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WORLD SOCIAL SECURITY FORUM
BRUSSELS 2019

World Social Security Forum
33rd ISSA General Assembly
Brussels, Belgium, 14–18 October 2019

Technical report on ageing-in-place and long-term care

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Summary

The phenomenon of population ageing has increased the demand for long-term care (LTC). Countries are responding differently to this challenge and with various degrees of urgency. This report reviews LTC systems in ten Member countries of the Organisation for Economic Co-operation and Development (OECD) that have enacted policy responses, some funded by contributions, some by taxes. Despite the different funding modalities in the ten countries, they all share concerns about financial sustainability and the cost-effectiveness of services. There is a prevailing tendency towards reforming these systems in accordance with the concept of ageing-in-place and the provision of care at home.

1. Introduction

Population ageing is one of the most significant social transformations of the twenty-first century with many implications on various sectors of societies. In 2017, there were an estimated 962 million people aged 60 or older worldwide, comprising 13 per cent of the global population. The number of seniors in the world is projected to reach 1.4 billion in 2030 and 2.1 billion in 2050. At the forefront of this impact is the requirement for adapted long-term care (LTC) services. While the extended family historically provided much support, changing family structures, the new demands of labour markets, and the size of the ageing population constitute a major challenge for elderly care. Acknowledging the increasingly pressing nature of this challenge, the International Social Security Association (ISSA) included the concepts of population ageing, health and LTC as core elements of the *10 global challenges for social security* report that was launched at the 2016 World Social Security Forum.

The ISSA's Technical Commission on Medical Care and Sickness Insurance has prepared this technical report to highlight that population ageing is a matter of concern for social security and healthcare systems. The report presents the approaches of ten countries in their efforts to establish or reform their LTC systems. The report commences with a literature review, then highlights health system challenges and social security concerns relevant to the reviewed systems. A concise description of the ten countries' approaches to LTC is presented based on the source of funding, either contribution-based or tax-based within the framework of Universal Health Coverage (UHC). The report offers a summary of the commonalities found among the studied systems and presents concluding thoughts.

2. Literature review

With rapid population ageing and changing family structures, care for the elderly is no longer considered a burden for family members alone, but rather a social responsibility. Life expectancy at birth is 80.6 years on average across OECD countries; people are living longer – but not necessarily healthier – with a rising burden of mental illness and chronic disease requiring LTC. In this regard, LTC programmes have been introduced in some countries since the mid-1990s to support elders who have difficulties to perform activities of daily life (ADL). Many OECD countries have implemented programmes to support home-based care in parallel to the existing institutional care. Importantly, this approach generally has a positive impact on individual well-being and is generally less expensive than institutional-based care, irrespective of whether a nursing facility or medical centre.

The World Health Organization (WHO, 2017) defines LTC as:

> the activities undertaken by others to ensure that people with, or at risk of, a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms, and human dignity.

LTC aims ultimately at supporting the functional capacity of people, instead of simply focusing on meeting basic health needs. This requires coordination between social services and healthcare to effectively respond to these needs. In 2002, the WHO released its policy on active ageing, defining it as "optimizing opportunities for health, participation, and security in order to enhance quality of life as people age."[1]

The United States Center for Disease Control and Prevention (CDC) defines ageing-in-place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level". This approach entails the benefits of familiar surroundings and better social interaction, together with a reduction in the cost of services. To prolong the duration of ageing-in-place, a range of necessary requirements for a continuum of care must be met comprising home adaptation, remote health monitoring, coordination of services at the community level and an age-friendly surrounding environment.

1. In support of this this policy, WHO has embarked on a Global Age-Friendly Cities project for 33 cities in 22 countries.

3. Healthcare system challenges

Growing and ageing populations, along with rising rates of noncommunicable diseases (NCDs) such as dementia, are driving demand for greater healthcare services, products and infrastructure tailored to these needs. The ten countries covered in this report face the same challenge of population ageing, as shown in Figure 1, but with different approaches in their responses. Life expectancy at birth among them ranges from 80.8 years to 88.8 years with the population aged 65+ ranging from 14 per cent to 27.8 per cent. Six out of the ten reported spending on LTC that is higher than the OECD average of 1.7 per cent of GDP; the highest levels are in the Netherlands 3.7 per cent and Sweden 3.2 per cent. Nevertheless, funding is not found to be sufficient, and cost-sharing has been applied in almost all the countries leading to inequalities of service distribution particularly for the lower socio-economic groups.

In contribution-based programmes where LTC is part of national health insurance (NHI), services provided in non-medical settings may not be recognized by the system, leading to overloads in hospitals and an increased cost of care. The exclusive provision of LTC as part of the national healthcare service (NHS) narrows the services to medical care and may overlook the social needs. Given the nature of NCDs and the frailty of the elderly, the NHS may not be well-equipped to provide the required care, a situation compounded by the global shortage of formal LTC professionals that risks affecting service quality.

Figure 1. *Percentage of population aged 65+ of the total population*

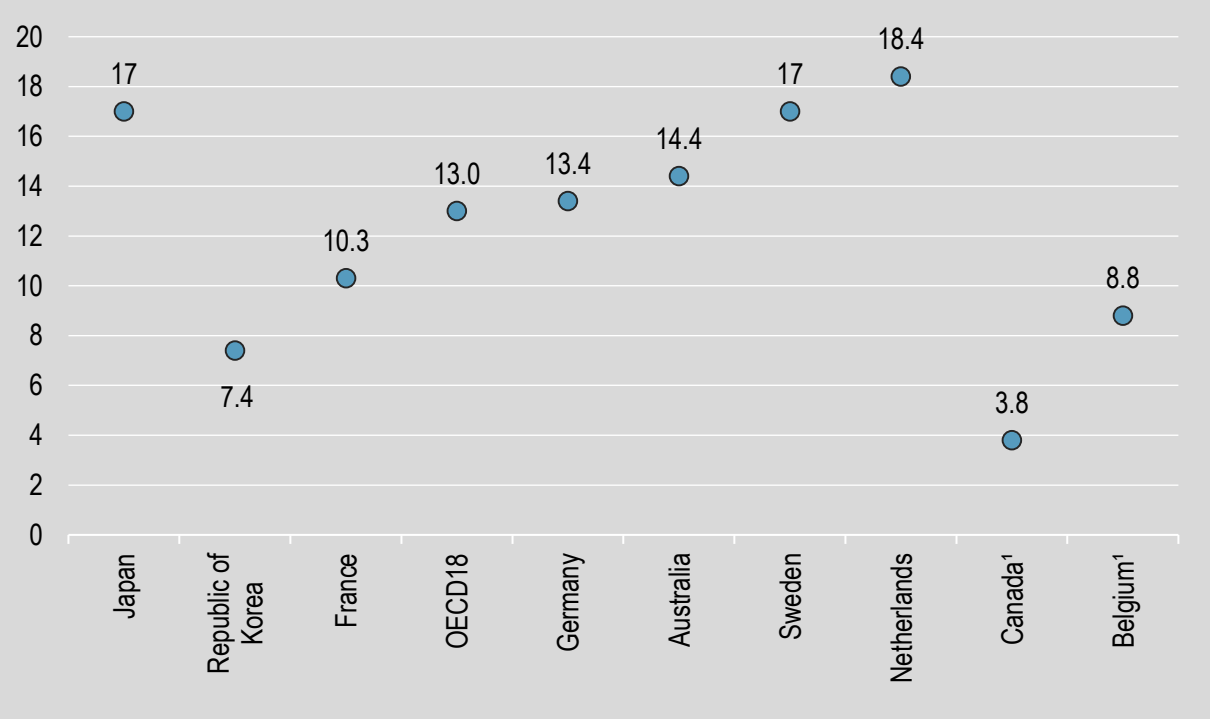
Source: OECD Health Statistics 2017.

4. Social security considerations

Organizing and funding social care in ageing societies is a policy challenge that requires a national strategy and strong political will. A lesson from Japan is that the sooner a country embraces the challenge, the better the outcome. As shown in Figure 2, the OECD average of beneficiaries accessing LTC is 13 per cent of people aged 65+ and the highest rates are reported in the Netherlands 18.4 per cent and Japan 17 per cent. Although difficult to measure, unmet need for care is still reported even in generous systems such as in Sweden.

LTC entails medical treatment and social care with an overlap of responsibilities between health and social services, leading to a coordination challenge, e.g. Belgium and the Republic of Korea. The application of cost sharing for LTC services requires adequate benefits from the social security system (SSS) for people to be able to pay out-of-pocket payments (OOP). When the SSS provides either limited or no support for LTC, informal caregivers assume this role. This can result in informal caregivers having to drop out of the labour force, with a consequent loss of contributory social security coverage and a potential increased future dependency on tax-financed social assistance. Few countries have implemented policies to support family carers and mitigate these possible outcomes. In Canada, the Employment Insurance provides financial assistance of up to 55 per cent of earnings, up to a maximum, to family care givers.[2]

Figure 2. *The proportion of people aged 65+ receiving long-term care (percentage)*



Note: [1] Values include only recipients of long-term care in institutions.

Source: OECD Health Statistics 2017.

2. See "Caregiving benefits and leave: What caregiving benefits offer".

5. Comparative analysis of national LTC systems

This section briefly reviews the national LTC programmes of ten countries. Each sub-section for each country starts with a description of the context, followed by a brief presentation of the system and benefits, the source of funding and current challenges.

5.1. Contribution-based LTC system

GERMANY			
Population	80.59 million	System Model	Mandatory LTCI
Average life expectancy	80.8 years	Legal Coverage	Universal
Population aged 65+	22.06%	Beneficiaries	13.4%
LTC Expenditure as % of GDP	1.3%	Cost-sharing	Yes (means-tested)

Context. Germany introduced the LTC Act in 1995 to establish Long Term Care Insurance (LTCI) as the fifth pillar of social insurance. The LTCI law aimed to combine universal social rights, cost control, expansion of care infrastructure, and the promotion of ageing-in-place with an emphasis on family-oriented support.

System. The system is characterized by having financially independent, organizationally independent, self-administrating insurers, instituted in each health insurance association, which carry out legally-mandated tasks under government supervision. The LTCI, following the health insurance system, covers the entire population. People who have private health insurance are obliged to buy private LTCI providing the same benefits package.

Benefits. The system covers only basic needs, recent reforms redefine five grades of care with increased new benefits. These include home care for ADLs, allowance for a caregiver, cost reimbursement, in-kind outpatient care, in-patient care covering fees for nursing homes, and mixed benefits. Beneficiaries of caregiver allowance can also be family members who opt to provide informal care. The country's recent reform attempts to expand the benefits package rather than to reduce out-of-pocket payments (OOP) for certain vulnerable groups.

Funding. LTCI is funded by salary deductions of contributions. In 2017, the rate was 2.55 per cent of income shared equally by employers and employees. Costs for services not covered by LTCI are paid by OOP. Sometimes, insured persons can apply for means-tested social assistance to cover these extra costs.

Current challenges. The system has undergone continuous reforms since 2002. With the increased new benefits, expenditures will grow along with a need to raise the contribution rate. The care infrastructure faces a shortage of out-patient and in-patient staff with an estimated current unmet need for 35,000 qualified care nurses.

JAPAN			
Population	126.5 million	System Model	Mandatory LTCI
Average life expectancy	88.8 years	Legal Coverage	Universal
Population aged 65+	27.87%	Beneficiaries	17%
LTC Expenditure as % of GDP	2%	Cost-sharing	Yes (10%)

Context. Since its introduction in 2000, Japan's social insurance LTCI system has operated with the objective of supporting people to maintain their independent daily life routine in accordance with their own abilities. Since 2014, reforms have sought to create a comprehensive regional care system wherein NHI and LTC are coordinated by local government.

System. The LTCI system is a universal, needs-based service and is not means tested. There is a formal national system for the assessment and certification of care needs. The programme is administered by municipalities, which set premiums and awards licenses to providers. Users choose the services they need from various providers. Fees for services are established by the federal government and are reviewed once every three years.

Benefits. The LTCI is available to all enrolled in the NHI aged 40 or older, categorized into two groups; "aged 65 or older" and "from age 40 to 64 diagnosed with a geriatric disease". The services provided are home-based, community-based and facility services. The municipalities have responsibility for operating the programme. There is no cash benefit to users or caregivers.

Funding. Participation is mandatory for all employed persons aged 40 or older. The elderly also pay a premium deducted from their pension that varies among municipalities. The services are financed 50 per cent from premiums and 50 per cent from general taxation. Beneficiaries assume a co-payment of 10 per cent for the services they use, plus accommodation costs for institutional care.

Current challenges. The most populated urban areas face a shortage of care facilities and long waiting lists. The shortage of health workers is a major challenge that is expected to worsen. Additional measures to attract more professionals from other Asian countries are being explored.

REPUBLIC OF KOREA			
Population	51.2 million	System Model	Mandatory LTCI
Average life expectancy	82.5 years	Legal Coverage	Universal
Population aged 65+	14.12%	Beneficiaries	7.4%
LTC Expenditure as % of GDP	0.8%	Cost sharing	Yes (15 to 20%)

Context. First announced in 2001, a proposal to launch a LTC system in the Republic of Korea was enacted in 2007, and implemented on 1 July 2008. Along with the National Responsibility Policy for Dementia Care, the Ministry of Health and Welfare (MOHW) announced a basic plan for community care in late 2018 as the first step towards integrated care.

System. The MOHW administrates the LTCI service. The National Health Insurance Service (NHIS) takes responsibility for operating the programme, carries out reviews and reimburses LTCI costs. The local government authorizes service providers and LTC institutions. People aged 65 or older are eligible for all types of LTC services. The LTC Grading Committee assesses beneficiaries are regards their having had difficulties in performing ADLs for at least 6 months.

Benefits. Benefits are divided into domiciliary services, including home care visits, bathing, nursing, day or night care, respite care, and welfare equipment service; facility benefits; and special cash benefits in exceptional cases.

Funding. Funding of the LTCI is distinct from the NHI, although both are administered by the NHIS. The contribution rate in 2018 is 7.38 per cent of health insurance premiums paid to NHI. The system is funded by contributions (60–65 per cent), tax subsidies (20 per cent), and co-payment of 15 per cent of home-based care costs and 20 per cent of institutional costs.

Current challenges. The majority of LTC beds are in hospitals with an unclear sharing of responsibilities between the NHI and LTCI. The system faces a shortage of LTC facilities, most of which are concentrated in urban areas, a lack of qualified care workers, and increased demands for improved services.

FRANCE			
Population	67 million	System Model	Mandatory LTCI
Average life expectancy	81.9 years	Legal Coverage	Universal
Population aged 65+	19.48%	Beneficiaries	10.3%
LTC Expenditure as % of GDP	1.7%	Cost-sharing	Yes (income-based)

Context. In 1997, the specific allowance for dependency for frail elderly people in France was approved, then replaced by the Personalised Allowance for Autonomy (APA) in 2001. The heat wave in 2003, that caused 15,000 deaths among elderly people living alone, was a turning point to make LTC a national priority and led to the creation of the National Solidarity Fund for Autonomy (CNSA) in 2004.

System. The public provision of LTC relies on a two-pronged system. The cost of health care is financed by the public health insurance scheme with cost-sharing for most goods and services, while social benefits are provided by the APA scheme. The system is decentralized and the APA is paid by the respective regional council (*Conseil départemental*). At a territorial level, there is a council which represents the different institutions that fund actions for the elderly (prevention, sport, and so on).

Benefits. There is a wide range of LTC services, either in institutions or at home. The APA benefits vary according to the person's level of dependency and income.

Funding. The French LTC system is a mixed system financed by both taxation and insurance contributions. The CNSA is funded from the employers' social insurance contributions; taxes including the Solidarity and Autonomy tax corresponds to 0.3 per cent of a company's total revenue; additional solidarity and autonomy contribution;[3] and a fraction of the social tax on capital income.

Current challenges. The decentralized provision of services enables close support; however, the consequent regional gaps of services is an issue. The link between medical care and LTC services at home is a challenge. The aim is to build an integrated response that meets people's specific needs. The cost of population ageing is, in general, a challenge for public spending sustainability.

3. Contribution Sociale Généralisée (CSG) et Contribution Solidarité Autonomie (CSA).

BELGIUM			
Population	11.5 million	System Model	Public Health Insurance
Average life expectancy	81.1 years	Legal Coverage	Universal
Population aged 65+	18.58%	Beneficiaries	8.8%
LTC Expenditure as % of GDP	2.3%	Cost-sharing	Yes

Context. LTC is not a social security branch in Belgium. LTC is provided for and reimbursed through a mix of services and provisions organized at different levels. Medical services are covered within the national health insurance, while social LTC services and allowances are part of the social protection provisions organized at regional level. Parts of the LTC services have been transferred to regional competence, since the sixth State Reform. This reform is part of a continuous process to transfer homogeneous competences to the four Regions/Communities for an autonomous provision of LTC services to people who do not require acute care.

System. Each region is responsible for regulating and financing LTC in institutions and at home for non-medical services. The federal government is responsible for the medical services of acute care in hospitals and at home through the universal public health insurance system. Within the sixth State reform, the regional authorities are fully competent for organizing or installing social benefits for LTC. The governments of the French-speaking parts have chosen to continue with the care allowances existing formerly at federal level. The Flemish regional community has reformed these allowance systems within its own LTCI scheme that is not means-tested and is restricted to its residents and residents of the Brussels Capital Region.[4]

Benefits. There are three types of LTC services: home care, residential care, and allowance for the elderly. The residential care includes homes for the elderly, nursing homes, and short-term residential care. Integrated Services for Home Care support programmes promoting ageing-in-place have been made possible and are operated on a local level. The allowance for assistance to elderly persons provides means-tested cash to offset expenses related to non-medical LTC. The Flanders LTCI scheme pays a monthly allowance to patients in need of care. This allowance is complemented by personal care budget allowances for persons with disabilities and severely dependent persons.

Funding. The bulk of LTC services are financed by the federal public compulsory health insurance system (60 per cent), general taxes (37 per cent) and the rest is out-of-pocket (OOP). The regionalized allowances for the elderly and targeted social welfare benefits are financed through general taxation. Flemish care insurance is financed through mandatory yearly contributions. Home assistance is financed through general taxation and OOP. Medical home care is reimbursed by the federal health insurance.

Current challenges. Belgium has a fragmented system of LTC that needs an integrated legal and governance framework for a clear delineation of responsibilities between the state and

4. The ormer "*Zorgverzekering*", now called the "*Zorgbudget*".

regional authorities in respect to the provision of LTC. The integration of care is therefore a shared challenge at all levels of governance; hence an integrated care plan[5] was signed by all the competent ministers in October 2015 including twelve pilot projects covering more than 2 million inhabitants. The issue is to guarantee the quality and continuity of care to every person in need of LTC.

THE NETHERLANDS			
Population	17.08 million	System Model	Compulsory NHI
Average life expectancy	81.4 years	Legal Coverage	Universal
Population aged 65+	18.73%	Beneficiaries	18.4%
LTC Expenditure as % of GDP	3.7%	Cost-sharing	Yes (income-dependant)

Context. The Netherlands provide LTC for the elderly as a service included in the NHI system. The LTC service, implemented since 1968, aims at providing home services by family members and supporting the elderly to lead a healthy life participating in community activities.[6]

***System*.** Everyone who lives in the Netherlands has LTCI under the Chronic Care Act (WLZ), formerly known as the Exceptional Medical Expenses Act (AWBZ). This covers care at home and institutional care for the elderly.

***Benefits*.** The WLZ care includes institutional care, personal care, nursing, and medical care. Beneficiaries of WLZ are not eligible for social support unless they opt to have support at home, which is a responsibility of the municipality under the Social Support Act (WMO). For benefits, personal co-payments are calculated depending on the need for care, income, household situation, and age. For people with chronic illnesses, a special cash benefit exists for the extra cost of living caused by a disability or chronic disease.

***Funding*.** The WLZ is funded by social security premiums as a percentage of workers' wages, earmarked taxes, and co-payments. There is a cost-sharing for all LTC services that is income-dependent.

***Current challenges*.** The system is facing funding pressures, as LTC expenses grow faster than wage-based contributions, the tax share of the budget is increasing. Future LTC costs are expected almost to double in the next decades, despite recent reforms.

5. For more information, see www.integreo.be.

6. A pioneering care facility for seniors with dementia, promoting ageing-in-place and quality LTC was constructed in 2009 as a nursing-home town named *Hogeweyk* in the Netherlands. The facility is called a *village*, not a hospital, and its inhabitants are called *residents*, not patients. The cost is between EUR 500 to EUR 2,500 a month. Hogeweyk is a not-for-profit organization, but the support of the Dutch social security system makes it sustainable.

5.2. Tax-funded LTC system

UNITED KINGDOM			
Population	64.77 million	System Model	NHS
Average life expectancy	80.8 years	Legal Coverage	Universal
Population aged 65+	18.04%	Beneficiaries	N/A
LTC Expenditure as % of GDP	1.5%	Cost-sharing	Yes (means-tested)

Context. The United Kingdom has a comprehensive LTC quality assurance legislation and structure. The Care Quality Commission, an independent regulator of health and adult social care, is responsible for assuring safety and quality. LTC services are managed separately by Wales, England, Scotland and Northern Ireland. Through the NHS & Community Care Act in 1990, the administrative structure of the centralized NHS was reformed and the internal competition system was adopted to promote the efficiency of the system.

***System*.** The central government is responsible for the overall policy on health and social services. The system for social care services is operated by the local authorities and overseen by the Department of Health. Health care services are run by the Department of Health. Cash payments of the attendance allowance are administered by the Department for Work and Pensions. Local authorities are responsible for ensuring that the needs of their local populations are being met.

Benefits. There are four levels of services depending on the LTC rating; critical, substantial, moderate, and low-needs. Formal services provided by local governments range from community-based care as nursing and home services, and institutional care, to means-tested cash benefits such as disability living allowance, and attendance and carer's allowances.

Funding. Health services under the National Health Service (NHS) are funded by the central government, mainly from general taxation but partly from national insurance contributions. Resources are distributed by the central government to local primary care trusts, which are responsible for commissioning a range of health services for their populations. Social services are funded by local authorities' resources that are derived from local taxes and user charges for services but mainly from central government grants. Beneficiaries do not pay most of the cost of services at home. However, institutional care is covered by a cost-sharing mechanism that is means-tested and covers some ratio of extra-cost.

Current challenges. The cost of services is increasing, including residential services that are expensive, both for individuals and the government, leading to questions related to the system's ability to protect the elderly with limited income.

AUSTRALIA			
Population	23.23 million	System Model	Subsidized care
Average life expectancy	82.3 years	Legal Coverage	Universal
Population aged 65+	16.14%	Beneficiaries	14.4%
LTC Expenditure as % of GDP	1%	Cost-sharing	Yes (means-tested)

Context. LTC in Australia caters to Australians aged 65+ who can no longer live without support in their own home. The Australian Government is the primary funder and regulator of the LTC system. The Aged Care Act 1997 and associated Aged Care Principles set out the legislative framework for funding and regulating LTC. The government supports ageing-in-place with regional community services.

System. The federal government has primary responsibility in financing and designing LTC for those aged 65+. The system has undergone major reform in recent years aiming at improving access, quality, consumer choice, and financial sustainability. Three main bodies are responsible for the regulation and compliance of services, and they share information to carry out their duties. The Department of Health is responsible for policy and compliance with the Act. The Australian Aged Care Quality Agency accredits providers. The Aged Care Complaints Commissioner handles complaints about services.

Benefits. Aged Care Assessment Teams independently assess the eligibility of individuals for residential care or home-based support packages. Once found eligible after the application of a means-test, beneficiaries can receive a federal subsidy for residential care or one of the home care packages provided in four levels depending on the needs. The services are delivered by various not-for-profit, for-profit, and government providers. The consumer-directed care provides service users flexibility to decide what types of care and services they access and how the services are delivered.

Funding. The system is taxation-based with means-tested user charges subjected to annual and lifetime caps. The services are subsidized by the Australian Government who provides approximately 95 per cent of the funding. The country is changing its policy to reduce out-of-pocket payments and enhance equity between pensioners and self-employed retirees.

Current challenges. Despite recent reforms, stakeholders argue for further changes to make the system more sustainable, consumer-driven and market-based.

CANADA			
Population	36.6 million	System Model	Decentralized
Average life expectancy	81.9 years	Legal Coverage	Near-universal
Population aged 65+	18.63%	Beneficiaries	3.8%
LTC Expenditure as % of GDP	1.2%	Cost-sharing	Yes

Context. Medical care and hospital care fall under the Canada Health Act and are covered through the universal healthcare system. Each of the ten provinces has its own approach to managing LTC, particularly home care. Québec implements LTC through a network of local community services centres that accommodate, temporarily or permanently, adults experiencing a loss of functional or psychosocial independence. The Old Age Security (OAS) programme provides monthly payment to people aged 65+.

***System*.** In the Canadian federation, jurisdiction over health and social services is a provincial responsibility. The federal government provides funding to provinces to ensure the portability of entitlements and services across the country. There is an effort to improve the quality of health care, to reduce waiting times and to promote primary health care through cooperation between the federal government and provinces.

***Types of benefits*.** Services at the provincial level include nursing homes, group home, care home, day-care, palliative care, respite care, and rehabilitation. Provinces cover a maximum number of hours of home care per month and any extra hours are paid by individuals. The OAS cash benefit is provided to all aged 65+ to ensure a minimum income for seniors.

***Funding*.** Canada functions as a single insurer for health care services through the enactment of relevant laws by the provinces and the territories, where health care resources are mostly funded by income taxes, consumption taxes, and corporate taxes. Provincial governments account for over 90 per cent of LTC finance in the public domain. The OAS programme is funded out of the general tax revenues of the Government of Canada. The federal government provides LTC funding to First Nations and veterans.

***Current challenges*.** The Canadian national Medicare system was not designed to deal with LTC needs and the lack of a national LTC system causes inequalities in access due to the variation of services among provinces. Out-of-pocket payments expenses have been high, as have levels of reported unmet needs.

SWEDEN			
Population	9.9 million	System Model	Decentralised
Average life expectancy	82.1years	Legal Coverage	Universal
Population aged 65+	20.26%	Beneficiaries	17%
LTC Expenditure as % of GDP	3.2%	Cost-sharing	Yes (3-4%)

Context. In 1992, the *Ädelreformen* (Elderly Reform) in Sweden was enforced and municipalities were given overall responsibility for social care for the elderly and the disabled. The Social Services Act regulates home-based care services and residential care including nursing homes. While the legal framework is set at a national level, the services are organized through a decentralized structure.

***System*.** The LTC system is recognized for being universal and comprehensive. Services are organized at a local level, with municipalities purchasing care from both public and private providers allowing free choice of providers by recipients.

***Benefits*.** LTC includes varying forms of assistance for ADL, both home-based and at institutions. Sweden encourages ageing-in-place, and services include assistive devices, transportation, housing adaptations, disability aids and support for informal caregivers. The cost of boarding and lodging is covered for institutional care, with a co-payment based on the income of the recipient.

***Funding*.** Most LTC services are financed through local municipal taxes. Government grants to municipalities cover around 11–12 per cent of the costs of LTC. The remaining expenses of 3–4 per cent are financed by user fees.

***Current challenges*.** The public spending on LTC is often described as generous and it is projected to increase in the future. The system is not attaining minimum care standards across all parts of the country to guarantee the quality of services and ensure efficiency.

6. Summing-up and discussion

Certain commonalities can be drawn from the ten countries covered in this report, particularly for the challenges presented in Table 1. The literature also draws attention to four main broad challenges for most LTC programmes; namely, access to affordable services, quality of care, employment of carers, and financial sustainability. Countries differently prioritize these challenges and their responses to them. Each country has a particular context. Nevertheless, the sharing of countries' experiences and lessons learned can be a good starting point for countries to benchmark progress. The Republic of Korea was able to learn from Germany and Japan's experiences and develop a model adapted to its situation. Such an approach should be further studied and evaluated.

The nature of LTC entails various forms of medical, social and community services. The fragmentation of services provided presents challenges for coordination. LTC services are found to have better outcomes in decentralized and regional systems with a client-centred approach.

The contribution-based systems need to be supplemented by tax, and the tax-based systems have a financial sustainability concern. Despite the fact that diversifying sources of funding improves the financial sustainability of systems, the application of cost-sharing – as one of these sources – builds a financial barrier to accessibility and contributes to higher levels of unmet needs. Nevertheless, earmarking taxes for LTC could be recommended, as is the case in France.

System reforms have been ongoing over the past decades, to readjust policies to emphasize home-based care, to address financial sustainability concerns, or to increase access by improving eligibility conditions and benefits. Many reforms seek to encourage ageing-in-place.

Table 1. *Common key challenges and alternatives*

<table>
<tr><th rowspan="2">Funding aspect
Diagnosis</th><th colspan="6">Contribution-based LTC system</th><th colspan="4">Tax-funded LTC system</th></tr>
<tr><td>Germany</td><td>Japan</td><td>Republic of Korea</td><td>France</td><td>Belgium</td><td>Netherlands</td><td>United Kingdom</td><td>Australia</td><td>Canada</td><td>Sweden</td></tr>
<tr><td rowspan="2">Common key challenges</td><td colspan="3">Shortage in care staff</td><td>N/A</td><td rowspan="2">Fragmented LTC system</td><td colspan="2" rowspan="2">Increasing cost</td><td rowspan="2">System sustainability</td><td rowspan="2">Lack of national LTC system</td><td rowspan="2">Increasing cost in the future</td></tr>
<tr><td>N/A</td><td colspan="3">Linkage between healthcare & LTC</td></tr>
<tr><td rowspan="2">Alternatives</td><td colspan="3">Providing professional education, providing incentives, etc.</td><td colspan="2">N/A</td><td colspan="4" rowspan="2">Considering consistent reforming current funding system to enhance efficiency</td><td rowspan="2">Setting minimum care standards</td></tr>
<tr><td>N/A</td><td colspan="4">Benchmarking the integrated service models from other countries</td></tr>
</table>

7. Conclusion

Many countries that are undergoing population ageing are considering establishing a formal LTC programme as part of their social protection system. In countries that have already established LTC programmes, various reforms initiatives are afoot.

The ISSA has promoted excellence for social security worldwide for decades and currently brings together over 320 social security institutions in 156 countries that provide social security to more than 3 billion people. Aligned with the 2030 Sustainable Development Goals agenda, wherein the Member States of the United Nations are working together to achieve Universal Social Protection (USP), the ISSA has joined the "Global Partnership for USP by 2030". To achieve UHC in the same context, closing the coverage gap is essential.

Besides coverage extension, the challenges and risks of population ageing, health care and LTC have been highlighted in the ISSA's *10 global challenges for social security* report series.

The ten countries covered in this report have already established LTC programmes with different modalities of funding. Financial sustainability is a considerable challenge for all, as is the difficulty to measure the effectiveness of systems with various levels and types of LTC needs. Arguably, an ageing-in-place model could be a cost-effective approach to provide people-centred LTC while avoiding the cost-burden of institutional care and ensuring the sustainability of services. There is no panacea for LTC, but the sharing of countries' experiences is recommended. In this regard, this report provides insights for countries where LTC programmes are still in their initial phase of development or are yet to become a part of the social security system.

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Acronyms

ADL	Activities of Daily Life
APA	Personalised Allowance for Autonomy (France)
AWBZ	Exceptional Medical Expenses Act (Netherlands)
CDC	Center for Disease Control and Prevention
CNSA	National Solidarity Fund for Autonomy (France)
GDP	Gross domestic product
ISSA	International Social Security Association
LTC	Long Term Care
LTCI	Long Term Care Insurance
MOHW	Ministry of Health and Welfare (Republic of Korea)
N/A	Not Available
NDCs	Noncommunicable Diseases
NHI	National Health Insurance
NHIS	National Health Insurance Service
NHS	National Healthcare Service
OAS	Old Age Security programme
OECD	Organisation for Economic Cooperation and Development
OOP	Out-of-Pocket payment
SDG	Sustainable Development Goals
SSS	Social Security System
UHC	Universal Health Coverage
USP	Universal Social Protection
WHO	World Health Organization
WMO	Social Support Act (Netherlands)
WLZ	The Chronic Care Act (Netherlands)