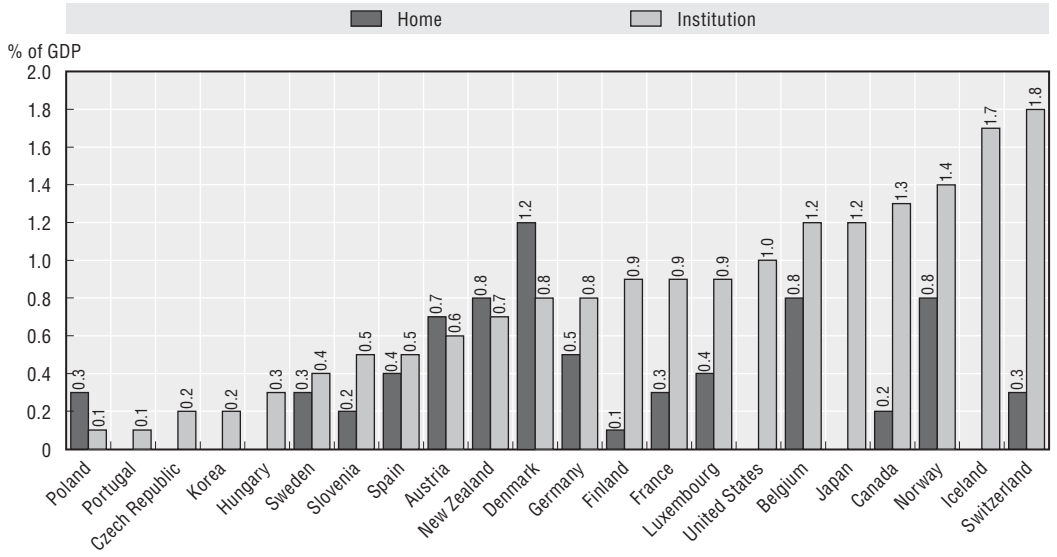
Long-term care is predominantly funded from public sources – even when taking underreporting of private expenditures into account.[5] The only exception is Switzerland, where the private share of LTC expenditure is over 60% of total spending, although some public social-care spending items are not reported. In aggregate, public and private LTC spending in Switzerland reaches the level of Nordic countries, but public LTC spending represents 0.8% of GDP, a figure comparable to public LTC spending in Germany and Australia. Private spending is also relatively high in the United States (40%), Germany (31%), Slovenia (27%) and Spain (25%). On average, the private share of total LTC spending is equivalent to about 15%, and is a lower fraction than the private share of total health spending (25%). Data on private LTC spending however may not include the high cost of board and lodging in nursing homes which, as explained in Chapters 7 and 9, account for the lion share of the cost borne by residential LTC users.

No place like home, yet spending on institutions remains high

People's preferences for receiving care in their homes do not translate into higher expenditures on home care. Most of the cost of long-term care still originates in the institutional sector (Figure 1.9), due, amongst others, to high worker density and high-cost infrastructure. Only in Denmark, Austria, New Zealand and Poland, does expenditure on home care exceed that of spending in institutional care.

Figure 1.9. **Spending on LTC in institutions is higher than spending at home in OECD countries**

Percentage of GDP, 2008



Note: Home care includes day-care expenditure. Data for Denmark, Japan and Switzerland refer to 2007; data for Portugal refer to 2006; and data for Luxembourg refer to 2005. Data for Poland exclude infrastructure expenditure, amounting to 0.25% GDP (2007). Data from the Czech Republic refer to health-related LTC expenditure only. Social expenditures on LTC are estimated at 1% of GDP (*Source*: Czech Ministry of Health, 2009).

Source: OECD Health Data 2010.

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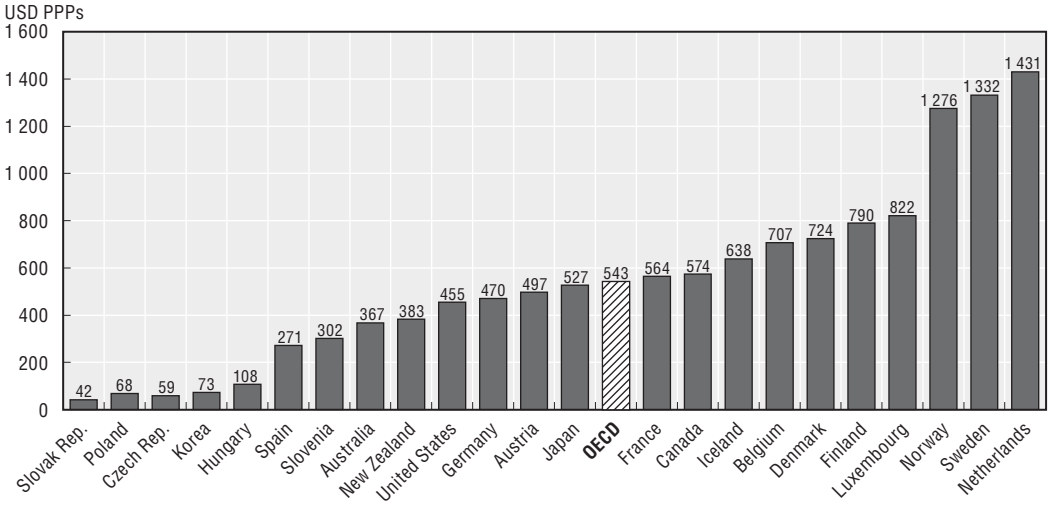
Expenditure on LTC per capita varies widely across the OECD, from USD 42 (international dollar) in the Slovak Republic to USD 1 431 in the Netherlands. Average per capita expenditure across the OECD is USD 543 (Figure 1.10).

LTC is a labour intensive sector

Total LTC spending is associated with the density of workers per 1 000 people aged over 80 years (Figure 1.11). The Netherlands, Sweden and Norway, spend relatively high on LTC and have a high LTC-worker density. The Czech Republic, the Slovak Republic, Hungary and Korea have both low expenditure and low LTC-worker density.

Figure 1.10. **Significant variation in LTC expenditure among OECD countries**

Per capita spending in USD PPPs, 2008 or latest available year



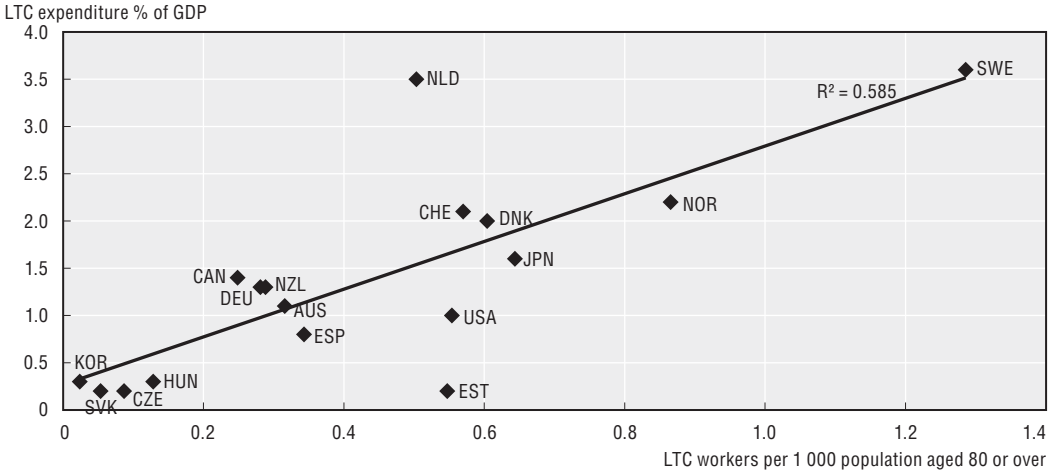
Note: PPPs stands for purchasing power parities. Data for the Czech Republic, United States, Austria, Canada, Iceland, Belgium, Denmark and Luxembourg refer to nursing long-term care only. Social expenditure on LTC in the Czech Republic is estimated at 1% of GDP (*Source*: Czech Ministry of Health, 2009). Data for Australia and Luxembourg refer to 2005; data for the Slovak Republic and Hungary refer to 2006; data for Denmark and Japan refer to 2007.

Source: OECD Health Data 2010.

StatLink http://dx.doi.org/10.1787/888932400760

Figure 1.11. **High LTC expenditure is associated with high LTC-worker density**

2008 or nearest year



Note: Data for Canada, the Czech Republic, Denmark, Estonia, Hungary, New Zealand, Norway, Switzerland and the United States refer to long-term care nursing expenditure only. Social expenditure on LTC in the Czech Republic is estimated at 1% of GDP (*Source*: Czech Ministry of Health, 2009).

Source: OECD Health Data 2010.

StatLink http://dx.doi.org/10.1787/888932400779

1.6. What services are provided?

Long-term care services can be provided in-kind (with the care recipient solely in the position of care receiver), as an allowance paid to the family carer (see Chapter 4), or as a cash benefit for the care recipient to hire the required services as they see fit. In-kind services can be nursing or ADL services provided at home, can consist of services which can also have a respite function for the carer, such as day care, and furthermore can include institutional

care provision such as in a nursing home and palliative care. Both in-kind service and cash benefits may require users to share a part of the cost and typically require an eligibility test. Most OECD countries provide both in-kind services and cash benefits, while a few countries have an in-kind system only (Australia, Hungary, Japan, New Zealand, Sweden and Mexico). In Austria, France and the Czech Republic, cash benefits are the main (but not only) form of benefits. Some Nordic countries have introduced voucher schemes[6] that can be used by the person in need of care to hire services.

Cash benefits provide care recipients with more choice to receive the services they need, by the provider they choose, at the conditions of their liking (Lundsgaard, 2005). However, countries vary in the way they implement cash-benefit schemes (see Box 1.3 for country examples). In Germany, Austria, the Czech Republic and Italy, for example, there is little control over the use of the benefit, while in other countries (for example in France), only accredited or approved service providers can be hired and expenditure is supervised. Similarly, countries vary in the requirements concerning hiring of family members. Table 1.1 offers an overview of cash-for-care schemes.

Box 1.3. **Cash-benefit schemes in selected OECD countries**

In the **United Kingdom**, direct cash payments have been offered as an alternative to pay personal carers since 1997. In 2010, a pilot programme of personal budgets in LTC was implemented. The direct payments take-up has been relatively low, showing significant local and user-group variations. Evaluations of the personal budgets scheme have shown evidence of cost-effectiveness in relation to social care outcomes, but weaker cost-effectiveness evidence in respect to psychosocial well-being. With regards to caregiving, preliminary evidence is promising, showing that personal budgets may be cost effective for carers.

Cash-for-care schemes have been very popular in **the Netherlands** since their implementation during the mid-1990s. The cash benefit equals on average EUR 14 500 annually, but can vary substantially based on a needs and an income assessment. The restrictions on the use of the cash benefits are minimal. Evaluations have indicated a high allocative efficiency of this cash-for-care system. High satisfaction among beneficiaries has been shown, as well as adequate purchasing power of the cash benefit, and low administrative costs of the system.

In 2008, a pilot programme for cash benefit was introduced in **Israel**, and was further expanded in 2010, covering 14.5% of the country. In order to be eligible for the cash benefit, an individual must receive medium or high-intensity care by a caregiver, who is not a family member. The amount of the cash benefit is 80% of the value of the in-kind benefit. Uptake of this scheme is still low, with varying take-up rates, depending on aspects such as age, income and benefit level. Beneficiaries in the cash-for-care scheme have shown greater satisfaction but decreased well-being, compared to individuals receiving in-kind benefits.

In **France**, the *Chèque emploi services universel* (CESU), allows the beneficiaries to pay for LTC services, or directly hire a caregiver. They can then seek reimbursement from the bank or an accredited national organisation. Among the advantages of this scheme are the optimisation of public expenditure and readability of public action. It is a policy priority, therefore, to promote the CESU through the National Solidarity Fund for Autonomy.

Source: OECD Expert Meeting on Long-term Care, November 2010.

Table 1.1. **Cash-for-care schemes**

Choice between in-kind and cash? Other information?		Programmes	Eligibility	Income-tested?	Asset-tested?	Tax free?	Benefit levels (monthly amounts)	Use restrictions?
Y/N: if Y: Do the different benefits vary in value?		National/subnational?	Target groups: Age/disability, remote areas					
Austria[1, 2]	No	All programmes are national						
		Pflegegeld	Needs			✖	EUR 148.30 to EUR 1 562.10 (2007)	
		24-hour care benefit	At least level 3 Pflegegeld	✖			EUR 550 for an employee, EUR 275 for an independent worker	
		Dementia care benefit	Needs			✖	EUR 1 200 to EUR 2 400	
Belgium[1, 2]	No	Programmes national except two: Flemish region and Brussels area						
		Allowance for assistance of the elderly	Income, needs, aged over 65 or veteran	✖		✖ (subnational)	Per annum EUR 925.06-EUR 6 209.71 (2010)	
		Zorgverzekering/Flemish Care Insurance	Needs			✖ (subnational)	EUR 130 flat allowance	
Czech Republic[2]	In-kind benefits not available	Care Allowance Appr. 10% of all persons aged over 65 receive care allowance	At least one year "dependent on care"				CZK 3 000 for I level); CZK 12 000 for IV (total dependency) (2009)	Benefits for services or care received from relatives
Denmark[1, 2, 3]	No	Availability varies according to municipality. BPA (Citizen Controlled Personal Assistance)	Minumum 20 hours help per week needed				Calculated by type and duration of assistance by local council; no minimum or maximum	Not for nursing care
Estonia[1, 2]	According to local governments, in-kind and cash benefits are available depending on needs and income. From EUR 13 to EUR 41 for individuals of pensionable age and EUR 17 to EUR 54 for persons below pensionable age (2010)							
Finland[1, 2, 3]	No	Care Allowance for Pensioners	Aged over 16, at least one year disabled, receiving disablity or retirement pension. Per 2010 extended to carees in institutional care			✖	Three monthly rates depending on needs and cost of care: EUR 57.32 to EUR 387.26 (2010)	
		Disability Allowance	Aged over 16, requiring care for more than six months			✖	EUR 199.71 to EUR 387.26	
France[1, 2]	Cash and in-kind benefits are separate	All programmes operate at a national level; APA: by public health insurance, administered regionally						
		Allocation personnalisée d'autonomie (APA)	Aged over 60, six dependency levels	✖		✖	EUR 529.56-EUR 1 235.65 (2009)	For assistance costs
		Allocation d'éducation d'enfant handicapé (AEEH)	80% disablity for a child, at least 50% disability for special care. Supplement to APA			✖	EUR 93.41 to EUR 1 029.10. Single parents gets more (2010)	Education and care costs of disabled child
		The PCH, intended to help fund certain expenses related to disability	Additional to AEEH. annual resources less than EUR 23 571, problems with more than two established activities	✖		✖	Regional disparities Techical aids: Max. EUR 3 960 (three years) Housing modification: Max. EUR 10 000 (ten years) Transport aid: Max. EUR 5 000 (five years)	For various social care and support

Table 1.1. **Cash-for-care schemes** *(cont.)*

Choice between in-kind and cash? Other information?		Programmes	Eligibility	Income-tested?	Asset-tested?	Tax free?	Benefit levels (monthly amounts)	Use restrictions?
Y/N: if Y: Do the different benefits vary in value?		National/subnational?	Target groups: Age/disability, remote areas					
Germany[1, 2, 3]	Yes. Cash benefits are lower in value than in-kind	LTC insurance. 52% of carees use cash (2008)	Be insured (two years), needs test, no prior legal or accident compensation insurance claims			✖	EUR 225-EUR 685 (2010)	
Italy[1, 2]	Cash and in-kind benefits are separate	*Indennita di accompagnaments* (Companionship Indemnity) Supplementary care allowances	Universal benefit, no age restrictions Locally decided, needs test			✖	Flat rate: EUR 472 to EUR 457.66 (2009) Varying rates according to local authority	
Ireland[1, 2]	Cash benefits depend on resource availablity	Home Care Package (Home Care Grant)	Aged over 65, in need of assistance to remain in the community			✖		
Korea[1, 2]	Yes. Cash benefits are lower in value than in-kind benefits	National Programme: Care Allowance	At least one of three criteria: 1. Live remote with few facilities 2. Unable to use LTC facilites due to disasters 3. Needing care but unsuitable for institutional LTC due to physical or mental condition			✖	Flat rate of WON 150 000 (*circa* EUR 84)	
Luxembourg[1, 2]	Yes. Cash benefits are lower in value than in-kind benefits	National Programme: Cash allowance for care/*Prestations en espèces*	Eligibility: Severely disabled, requiring ≤ 14 hours of assistance weekly			✖ (up to EUR 3 600 a year)	EUR 267 to EUR 1 100	Cash for the first 10.5 hours of care per week
Mexico[1]	No	*National Programa 70 y más* *Oportunidades Program*	Eligibility: Aged over 70, living in a locality of up to 30 000 inhabitants; not receiving aid from *Oportunidades*; attending bi-monthly medical consultations Aged over 70			✖ ✖	MXN 500 bimonthly MXN 295	
Netherlands[1, 2]	Yes. Cash benefits 15% lower than value of benefits in kind	Personal Care Budgets (*Persoonsgebonden budget*, PGB) 12% of carees use PGB (2008)	Eligibilty: No age criteria, Needs assessment based on duration and care by family				Average annual budget EUR 15 000-EUR 18 000	All expenses except for 1.5% must be justified. Unspent funds are returned. PGB is stopped after fraud
New Zealand[1, 2]	Cash and in-kind benefits are complementary	Disability allowances	Eligiblity: Disability test, suffering from disability for six months	✖		✖	Maximum NZD 56.98 per week (April 2010)	
Slovenia[1, 2]	Attendance allowance given to those aged over 65 suffering from chronic disorders or at least 70% reduced mobility. Not income tested but cannot be chosen in lieu of in-kind benefits by the care recipient							

Table 1.1. **Cash-for-care schemes** *(cont.)*

Choice between in-kind and cash? Other information?		Programmes	Eligibility	Income-tested?	Asset-tested?	Tax free?	Benefit levels (monthly amounts)	Use restrictions?
Y/N: if Y: Do the different benefits vary in value?		National/subnational?	Target groups: Age/disability, remote areas					
Spain[1, 2]	Yes. Cash benefits varies with programme (*el Programa Individual de Atencion*)	National, implemented at regional level	Assessment of the degree of dependency by the Scale of Dependency test				Calculation of cost and hours of care	
		Allowance for caree to hire services	Dependency grade	✖		✖	EUR 400 to EUR 831.47 (2009)	Hiring through accredited centers
		Allowance for caree receiving informal care	Carer must be a relative of caree; in rural areas a neighbour is eligible	✖		✖	EUR 300 to EUR 519.13 (2009)	To compensate informal carer
		Allowance for personal assistance	High dependency	✖		✖	EUR 609 to EUR 812 (2009)	Expenses justified; carer must have professional qualifications
Sweden[1, 2, 3]	Cash and in-kind benefit are complementary	National, implemented locally						
		Attendance allowance	Differences across municipalities. Minimum need of 17 hours/week			✖	Estimated SEK 3 000 per month	
		Assistance allowance	Aged over 65, ADL, requiring over 20 hours of help a week			✖	Amount according to estimated hours of required assistance	
Switzerland[1, 2]	No. Cash and in-kind benefit are complementary	"Helplessness" Allowance (*Allocation pour impotent*/API) of AVS/AI	Moderate or severe impairment, not eligible for Disability Allowance from Accident Insurance				CHF 456-CHF 1 824. When at home, cash benefit is half	
United Kingdom[1, 2]	No. Cash benefits and in-kind benefits are complementary	National, implemented locally		✖	✖			
		Attendance Allowance (AA)	Age 65+, requires ≥ six months assistance			✖	GBP 47.80-GBP 71.40 a week	
		Independent Living Fund (ILF)	Age 16-65, receiving highest rate of Disability Living Allowance; the higher rate of AA or at least the financially equivalent rate of Constant AA		✖		Maximum of GBP 475 weekly	Restricted for support and IADL. Not to hire a relative, but exceptions
		Disability Allowance	For children and adults under age 65 who need help with personal care or have walking difficulties, because they are physically or mentally disabled			✖	Care component: Three rates depending on level of care needed: GBP 18.95, GBP 47.80 or GBP 71.40 a week. Mobility component: Two rates depending on level of mobility needs: GBP 8.95 or GBP 49.85 a week	
		Direct payments	Local Community Care Assessment	✖		✖	Varies according to needs assessment	For LTC services/equipment. Not to hire a relative, but exceptions
United States[1, 2]	There are federal incentives for states and some "experiments" with cash-for-care schemes. The CLASS Act, which promotes a voluntary insurance programme, will offer cash benefits for use on LTC nursing home or home care costs. Until now, several states, including California. Colorado, Kansas, Maine, Michigan, Oregon, Washington, Florida and New Jersey have tested cash benefits for ADL/IADL assistance. As of 2010, a national cash benefits programme for LTC does not exist							

1. Benefits in kind.
2. Benefits in cash.
3. Vouchers.

Source: OECD 2009-10 Questionnaire on Long-term Care Workforces and Financing.

In some cases, cash benefits are provided when no or few formal (public) services are available *(e.g.,* Spain, some central European countries). The Korean LTC insurance system provides cash benefits only for those living in remote areas, having difficulties utilising LTC facilities due to natural disasters or similar reasons or to those unsuitable for admission in an institutional setting.

A cash-for-care programme aims to *contribute to* the costs of care, but does not necessarily provide sufficient payment to buy all the needed care. In Germany, the value of cash benefits is set at a lower level than the cost of equivalent in-kind services. In some countries, cash benefits can offer income support *(e.g.,* Disability Living Allowance in the United Kingdom, Slovenia and the Slovak Republic). The Finnish care allowance for pensioners shows characteristics of both: it is provided as income support and eligibility depends on the duration of disability, but the title refers to care. This also applies to the Belgian APA/THAB[7] (an income-support measure for those unable to cover LTC costs, based on an income and needs' assessment. New Zealand's disability allowance and the invalid's benefit are income-support measures, similar to the invalid benefit, which are described in terms of a share of wages. The Irish disability allowance, aimed at those at least one year disabled, and of working age (aged 16-66 years), too, aims to provide an income.

Countries differ in the way the benefit amount is calculated. In some cases *(e.g.,* Austria, the Czech Republic) it is a flat rate, which depends on the need for care; in others *(e.g.,* France, the United Kingdom and Spain) income or asset testing is also required, which may lead to substantial reduction of the available amounts. In Spain, for instance, those eligible but above a certain income ceiling may receive only 40% of the allowance.

Countries vary also in the tax treatment of the cash benefit. Whereas most care recipients will receive the benefit tax free (the Netherlands, the Czech Republic, Germany), in Luxembourg benefits above EUR 3 600 annually are taxed.

The Netherlands is the only known country where unspent budget needs to be returned, and, as in Luxembourg, the cash scheme can be cancelled in case of fraud (then the user will have no option but to receive care in kind).

1.7. How did countries get here? Where are they going?

Table 1.2 summarises recent policy development in LTC schemes and systems across the OECD. Some countries have implemented changes or reforms affecting only specific aspects of the system, without however changing the main features. For instance, Mexico, a "young" OECD country, installed its first National Gerontology Plan. The Belgian region Flanders introduced a mandatory LTC insurance which supplements the main public LTC coverage. The Swiss cantons started a human resource planning exercise for health and long-term care. Other countries – Germany and France being an example – face a more or less continuous stream of policy adjustments and changes to their system. France is discussing reforms and, potentially, the creation of a fifth social security pillar (early 2011). The United Kingdom (England) has produced in recent years a number of strategic plans on specific issues and target groups, for instance on Independent Living (2006), a Carers Strategy (UK HM Government, 2008), a strategy aimed at older workers that includes the issue of combining work and other commitments such as care (2006) and a vision for adult social care (2010). France has developed a targeted Alzheimer Plan (2008-12), as the United Kingdom did in 2009, while other countries have developed broad strategy

Table 1.2. **Selected LTC policy changes over the past ten years in OECD countries at a glance**

		Coverage			Use			Provision	
	Title of policy or reform	Financing	Cost sharing	Access (eligility) and changes in services	Benefits	Choice	Carer support	Workforce	Quality
Australia			♦	♦	♦	♦		♦	♦
Austria					♦		♦	♦	
Belgium	Care insurance (Flanders) (2003)								
	3rd protocol: Conversion of rest home beds in nursing home beds (2005-11)	♦							
Canada					♦		♦	♦	
Czech Republic		♦		♦	♦	♦			♦
Denmark	Quality reform (2007)							♦	♦
Finland	National Framework for High-quality Services for Older People (2008)			♦	♦				♦
France	Old Age Solidarity Strategy (2007-10)								
	Alzheimer Plan (2008-12)	♦	♦	♦		♦	♦	♦	♦
Germany	LTC insurance reform (2008)	♦	♦	♦	♦	♦	♦	♦	♦
Ireland	Fair deal (2009)	♦	♦	♦					
Iceland	A new strategy plan for elderly care (2008)		♦	♦		♦		♦	♦
Japan	Partial Revision LTC Insurance Act (2005-06)	♦	♦		♦			♦	
	Revision of LTC Insurance Act (2009)								
Korea	National LTC insurance (2008)	♦	♦	♦	♦			♦	♦
Luxembourg				♦	♦	♦			♦
Mexico	Institutional Gerontology Plan (2006)								
Netherlands	Social Support Act (2007)	♦		♦	♦			♦	♦
	Care Innovation Platform (2007)								
New Zealand			♦	♦			♦	♦	♦
Portugal	National Network for Integrated Continuous Care (RNCCI) fully implemented in 2016 (2006)	♦		♦	♦				
Slovakia					♦	♦	♦		
Spain	Long-term care law (2006)	♦	♦	♦		♦	♦	♦	
Switzerland								♦	
United Kingdom	Supporting people with long-term conditions (2005)								
	Carers Strategy (2008, refreshed 2010)			♦			♦		
	Working to put people first (2008)								
	Dementia strategy (2009)								
United States	Increasing grants to States for Money Follows Person Programme (2005)								
	More "waivers' assisting states" home-based care programmes (2005)								
	Private LTC insurees can protect more assets if ending up spending down for Medicaid (2005)	♦	♦		♦	♦		♦	
	New opportunities (with increased federal co-funding) for States to offer home-based care services (2010)								
	Class Act (2010, to be implemented 2012)								

Note: Policy developments may refer to more than one cell. For instance the introduction of a (mandatory) LTC system may relate amongst others to access, benefits, co-payments, financing and choice. Coverage issues will be discussed more in depth in Chapters 7 to 9, carers issues in Chapters 3 and 4, workforce issues in Chapters 5 and 6.

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing, and additional documentation (such as National Strategy reports for Social Protection and Inclusion 2008-10).

documents which still need to be operationalised such as the Icelandic New Strategy for Elderly Care or the Finnish National Framework for High Quality Services for Older People.

Coverage reforms

Coverage reforms relate to *financing* (including *cost sharing*), and *access to services* (including the number and type of). Over the last ten years, a growing number of OECD countries have implemented or expanded policies aimed at increasing LTC coverage and services, while also aiming to improve service provision to specific groups such as those with severe disability or suffering from dementia.

Seven countries made changes to their *financing for LTC*. Two new financing LTC systems were installed, one tax-based (in Spain, 2006), and one based on a national compulsory insurance (Korea, 2008). Both have consequences for access (defining eligibility), benefits (what is covered, what not), payments for (what do citizens pay under what circumstances) and have workforce repercussions (because both countries implemented rules about who can provide services).

Germany, which had introduced LTC insurance in 1994, implemented several ongoing reforms to the system. For instance, in 2004 Germany required retirees to contribute to LTC insurance, while, since 2005, those without children have to pay higher contributions. In 2008, portability across insurers was improved, while market incentives were introduced in 2007 and LTC insurance was made compulsory also for high-income people in 2008. Japan reviews its LTC insurance every three years and has adjusted premia and providers' fees three times, while, in 2006, community and preventive services where strengthened. The Irish *A Fair Deal* (2009) changes the way co-payments and income and asset testing are adjusted to prevent extreme poverty and make access to private providers easier. New Zealand, too, is phasing out asset testing for admission to nursing homes. The Netherlands is perhaps the only country that cut back its system. In 2007, IADL support was transferred out of LTC insurance to municipalities' responsibilities. Per 2012, the CLASS Act is planned to be introduced in the United States, as part of its 2010 Affordable Care Act.[8] CLASS is a privately financed, government provided, voluntary insurance scheme that aims to provide a daily cash allowance to people in need for care after five years enrolment.

Cost-sharing reforms take different shapes. For example, Korea requires a 20% cost sharing on institutional care and a 15% user co-payment for home care, which includes ADL support, as well as for services such as transport, day/night care, short-term respite care and equipment such as wheelchairs and orthopaedic mattresses. In Australia, several changes in cost sharing were implemented over the years to bring more equity between pensioners and self-employed retirees, and reduce co-payments for those with few assets. As mentioned, the Irish *Fair Deal* (2009) substantially changed asset-testing rules, by capping cost sharing at 15% of the asset value over a maximum period of three years.

Access-related reforms involve changes in eligibility procedures or changes in scope and types of services available in the system. Several countries, find that a "one-size-fits-all" assessment and service provision requires adjustment over time as new considerations and target groups may come into play, or as the current model does not fit needs. Thus, some countries have improved benefits for those with severe disabilities and/or those suffering from dementia. Australia simplified its eligibility procedures, while expanding residential support in remote areas as well as increasing residential capacity from 100 places per 1 000 people aged over 70 years in 1985 to 113 in 2011. Finland aimed

for integrated assessment of an individual's need in its 2008 National Framework for high-quality services for older people. Both Ireland and France, the latter in the context of the 2007-10 Old Age Solidarity Strategy and the 2008-12 National Alzheimer Plan, have set targets for increasing services in the community, where Finland aims to reduce residential care use from 6.5 to 3% of the population by 2012 and encourage community care. New Zealand implemented in 2008 a national assessment tool.

Use-related reforms

Use-related reforms refer to *benefits and choice*. Most OECD countries expanded LTC-related benefits, including tailored specifics for those living in rural areas and suffering from dementia. The use of cash benefits, information dissemination via for example the internet, and competition between providers are among the options used to improve consumer choice of provider and benefits.

Several countries improved their *benefit package*. For example, Australia, Austria, Finland, Luxembourg (for home and palliative care) and Germany included benefits for special target groups, such as those with severe disabilities or those suffering from dementia. In 2009, Luxembourg started dedicated targeted training for LTC workers. Germany expanded benefits by the (2009) introduction of disease-specific activity measures in the LTC insurance. In 2004, Canada developed a ten-year plan to strengthen health care which provides some short-term home-care services free of charge. Finland aims to improve care provision at home and reduce institutional care. Australia increased benefits for those suffering from severe disability or dementia, and expanded public funding for transitional care services between the health and LTC system.

User choice is increasingly relevant. Cash benefits are one main vehicle being introduced in ever more countries (see Table 1.1). Other options have included providing additional information for users to navigate through the system, for example via easy-to-use websites (Australia). The United States has increased federal co-funding for *money follow the person* programmes, started in 2005. These programmes stimulate service provision at the place where the person in need of care wants it delivered, for instance in his own home, and increased funding for the states to assist states' home-based care programmes in 2010. Some Nordic European countries introduced or expanded market incentives to stimulate private providers into the market.

Supporting carers

Increasingly OECD countries implement policies to support carers, for example through improved options for care leave, either paid (Canada) or unpaid (Germany), or the introduction of targeted carer allowances. Germany, Austria, and the Slovak Republic pay pension contributions to carers or have introduced special pension rights for carers (Spain), while Austria also pays health-insurance contributions and Germany provides low-rate unemployment insurance. Similarly, the Slovak Republic introduced a carer allowance for those below a certain income threshold in 2009. The United Kingdom published a Carers Strategy (UK HM Government, 2008), announcing several measures to support family carers such as expansion of respite services, measures to support carers to (re-)enter the job market, actions to improve support for young carers, General Practitioners and other professionals training to recognise and support carers. Pilot projects have been started on annual health checks for carers, while the right to request flexible working time for carers was extended.

Provision of service reforms

Provision of service reforms relate to the *LTC workforce* and to *quality of care*. Many countries report *workforce* related measures. Some measures include a wage increase, as in Japan (2009), funding of human resource development initiatives and supporting efforts to increase retention. Canada supports initiatives to allow nurses to devote 20% of their working time to professional development (Newfoundland/Labrador). The German federal government, in 2005, took over the cost of adult re-education in the third year of retraining, thus stimulating supply, while Luxembourg implemented a major training programme on palliative care to combine with its new palliative care benefit. Austria (2007) and Italy (2002, 2009) took measures to regulate the foreign-born care workers working in home care, while France aims to increase the worker density per resident in an LTC facility and set in place a recruitment and job-creation programme (2008). New Zealand developed workforce funding initiatives (2007), while England aims for further professionalisation of the social care workforce through a variety of means (2009). Austria has developed means for lower-level care workers to perform nursing or medical tasks, under supervision. Other measures include the implementation of legal qualification requirements (Spain, Austria, Germany), improving benefit packages for LTC workers (Belgium) or increasing worker density in certain specific care settings (France, Germany).

Issues relating to *quality* have become increasingly important. Australia set up a new quality system, including a review of accreditation procedures for providers, improved monitoring and dealing with complaints. The Czech Republic and the Slovak Republic implemented oversight policies, authorisation and compliance of providers' quality, while Germany enhanced quality supervision and aims at enhancing quality *management* of providers, together with improved consumer voice. Ireland published in 2009 the National Quality Standards for Residential Care Settings for older people, while Austria produced a handbook on dementia and Luxembourg has installed a Committee on quality of care.

Other measures include:

- stimulating the volunteering services (Switzerland, Germany);
- the installation of an Office for Older People within the government structure in Ireland (2008);
- conditional adjustment payments in Australia, aimed to strengthen management and governance for provider organisations that are willing to enrol into the scheme, as well as support for remote facilities;
- measures that aim to cross the borders between health care and long-term care, for instance by dedicated staff (United Kingdom), by the introduction of more transfer facilities (Australia) or by policies that enable continuity of worker across these borders, by introducing more options for co-operation and stimulating integrated care (Germany).

Workforce policies aim both at increasing the supply and the quality of care workers. This led to professionalisation initiatives and targeted training. Quality oversight – especially related to institutional care – and incentives to improve quality are the most common. In 2007, the Netherlands installed a Care Innovation Platform, aimed at the development, structural dissemination and implementation of innovations in (long-term) care provision.

1.8. Conclusions

LTC is a growing sector of the economy, serving predominantly people aged 65 years and over, who need assistance with the activities of daily living (ADL). Even though the older population is not the only target group, demand for LTC is highly age-related. LTC is a labour intensive sector comprised of formal workforce, but mostly of family carers, and in particular women. Despite that, the size of LTC workforce does not necessarily reflect the number of those in need, resulting often in shortages.

The structure and financing of LTC systems vary markedly between countries. The majority of LTC cost originates from the institutional sector, despite people's preferences to receive care in their homes. These costs are mostly funded from public sources. As far as benefits are concerned, these can either be in-kind or cash allowances. Cash benefits may either be granted to the family carer, or to the care recipient, allowing more choice regarding the services needed. All these methods have advantages and drawbacks.

Over the last decade, an increasing number of OECD countries has implemented or expanded policies targeted at the increase of LTC coverage and services, while at the same time aiming at improving service provision to those who are most in need. Some countries, such as Germany and Canada, have implemented policies to support carers, while others, such as New Zealand and Japan, have introduced system reforms related to the LTC formal workforce and quality. Many have introduced or are discussing reforms in financing and coverage of LTC.

Notes

1. Of these Dutch working-age family carers, 40% cares more than eight hours per week, 66% cares more than three months, 74% cares more than eight hours per week and/or more than three months, and 31% cares both more than eight hours per week *and* more than three months (SCP, 2010).
2. These place a monetary value to the work of unpaid carers, by multiplying the estimated number of hours of informal care by an estimated hourly value, based on the minimum wage and/or the average wage for formal LTC workers.
3. National data collections can underestimate private care provision and self-employed workers.
4. Total formal spending excludes the economic value and costs of family caring and other informal care. Spending data underestimate the private share.
5. Data tend to be limited to financial flows monitored by governments (*e.g.* mandatory co-payments), and there is therefore underreporting of direct out-of-pocket payments. Private LTC spending data do not cover informal payments.
6. The voucher represents a monetary value to be used for buying services such as care provided at home (or from home), in institutional settings, or through other services, such as night or day care, and palliative services. See Chapter 10 for a discussion on the impact of using vouchers on efficiency.
7. APA/THAB: *Allocation pour personnes âgées/Tegemoetkoming Hulp aan Bejaarden*.
8. CLASS stands for Community Living Services and Support.

References

Alber, J. and U. Köhler (2005), *Health and Care in an Enlarged Europe,* European Foundation for the Improvement of Living and Working Conditions, Dublin.

Alzheimer Europe (2006), *Dementia in Europe Yearbook 2006,* Luxembourg.

ABS – Australian Bureau of Statistics (2008), *A Profile of Caregivers in Australia*, Canberra.

Brookmeyera, R., E. Johnsona, K. Ziegler-Grahamb and H. Michael Arrighic (2007), "Forecasting the Global Burden of Alzheimer's Disease", *Alzheimer's & Dementia*, Vol. 3, pp. 186-191.

Ferri, C.P., M. Prince, C. Brayne, H. Brodaty, L. Fratiglioni, M. Ganguli, K. Hall, K. Hasegawa, H. Hendrie, Y. Huang, A. Jorm, C. Mathers, P.R. Menezes, E. Rimmer and M. Scazufca (2005), "Alzheimer's Disease International Global Prevalence of Dementia: A Delphi Consensus Study", *The Lancet*, Vol. 366, pp. 2112-2117.

Fujisawa, R. and F. Colombo (2009), "The Long-term Care Workforce: Overview and Strategies to Adapt Supply to a Growing Demand", *OECD Health Working Paper*, No. 44, OECD Publishing, Paris.

Giannelli, G.C., L. Mangiavacchi and L. Piccoli (2010), "GDP and the Value of Family Caretaking: How Much Does Europe Care?", *IZA Discussion Paper,* No. 5046, Bonn.

Gleckman, H. (2009), *The Future of Long-term Care: What Is Its Place in the Health Reform Debate?,* Urban-Brookings Tax Policy Centre, accessible at *www.taxpolicycenter.org/UploadedPDF/411908_longterm_care.pdf*.

Glendinning, C., F. Tjadens, H. Arksey, M. Moree, N. Moran and H. Nies (2009), "Care Provision Within Families and its Socio-Economic Impact on Care Providers", *Report for the European Commission DG EMPL. Negotiated Procedure VT/2007/114,* Social Policy Research Unit, University of York/Vilans, York/Utrecht.

Government of France (2008), *National Plan for Alzheimer and Related Diseases 2008-2012*.

Government of Portugal (2008), *National Strategy for Social Protection and Social Inclusion 2008-2010*.

Grammenos, S. (2005), *Implications of Demographic Ageing in the Enlarged EU in the Domains of Quality of Life, Health Promotion and Health Care. Studies on the Policy Implications of Demographic Changes in National and Community Policies*, Lot 5 Contract VC/2004/0076, No. S12.396079, Brussels.

Groth, H., R. Kingholz and M. Wehling (2009), "Future Demographic Challenges in Europe: the Urgency to Improve the Management of Dementia", *WDA-HSG Discussion Paper Series on Demographic Issues*, No. 2009/4.

Houser, A. and M. Gibson (2008), "Valuing the Unvaluable. The Economic Value of Family Caregiving. 2008 Update", *Insight on the Issues,* Vol. 13, November, accessible at *http://assets.aarp.org/rgcenter/il/i13_caregiving.pdf*.

Lamura, G., C. Chiatti, M. Di Rosa, M.G. Mechiorre, F. Barbabella, C. Greco, A. Principi and S. Santin (2010), "Migrant Workers in the Long-term Care Sector : Lessons from Italy", *Health and Ageing Newsletter*, No. 22, Geneva Association, April.

Lundsgaard, J. (2005), "Consumer Direction and Choice in Long-term Care for Older Persons, Including Payments for Informal Care. How Can it Help Improve Care Outcomes, Employment and Fiscal Sustainability?", *OECD Health Working Paper*, No. 20, OECD Publishing, Paris.

Manaaki, T. (2009), "How Should We Care for the Carers, Now and into the Future?", National Health Committee of New Zealand, accessed on 5 February 2010 at *www.nhc.health.govt.nz/moh.nsf/pagescm/7661/$File/caring-for-the-carers-nhc-2010.pdf*.

Martin, B. and D. King (2008), *Who Cares for Older Australians? A Picture of the Residential and Community-based Aged Care workforce, 2007*, Australian Government, Department of Health and Ageing/National Institute of Labour Studies, Flinders University and Commonwealth of Australia.

Ministerie van VWS (2007), *Arbeidsmarktbrief: Werken aan zorg,* MEVA/ABA/2807123, Netherlands.

NAC and AARP (2005), "Caregiving in the US", National Alliance for Caregiving and American Association of Retired Persons, accessible at *www.caregiving.org/data/04execsumm.pdf*.

Ngai, L.R. and C.A. Pissarides (2009), "Welfare Policy and the Distribution of Hours of Work", *CEP Discussion Paper*, No. 962, December 2009.

OECD (2008), *International Migration Outlook,* OECD Publishing, Paris.

PHI (2010), "Who Are the Direct Care Workers?", *Facts*, No. 3, February 2010 update, PHI, New York.

SCP (2010), *Mantelzorg uit de doeken,* Sociaal en Cultureel Planbureau, Den Haag.

UK Department of Health (2005), "Supporting People with Long-term Conditions. An NHS and Social Care Model to Support Local Innovation and Integration", Department of Health, Leeds.

UK HM Government (2008), "Carers at the Heart of 21st-century Families and Communities. A Caring System on Your Side. A Life of Your Own", accessible at *http://image.guardian.co.uk/sys-files/Society/documents/2008/06/10/carers_strategy.pdf*.

Wimo, A. and M. Prince (2010), *World Alzheimer Report 2010. The Global Economic Impact of Dementia,* Alzheimer's Disease International, accessible at *www.alz.co.uk/research./files/worlalzheimer report2010.pdf*.