Incorporating Long-term Care into the New York Health Act

Lessons from Other Countries

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In developing the plan for incorporating long-term care into the New York Health Act, we felt we should learn from the experience of other countries which, in most cases, have already developed such national, universal programs. We looked at eight countries which, in their economic status and standard of living, are most similar to ours. They are: Canada, Denmark, England, France, Germany, Japan, Netherlands, and Sweden.

In the first section of this document we present tables comparing them on four aspects of such a long-term care program: standards of eligibility for the program, financing, assessment of an individual's need for services, the role of informal care by family or friends, and public satisfaction with the program.

In the second section, we present detailed summaries of the programs of each of these countries, including the lessons we might learn from each of them.

We hope these materials will prove useful to those analyzing the structure and implications of such a program for New York State

COUNTRY COMPARISONS

	Eligibility	
	Means-Tested Eligibility?	***Needs-Assessment***
Canada	Canada does not have a universal LTC policy.	Regional bodies determine the level of LTC need that residents require. Such health authorities often use a standardized assessment tool that attempts to measure one's health, ability to complete ADLs, and system of social support.
Denmark	No; every lawful resident is eligible for care. The ability to access personal care, or to receive help with day to day activities is entitled and available regardless of wealth or age.	Although Denmark does have a comprehensive system of assessment, the Ministry of Social Affairs left much of the responsibility to the municipalities. For example, since 1996 everyone aged 75 and older in Denmark has been entitled to "preventative visits" by a municipality-hired case manager. For these visits, the Ministry provided guidelines of what types of assessments must be done; however, the overall structure of such visits, is decided by the municipality. In general, the Barthel Index is used to assess functional impairment, but several different versions are used throughout Denmark. Denmark is unique in that there are no pre-defined categories of dependency/need.
England	Yes, for social services. The means-test looks at income, assets, and the availablity of informal care. Nursing care, on the other hand, is provided without means-testing by the NHS.	The assessment of the needs of the resident is completed by local authorities. There are criteria that were implemented by the "Fair Access to Care initiative" that define four different levels of need eligibility: low, moderate, substantial, and critical. This national framework was implemented to ensure that residents with similar levels of needs would provide care that aimed at achieving similar outcomes; however, it does not necessitate that these residents receive the same amount of care in different localities. Local councils are still able to decide what services will be provided for the different eligibility bands. Furthermore, they have the option of setting up "sub-bands" as well.
France	No, not for eligibility. Cost sharing is determined based on means testing.	In France, a scale called the AGGIR scale is used to assess the level of care that is needed. This scale assigns individuals to one of six degree of dependency based on the amount of difficulty that the individual has with ADLs. Of these six degrees, only the people who belong to Gir1-Gir4 (Gir1 is the most dependent category) receive the main allowance for autonomy (the APA). The process of assessment is three steps. First, the elderly resident submits a request. Then, he/she is evaluated by a social and health team. This team will define the care package. This plan will combine three different types of help including housework, personal services and equipment. Once this is made, the social worker (or other evaluator) will give the elderly resident the contact information of the organizations and people providing such services (Jönsson et al 2009). Finally, there will be a final agreement made by departmental authorities. Because France hopes to maintain freedom of choice, the resident (or family) has the responsibility of choosing the provider and contacting them.
Germany	No, the German long term care social insurance program is not means tested for eligibility, although cost-sharing contributions are means-tested.	The system by which German citizens are determined to be qualified for the program is undergoing reform at the moment. In the past, a person was considered eligible if they were unable to perform regular activities of daily living (ADLs) because of physical or mental illness or disability for at least six months. Under this system, there were three levels of severity. The first level of severity meant that the person needed assistance with at least 2 ADLs per day and one domestic task several times per week amounting to at least 90 minutes of care per day. Level 2 meant that the person needed assistance with ADLs 3 times each day and needed domestic care assistance several times per week, amounting to 180 minutes of care needed each day. Level 3, the most severe level, was reserved for people who needed assistance with ADLs all day and domestic assistance several times each week, totaling at least 300 minutes of care per day. Such assessments were conducted by the Medical Board of the sickness insurances. On August 12, 2015 the Federal Cabinet passed a bill to strengthen long term care in Germany. Part of this bill included a new evaluation system that six areas to measure--mobility, cognitive and communicative abilities, behavior and psychological problems, self reliance, coping with and independent handling of demands and pressures caused by illness or the need for therapy, organizing everyday life and social contacts--and created five categories of need.

	Eligibility	
	Means-Tested Eligibility?	***Needs-Assessment***
Japan	In Japan, there is no means testing for the LTC insurance. It is a universal program that is not dependent on the financial situation of the family or senior.	Japan utilizes a universal assessment tool that establishes seven (as of 2006) levels of care. After assessment, the assistance level and monthly benefits are communicated to the applicant. The certification must be renewed or amended every six months.
Netherlands	The Dutch LTC system is universal. There are no means testing for eligibility of services; however, cost sharing is determined via means-testing.	Eligibility for the AWBZ is determined by assessing the needs of the resident. This needs assessment is conducted by the CIZ (the Centre for Care Assessment), an independent organization with no financial incentives. The role of the CIZ is to determine if a resident should be deemed eligible for AWBZ because of either a "somatic, psycho-geriatric or mental disorder or limitation" or "an intellectual, physical, or sensory disability" (Mot et al 2010). The assessment process of the CIZ is referred to as the funnel model. It is completed in a step-wise fashion. First, the CIZ analyzes the situation of the resident: not only are disorders and any disabilities evaluated at this step, the circumstances—availability of usual and informal care and the existing use of programs like welfare and care provisions—are also investigated. During the second step the CIZ attempts to determine how best to solve the care problems of the resident. It does by looking to see if care can be provided outside of the AWBZ by usual family care (usual care is expected by the government, but there is a limit set on what is deemed "usual"), other publicly funded programs, or general provisions that are available to all residents. Thirdly, the role of voluntary care is investigated. If informal care exceeds "usual" care an entitlement exists; however, if the informal caregivers want to continue giving care, and the recipient want to continue receiving it, the potential entitlement under AWBZ may be adjusted downwards. Next, during the fourth step, the CIZ decides whether home or institutional care is preferable. Once these four steps are completed, a final decision on the entitlement is determined.
Sweden	There is no means testing for eligibility.	The amount of care given is determined by an assessment of needs. As of 2010, there was no general guidance provided by central authorities about how to assess for needs. Therefore, the method varied depending on the local authority. Several different models were used including, but not limited to, the Katz ADL index, the Residential Assessment Instrument, and the Geriatric depression scale.

	Financing	
	Percent GDP	***Cost Sharing***
Canada	2006-2010: 1.2% of GDP on public expenditure for LTC	The amount that is paid for by the province—and the amount covered by the family—varies from province to province. Furthermore, there is often a "spending-down" requirement in which residents of long term care facilities are required to "spend-down" their assets in order to qualify for the government subsidy
Denmark	2005: 1.95% of GDP; 2007: 1.7% of GDP; From 2006-2010: average of 2.2% of GDP spent on public expenditure for LTC	Schulz claims, in her report on the LTC system in Denmark (for the Assessing Needs of Care in European Nations—ANCIEN—project), that user fees do exist but play a very small role in the overall funding. Permanent, residential, assistance is free, but local counsils can charge payments for expenses that are not staff expenses such as laundry coins and meals.
England	2006-2010: average of 0.9% of GDP spent on public expenditure for LTC	Cost sharing plays an important role within the UK's LTC system, especially because social services are provided on a means-tested basis. Both eligibility, and the amount of costs that will be covered out of pocket, are determined based on this means-testing.
France	2010: 1.73% of GDP on LTC; 2006-2010: average of 1.1% of GDP spent on public expenditure for LTC.	Although the benefit is not means-tested, the amount is reduced progressively with increased income. It is reduced (from the full benefit) from 0% to 80% (meaning 100% of the full benefit to 20% of the full benefit)
Germany	2005: Total of 1.28% of the GDP was spent on LTC; 2006-2010: average of .9% of the GDP was spent on public expenditure for LTC.	The system does contain a cost-sharing component—with the amount of cost-sharing to be contributed determined by means-testing.
Japan	2010: 1.2% of the GDP was spent on LTC; 2006-2010: an average of .7% of the GDP was spent on public expenditure for LTC.	There is a 10% co-payment for services. In 2005, there was a reform that made it so that middle and high income users were no longer subsidized for hotel costs in institutional facilities (private nursing home hotel costs are also non-subsidized)
Netherlands	2010: 3.7% of the GDP was spent on LTC (highest of all OECD countries); 2006-2010: an average of 2.3% of the GDP was spent on public expenditure for LTC.	User charges, outside of institutions, are paid via a 12.60 Euro/hour co-payment. An income-dependent maximum is set. For example, for a person with a yearly income of 40,000 Euros, the maximum user fee is 307.83 Euros per four weeks, or about 4000 euros per year. In an institution, there are two different phases of cost-sharing: low for the first six months, and high after. While there are different levels set based on income, at the very least, a single resident must have remaining in their income at least 276.41 Euros per month to spend freely. Cost sharing is set up with this limit in mind
Sweden	2006: 3.5% of the total GDP was spent on LTC.	4-5% of LTC costs are covered by user fees. The central government sets a maximum monthly fee for long-term care which is related to the financial situation of the citizen. This came from the max-fee reform in 2002 that made it so the maximum fee was 180 Euro/month. In 2011, another reform set the maximum fee at 184 Euros.

	Needs Assessment
Canada	Regional bodies determine the level of LTC need that residents require. Such health authorities often use a standardized assessment tool that attempts to measure one's health, ability to complete ADLs, and system of social support.
Denmark	Although Denmark does have a comprehensive system of assessment, the Ministry of Social Affairs left much of the responsibility to the municipalities. For example, since 1996 everyone aged 75 and older in Denmark has been entitled to "preventative visits" by a municipality-hired case manager. For these visits, the Ministry provided guidelines of what types of assessments must be done; however, the overall structure of such visits, is decided by the municipality. In general, the Barthel Index is used to assess functional impairment, but several different versions are used throughout Denmark. Denmark is unique in that there are no pre-defined categories of dependency/need.
United Kingdom*	The assessment of the needs of the resident is completed by local authorities. There are criteria that were implemented by the "Fair Access to Care initiative" that define four different levels of need eligibility: low, moderate, substantial, and critical. This national framework was implemented to ensure that residents with similar levels of needs would provide care that aimed at achieving similar outcomes; however, it does not necessitate that these residents receive the same amount of care in different localities. Local councils are still able to decide what services will be provided for the different eligibility bands. Furthermore, they have the option of setting up "sub-bands" as well.
France	In France, a scale called the AGGIR scale is used to assess the level of care that is needed. This scale assigns individuals to one of six degree of dependency based on the amount of difficulty that the individual has with ADLs. Of these six degrees, only the people who belong to Gir1-Gir4 (Gir1 is the most dependent category) receive the main allowance for autonomy (the APA). The process of assessment is three steps. First, the elderly resident submits a request. Then, he/she is evaluated by a social and health team. This team will define the care package. This plan will combine three different types of help including housework, personal services and equipment. Once this is made, the social worker (or other evaluator) will give the elderly resident the contact information of the organizations and people providing such services (Jönsson et al 2009). Finally, there will be a final agreement made by departmental authorities. Because France hopes to maintain freedom of choice, the resident (or family) has the responsibility of choosing the provider and contacting them.

	Needs Assessment
Germany	The system by which German citizens are determined to be qualified for the program is undergoing reform at the moment. In the past, a person was considered eligible if they were unable to perform regular activities of daily living (ADLs) because of physical or mental illness or disability for at least six months. Under this system, there were three levels of severity. The first level of severity meant that the person needed assistance with at least 2 ADLs per day and one domestic task several times per week amounting to at least 90 minutes of care per day. Level 2 meant that the person needed assistance with ADLs 3 times each day and needed domestic care assistance several times per week, amounting to 180 minutes of care needed each day. Level 3, the most severe level, was reserved for people who needed assistance with ADLs all day and domestic assistance several times each week, totaling at least 300 minutes of care per day. Such assessments were conducted by the Medical Board of the sickness insurances. On August 12, 2015 the Federal Cabinet passed a bill to strengthen long term care in Germany. Part of this bill included a new evaluation system that six areas to measure--mobility, cognitive and communicative abilities, behavior and psychological problems, self reliance, coping with and independent handling of demands and pressures caused by illness or the need for therapy, organizing everyday life and social contacts--and created five categories of need.
Japan	Japan utilizes a universal assessment tool that establishes seven (as of 2006) levels of care. After assessment, the assistance level and monthly benefits are communicated to the applicant. The certification must be renewed or amended every six months.

	Needs Assessment
Netherlands	Eligibility for the AWBZ is determined by assessing the needs of the resident. This needs assessment is conducted by the CIZ (the Centre for Care Assessment), an independent organization with no financial incentives. The role of the CIZ is to determine if a resident should be deemed eligible for AWBZ because of either a "somatic, psycho-geriatric or mental disorder or limitation" or "an intellectual, physical, or sensory disability" (Mot et al 2010). The assessment process of the CIZ is referred to as the funnel model. It is completed in a step-wise fashion. First, the CIZ analyzes the situation of the resident: not only are disorders and any disabilities evaluated at this step, the circumstances—availability of usual and informal care and the existing use of programs like welfare and care provisions—are also investigated. During the second step the CIZ attempts to determine how best to solve the care problems of the resident. It does by looking to see if care can be provided outside of the AWBZ by usual family care (usual care is expected by the government, but there is a limit set on what is deemed "usual"), other publicly funded programs, or general provisions that are available to all residents. Thirdly, the role of voluntary care is investigated. If informal care exceeds "usual" care an entitlement exists; however, if the informal caregivers want to continue giving care, and the recipient want to continue receiving it, the potential entitlement under AWBZ may be adjusted downwards. Next, during the fourth step, the CIZ decides whether home or institutional care is preferable. Once these four
Sweden	The amount of care given is determined by an assessment of needs. As of 2010, there was no general guidance provided by central authorities about how to assess for needs. Therefore, the method varied depending on the local authority. Several different models were used including, but not limited to, the Katz ADL index, the Residential Assessment Instrument, and the Geriatric depression scale.

	Informal Care-Givers	
	Overview	***Support***
Canada	Informal care plays a large role in the LTC scheme in Canada. In general, the majority of informal care-givers are children or spouses. There are about 2.7 million Canadians that are providing LTC	Informal care-givers are supported in several ways in the Canadian LTC system. First, Canadian benefits allow for informal care-givers to take up to 6 weeks of paid leave to care for a loved one at the end of life. There are also tax benefits provided on an individual basis for informal care. There are also respite programs available for many Canadians; however, the CLHIA Report (2012) argues that the availability of such programs varies drastically across the different parts of the country.
Denmark	Denmark has a high proportion of its population providing informal care; however, this care is less intensive than the care provided via informal mechanisms than in many other countries.	There are cash payments available; however, they are not commonly used in Denmark
England	The UK's LTC system heavily relies on informal (unpaid) care. This care is provided by different sources, but most commonly it is provided by a spouse or child. It is estimated that 85% of all elderly with a disability living in private homes receive some form of informal care.	Within the UK system, there is financial support for the informal care-giver. This support—termed the Carer's allowance—is a cash benefit that is paid to informal care-givers who work long hours. In general, about 62 euros/week is paid to informal care-givers who provide 35+ hours of care, earn less than 110 Euros/week, are not in full-time education, and look after someone who qualifies for disability benefits. An interesting distinction has been made about the UK's carer's allowance: it is not meant to act as payment for informal care, but rather as a compensation for the loss of earnings a care-giver sees.
France	In France, about 22.5% of elderly residents (over 65 years old) receive informal practical help—from people who do not live with them (relatives or friends) while 7.3% receive informal personal care.	Policy trends have aimed to recognize, and ameliorate, the toll on such care-givers, of which, about 42% declare having negative consequences—both psychological and physical. There have been two different attempts to support such workers. In 2007, a law was passed to allow carers to take up to three months off of work without losing retirement rights. Another measure was to invest in day-care services. Unlike many LTC programs, there is no payment to relatives in this program.

	Informal Care-Givers	
	Overview	***Support***
Germany	The German system relies heavily on informal care, with 37.1% of people over 65 receiving practical help and 9% receiving personal care from informal caregivers.	Informal care-givers are incentivized within the German system by the provision of cash benefits. Under the recent expansion of the German long term care system, caregivers are being further incentivized. For example, caregivers will now be paid pension contributions if they provide over ten hours of care per week. Furthermore, coverage in unemployment insurance for such providers will be expanded
Japan	One of the main goals of the Japanese LTC program is to reduce the burden on family givers. In fact, this has been given as one reason not to include cash payments (as it may put pressure on family carers—mostly women—to stay home and provide care). One of the goals of this was to increase the amount that family members who were providing care would be able to work. The average time that family carers spent caring dropped significantly after the introduction of this program (by .81 hours/day). Unfortunately, for middle and low income individuals the amount of time spent working showed no significant change after the introduction of the LTC program. One explanation could be that the opportunity cost of providing informal care for higher income residents is much higher than for low income individuals because of their higher salary. Furthermore, care leave is often offered to full-time workers with high income, so they are able to have the flexibility needed to still provide small amounts of care.	There are no cash benefits provided in the Japanese LTC program.
Netherlands	The Netherlands has a high proportion of its population providing informal care; however, this care is less intensive than many other countries. Of the population 65 and older in the Netherlands, 28.8% receive some practical help from informal care-givers, but only 3.2% receive any personal help.	There are cash benefits for informal care givers, but they play a small role within the LTC system.

	Informal Care-Givers	
	Overview	***Support***
Sweden	Sweden has a high proportion of its population providing informal care; however, this care is less intensive than in many other countries. In Sweden, 42% of people needing help with 1-2 tasks receive family care and this number, of older residents receiving informal care, has been increasing. From 2002/3-2009/10 help from non-cohabiting family members increased from 48 to 63 percent of non-institutionalized older people receiving informal help. Now, 8 out of 10 adults provide some care for an older person, and one study suggested that 31.1% of older adults (65+) receive informal practical help while 3.1% receive informal personal care.	National policy on support for family carers strongly stresses that family care must be provided voluntarily; however, there are systems of support such as cash payments to relatives. As of July, 2009, municipalities have been required to support informal caregivers in several ways, although these vary depending on the municipality. For example, there is a cash benefit that varies between SEK 1,000-3,000 per month provided to the care-recipient (to be given to the informal care-provider); however, this is not available (as of 2010) nationwide. Other support can come in the form of support groups, relief support, temporary residence for care recipients, volunteer services, and much more.

	Satisfaction Surveys
Canada	Assessing Canadian's satisfaction with their long term care system would prove very difficult as it varies drastically across each providence.
Denmark	One study showed that less than 25% of Danish citizens were "dissatisfied with the performance of their LTC system," the lowest percentage of all European countries studied for this policy project.
England	One study found that about 40% of UK citizens were "dissatisfied with the performance of their LTC system," near the middle of European countries studied.
France	One study found that about 25% of French citizens were "dissatisfied with the performance of their LTC system," the second lowest percentage of all European countries studied for this policy project.
Germany	One study found that about 40% of German citizens were "dissatisfied with the performance of their LTC system." Germany's satisfaction rate was near the top third of countries studied
Japan	In a summary of answers from 11,181 people in 9 different prefectures in Japan, it was found that 86% of LTC insurance users are "satisfied" or "nearly satisfied." Only 5% are "slightly dissatisfied" or "dissatisfied." It was found that only 17% of users believed that the fee was "too expensive" (and 21% believed it was "slightly expensive") and about 21% felt that they had a "heavy emotional burden" because of the premium.
Netherlands	One study found that less than 30% of Dutch citizens were "dissatisfied with the performance of their LTC system." Of the European countries studied the lowest percent dissatisfaction was Denmark, with less than 25% dissatisfaction.

	Satisfaction Surveys
Sweden	One study found that less than 30% of Swedish citizens were "dissatisfied with the performance of their LTC system." Sweden's satisfaction rate was in the top four countries studied, barely behind Denmark, France and Belgium

Selected
Long-Term Care Programs Internationally

		Canada	Denmark	United Kingdom*
Type of LTC System		No universal LTC Policy is included within the Canada Health Act.	The Consolidation Act on Social Services (CASS) utilizes a state responsibility model in which each state (municipality) is in charge of providing care for the elderly that meets the country-wide expectation that all have free and equal access to the assistance that is offered.	While England has a long term care system, it should be considered a "safety-net" program—similar to Medicaid—not a universal LTC system. The program consists of two main parts: (1) long term nursing, and (2) social care. The nursing care is provided under the National Health Service (NHS), and is available to all residents (without means testing). On the other hand, social care under the LTC system is attached to means-testing.
Demographics	*Population*	2015: 35,851,770	2016: 5,707,251	2015: 65,138,230
	Seniors	2012: 14% over 65; (Projected) 2036: 25% over 65	2016: 25% over 60; (Projected) 2060: 31% over 60	2015: 18% over 65; (Projected) 2040: 24.2% over 65
	Elderly	2012: 4.1% over 80; (Projected) 2036: 7.6% over 80	2016: 4.3% over 80; (Projected) 2060: 10.18% over 80	2010: 2% over 85; (Projected) 2035: 5% over 85
Eligibility	*Means-Tested Eligibility?*	Canada does not have a universal LTC policy.	No; every lawful resident is eligible for care. The ability to access personal care, or to receive help with day to day activities is entitled and available regardless of wealth or age.	Yes, for social services. The means-test looks at income, assets, and the availablity of informal care. Nursing care, on the other hand, is provided without means-testing by the NHS.
	Needs-Assessment	Regional bodies determine the level of LTC need that residents require. Such health authorities often use a standardized assessment tool that attempts to measure one's health, ability to complete ADLs, and system of social support.	Although Denmark does have a comprehensive system of assessment, the Ministry of Social Affairs left much of the responsibility to the municipalities. For example, since 1996 everyone aged 75 and older in Denmark has been entitled to "preventative visits" by a municipality-hired case manager. For these visits, the Ministry provided guidelines of what types of assessments must be done; however, the overall structure of such visits, is decided by the municipality. In general, the Barthel Index is used to assess functional impairment, but several different versions are used throughout Denmark. Denmark is unique in that there are no pre-defined categories of	The assessment of the needs of the resident is completed by local authorities. There are criteria that were implemented by the "Fair Access to Care initiative" that define four different levels of need eligibility: low, moderate, substantial, and critical. This national framework was implemented to ensure that residents with similar levels of needs would provide care that aimed at achieving similar outcomes; however, it does not necessitate that these residents receive the same amount of care in different localities. Local councils are still able to decide what services will be provided for the different eligibility bands. Furthermore, they have the option of setting up "sub-bands" as well.
Financing	*Percent GDP*	2006-2010: 1.2% of GDP on public expenditure for LTC	2005: 1.95% of GDP; 2007: 1.7% of GDP; From 2006-2010: average of 2.2% of GDP spent on public expenditure for LTC	2006-2010: average of 0.9% of GDP spent on public expenditure for LTC
	Overview of Scheme	Canada has no universal LTC plan; however, some costs are subsidized by the government. For example, nursing home care is subsidized in all Canadian provinces.	The vast majority of this care is financed by taxes, but the municipalities can also receive grants and subsidies from the national government. These are often used to expand specific services such as dementia services.	In 2006, the total expenditure on long-term care services amounted to about 20 billion Euros. 20.6% of this was funded through the NHS, 39.7% through local authorities, and 39.7% by families and individuals. Of that 39.7%, 10% was from user fees and the other 29.7% were from private expenditures.

Selected
Long-Term Care Programs Internationally

		Canada	Denmark	United Kingdom*
	Cost Sharing	The amount that is paid for by the province—and the amount covered by the family—varies from province to province. Furthermore, there is often a "spending-down" requirement in which residents of long term care facilities are required to "spend-down" their assets in order to qualify for the government subsidy	Schulz claims, in her report on the LTC system in Denmark (for the Assessing Needs of Care in European Nations—ANCIEN—project), that user fees do exist but play a very small role in the overall funding. Permanent, residential, assistance is free, but local counsils can charge payments for expenses that are not staff expenses such as laundry coins and meals.	Cost sharing plays an important role within the UK's LTC system, especially because social services are provided on a means-tested basis. Both eligibility, and the amount of costs that will be covered out of pocket, are determined based on this means-testing.
Benefits		The types of benefits and services provided vary largely across different provinces. Many provinces will cover some costs of home and institutional care; however, there is little federal oversight on what is done so such systems vary drastically across provinces.	In general, people are eligible for several different types of services including home nursing, home care, and practical help. Home nursing refers to the medical care that a resident needs such as wound care. This is provided by a professional nurse in home (after being prescribed by a physician). Health services include those services that promote health and rehabilitation. Finally, practical help refers to personal care services, such as help with ADLs, and domestic tasks, such as meal preparation. These can be provided by many different professionals such as paraprofessionals, personal care workers, and housekeepers. Intensive informal care is not common; however, it can be	There are several different formal services offered within the UK LTC system including community health services, independent care homes, nursing homes, home care, and day-care services. As previously described, nursing care is provided regardless of one's financial availability. Along with accessing services provided in kind for nursing care, it is also possible to qualify what is termed an "attendance allowance." This is a type of cash benefit provided to those who need frequent attention during the day (or night) for help with "bodily functions" or supervision during the day (or night) to ensure the safety of the resident—or others. Another service that can be utilized is called the "individual
Providers	*Public*	25.2% of LTC beds were in government owned facilities.	The public sector is the main provider o	Services are provided across all three sectors.
	For-Profit	40.7% of LTC beds were in for-profit institutions.	Denmark has introduced policies to incentivize the purchase of market-based home care services. For example, a scheme in Denmark allows people over 65 to take a 30% tax subsidy to be used to purchase assistance with domestic chores. This has led to the creation of a for-profit market.	Services are provided across all three sectors.
	Not-For-Profit	10.2% of LTC beds were in religious facilities and 23.9% were in not-for-profit facilities.	NA	Services are provided across all three sectors.
Private Insurance		In 2010, about 385,000 residents of Canada were covered with private LTC insurance.	No	Minimal

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Informal Care-Givers	*Overview*	Informal care plays a large role in the LTC scheme in Canada. In general, the majority of informal care-givers are children or spouses. There are about 2.7 million Canadians that are providing LTC	Denmark has a high proportion of its population providing informal care; however, this care is less intensive than the care provided via informal mechanisms than in many other countries.	The UK's LTC system heavily relies on informal (unpaid) care. This care is provided by different sources, but most commonly it is provided by a spouse or child. It is estimated that 85% of all elderly with a disability living in private homes receive some form of informal care.
	Support	Informal care-givers are supported in several ways in the Canadian LTC system. First, Canadian benefits allow for informal care-givers to take up to 6 weeks of paid leave to care for a loved one at the end of life. There are also tax benefits provided on an individual basis for informal care. There are also respite programs available for many Canadians; however, the CLHIA Report (2012) argues that the availability of such programs varies drastically across the different parts of the country.	There are cash payments available; however, they are not commonly used in Denmark	Within the UK system, there is financial support for the informal care-giver. This support—termed the Carer's allowance—is a cash benefit that is paid to informal care-givers who work long hours. In general, about 62 euros/week is paid to informal care-givers who provide 35+ hours of care, earn less than 110 Euros/week, are not in full-time education, and look after someone who qualifies for disability benefits. An interesting distinction has been made about the UK's carer's allowance: it is not meant to act as payment for informal care, but rather as a compensation for the loss of earnings a care-giver sees.
Satisfaction Rates		Assessing Canadian's satisfaction with their long term care system would prove very difficult as it varies drastically across each providence.	One study showed that less than 25% of Danish citizens were "dissatisfied with the performance of their LTC system," the lowest percentage of all European countries studied for this policy project.	One study found that about 40% of UK citizens were "dissatisfied with the performance of their LTC system," near the middle of European countries studied.

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Long-Term Care Programs Internationally

		France	Germany	Japan
Type of LTC System		France's most recent (and current) long term care (LTC) policy, called the APA (personalized allowance for autonomy), was created in July of 2001 (the first allowance was approved in 1997). In 2004, the CNSA—another plan—was introduced to increase the national funding of the APA. The French program financed through general tax revenues only and is able to fund about 70% of care. Part of this is because the French system cuts benefits to high income seniors.	Implemented in 1995, Germany's long term care system is based on a mandatory central government social insurance model.	Japan's long term care (LTC) system is a social insurance program that was created in 2000. It became the third pillar of social security joining healthcare and pensions.
Demographics	*Population*	2015: 66,808,385	2014: 81,197,537	2013: 127,000,000
	Seniors	2015: 19% over 65; (Projected) 2060: 33% over 65	2013: 20% over 65; (Projected) 2060: 33% over 65	2010: 23% over 65; (Projected) 2050: 40% over 65
	Elderly	(Projected) 2020: 4 million people over 80; (Projected) 2040: 70 million people over 80.	2013: 5% over 80; (Projected) 2016: 13% over 80	2015: 7.9% over 80; (Projected) 2050: 16.5% over 80
Eligibility	*Means-Tested Eligibility?*	No, not for eligibility. Cost sharing is determined based on means testing.	No, the German long term care social insurance program is not means tested for eligibility, although cost-sharing contributions are means-tested.	In Japan, there is no means testing for the LTC insurance. It is a universal program that is not dependent on the financial situation of the family or senior.
	Needs-Assessment	In France, a scale called the AGGIR scale is used to assess the level of care that is needed. This scale assigns individuals to one of six degree of dependency based on the amount of difficulty that the individual has with ADLs. Of these six degrees, only the people who belong to Gir1-Gir4 (Gir1 is the most dependent category) receive the main allowance for autonomy (the APA). The process of assessment is three steps. First, the elderly resident submits a request. Then, he/she is evaluated by a social and health team. This team will define the care package. This plan will combine three different types of help including housework, personal services and equipment. Once this is made, the social worker (or	The system by which German citizens are determined to be qualified for the program is undergoing reform at the moment. In the past, a person was considered eligible if they were unable to perform regular activities of daily living (ADLs) because of physical or mental illness or disability for at least six months. Under this system, there were three levels of severity. The first level of severity meant that the person needed assistance with at least 2 ADLs per day and one domestic task several times per week amounting to at least 90 minutes of care per day. Level 2 meant that the person needed assistance with ADLs 3 times each day and needed domestic care assistance several times per week, amounting to 180 minutes of care needed each day. Level 3, the most severe level, was reserved for people who needed assistance with ADLs all day and	Japan utilizes a universal assessment tool that establishes seven (as of 2006) levels of care. After assessment, the assistance level and monthly benefits are communicated to the applicant. The certification must be renewed or amended every six months.
Financing	*Percent GDP*	2010: 1.73% of GDP on LTC; 2006-2010: average of 1.1% of GDP spent on public expenditure for LTC.	2005: Total of 1.28% of the GDP was spent on LTC; 2006-2010: average of .9% of the GDP was spent on public expenditure for LTC.	2010: 1.2% of the GDP was spent on LTC; 2006-2010: an average of .7% of the GDP was spent on public expenditure for LTC.
	Overview of Scheme	The French LTC plan is paid for by three different methods: (1) taxes, (2) contributions through social insurance, and (3) families. Furthermore, there is also private insurance available in France. The way the public expenditure is spent differs in institutions versus home care. In institutions, the overall fee is paid for in three ways. First, the nursing care is paid for by health insurance, dependency is partially covered by APA (for care services such as ADLs), and the lodging fees are paid for by the families. Lodging fees can vary drastically, from 12,000 to 29,000 Euros per year. Home care is paid for with several different sources. The APA pays a portion (about 4.5 billion Euros in 2007) along with the	Long term care costs are paid for by the following methods: 56.8% by social insurance, 1.7% by private long term care insurance, 8.3% by social assistance, 1.9% by welfare for war victims, and 31.3% out of pocket.	Japan's LTC insurance program is technically considered a social insurance; however, about 45% of funding comes through taxes. Another 45% comes through social contributions and 10% comes from co-payments.

Selected
Long-Term Care Programs Internationally

		France	Germany	Japan
	Cost Sharing	Although the benefit is not means-tested, the amount is reduced progressively with increased income. It is reduced (from the full benefit) from 0% to 80% (meaning 100% of the full benefit to 20% of the full benefit)	The system does contain a cost-sharing component—with the amount of cost-sharing to be contributed determined by means-testing.	There is a 10% co-payment for services. In 2005, there was a reform that made it so that middle and high income users were no longer subsidized for hotel costs in institutional facilities (private nursing home hotel costs are also non-subsidized)
Benefits		Many services are available in France. These services "include nursing and residential homes, hospital, home nursing care services, home care services, day care centres and support for informal carers" (Joel et al 2010). About 10% of elderly residents (and about two-thirds of those with dependency) live in nursing homes showing that, in general, home-based services are preferred (both by the residents and by government policies).	Within the German system, there are three options for benefits. The first option is a cash benefit. Secondly, care can be contracted directly with the insurance, and thirdly, a beneficiary could receive a combination of these two options. Social insurance will pay for both nursing home care and care-in-kind home services. In 2009, about 2.34 million people were eligible for benefits.	There are many services that can be utilized within this system. They range from care prevention services to at home or institutional care. In the home, care services include practical and personal care, nursing, bathing, rehabilitation services along with funds to purchase needed equipment. There are also community services provided such as commuting and day care services. There are several types of institutional care settings such as the nursing home, geriatric intermediate care centers, and LTC health centers. The latter two are for patients who are stable but need extensive rehabilitation or nursing. Japan's LTC system does not provide cash benefits.
Providers	*Public*	60% of LTC beds were public in 2007. About 30% of home nursing care services are provided by public organizations.	There are municipally run institutional facilities.	There are some municipally run institutional facilities.
	For-Profit	14% of LTC beds were for-profit in 2007. The for-profit sector is currently growing, and surely represents a larger portion of LTC beds now.	There are private, for-profit, institutional facilities.	There are some private, for-profit institutional facilities. Most home care is for-profit, with 55.1% of 20,885 businesses that provided home care in 2008 being for-profit entities.
	Not-For-Profit	26% of beds were not-for-profit in 2007. Two-thirds (approx.) of home nursing care services are provided by not-for-profit organizations.	LTC is provided mainly by private, not for profit organizations.	Most institutional care is provided by private, non-profit providers.
Private Insurance		Proportionally, the French private insurance market is the largest market. A total of 2.1 billion Euros was spent on this market in 2007.	There is a private insurance option in Germany chosen by approximately 9 million people (or about 9% of the population). This private insurance model is provided for high income individuals who choose to opt out of the social insurance model—note that carrying long term care insurance is mandatory within the German system so opting out of the social insurance can only be done if private insurance is purchased.	No

Selected
Long-Term Care Programs Internationally

		France	Germany	Japan
Informal Care-Givers	*Overview*	In France, about 22.5% of elderly residents (over 65 years old) receive informal practical help—from people who do not live with them (relatives or friends) while 7.3% receive informal personal care.	The German system relies heavily on informal care, with 37.1% of people over 65 receiving practical help and 9% receiving personal care from informal caregivers.	One of the main goals of the Japanese LTC program is to reduce the burden on family givers. In fact, this has been given as one reason not to include cash payments (as it may put pressure on family carers—mostly women—to stay home and provide care). One of the goals of this was to increase the amount that family members who were providing care would be able to work. The success of the LTC Insurance program in meeting this goal was investigated by Tamiya et al (2011) who found that the average time that family carers spent caring dropped significantly after the introduction of this program (by .81 hours/day). Unfortunately, for middle and low income individuals the amount of time spent working showed no significant change
	Support	Policy trends have aimed to recognize, and ameliorate, the toll on such care-givers, of which, about 42% declare having negative consequences—both psychological and physical. There have been two different attempts to support such workers. In 2007, a law was passed to allow carers to take up to three months off of work without losing retirement rights. Another measure was to invest in day-care services. Unlike many LTC programs, there is no payment to relatives in this program.	Informal care-givers are incentivized within the German system by the provision of cash benefits. Under the recent expansion of the German long term care system, caregivers are being further incentivized. For example, caregivers will now be paid pension contributions if they provide over ten hours of care per week. Furthermore, coverage in unemployment insurance for such providers will be expanded	There are no cash benefits provided in the Japanese LTC program.
Satisfaction Rates		One study found that about 25% of French citizens were "dissatisfied with the performance of their LTC system," the second lowest percentage of all European countries studied for this policy project.	One study found that about 40% of German citizens were "dissatisfied with the performance of their LTC system." Germany's satisfaction rate was near the top third of countries studied	In a summary of answers from 11,181 people in 9 different prefectures in Japan, it was found that 86% of LTC insurance users are "satisfied" or "nearly satisfied." Only 5% are "slightly dissatisfied" or "dissatisfied." It was found that only 17% of users believed that the fee was "too expensive" (and 21% believed it was "slightly expensive") and about 21% felt that they had a "heavy emotional burden" because of the premium.

Selected
Long-Term Care Programs Internationally

		Netherlands	Sweden
Type of LTC System		In 1968, the Exceptional Medical Expansion Act created a long-term care insurance system called the AWBZ. This plan is universal and publically funded. (NOTE: there was a recent reform--in 2015--in which the LTC policy was massively overhauled. This looks at the plan pre-2015).	In 1957, the Social Services Act was introduced in Sweden. This act gave the Swedish municipalities responsibility for providing home care to elderly or disabled citizens. The Social Services Act has evolved into the long term care structure that exists today in which municipalities are in charge of providing many services for elderly citizens. Sweden's long term care system is universal and publically funded. There are three different authorities in charge of managing this system: the central government, the county councils, and the local authorities.
Demographics	*Population*	2016: 16,979,729	2015: 9,798,871
	Seniors	20165: 18% over 65; (Projected) 2050: 24.5% over 65.	2011: 19% over 65; (Projected) 2060: 25% over 65
	Elderly	2011: 4% over 80; (Projected) 2050: 10% over 80.	2011: 5% over 80; (Projected) 2060: 6.3% over 80
Eligibility	*Means-Tested Eligibility?*	The Dutch LTC system is universal. There are no means testing for eligibility of services; however, cost sharing is determined via means-testing.	There is no means testing for eligibility.
	Needs-Assessment	Eligibility for the AWBZ is determined by assessing the needs of the resident. This needs assessment is conducted by the CIZ (the Centre for Care Assessment), an independent organization with no financial incentives. The role of the CIZ is to determine if a resident should be deemed eligible for AWBZ because of either a "somatic, psycho-geriatric or mental disorder or limitation" or "an intellectual, physical, or sensory disability" (Mot et al 2010). The assessment process of the CIZ is referred to as the funnel model. It is completed in a step-wise fashion. First, the CIZ analyzes the situation of the resident: not only are disorders and any disabilities evaluated at this step, the circumstances—availability of usual and informal care and the existing use of programs like welfare and care provisions—are also investigated. During the second step the CIZ	The amount of care given is determined by an assessment of needs. As of 2010, there was no general guidance provided by central authorities about how to assess for needs. Therefore, the method varied depending on the local authority. Several different models were used including, but not limited to, the Katz ADL index, the Residential Assessment Instrument, and the Geriatric depression scale.
Financing	*Percent GDP*	2010: 3.7% of the GDP was spent on LTC (highest of all OECD countries); 2006-2010: an average of 2.3% of the GDP was spent on public expenditure for LTC.	2006: 3.5% of the total GDP was spent on LTC.
	Overview of Scheme	The AWBZ is funded largely by income-related premiums that constitute a social security contribution. These premiums are paid by all citizens over 15 years old with a taxable income. In 2008, the premium was a 12.5% tax for any income above 47,400 dollars. Approximately 68% of LTC costs under the AWBZ are funded in this manner. Twenty-four percent of the costs are covered with taxes and the remaining nine percent of costs are covered with user charges.	In the Swedish system, the majority of funds covering the long term care system in Sweden come from a municipal tax. This provides for about 85% of the cost. Another 10% of the cost comes from national taxes. The remaining 4-5% of the cost is paid for by service fees.

Selected
Long-Term Care Programs Internationally

		Netherlands	Sweden
	Cost Sharing	User charges, outside of institutions, are paid via a 12.60 Euro/hour co-payment. An income-dependent maximum is set. For example, for a person with a yearly income of 40,000 Euros, the maximum user fee is 307.83 Euros per four weeks, or about 4000 euros per year. In an institution, there are two different phases of cost-sharing: low for the first six months, and high after. While there are different levels set based on income, at the very least, a single resident must have remaining in their income at least 276.41 Euros per month to spend freely. Cost sharing is set up with this limit in mind	4-5% of LTC costs are covered by user fees. The central government sets a maximum monthly fee for long-term care which is related to the financial situation of the citizen. This came from the max-fee reform in 2002 that made it so the maximum fee was 180 Euro/month. In 2011, another reform set the maximum fee at 184 Euros.
Benefits		The AWBZ funds several types of services: including home-based services, institutional care, cash allowances for individuals, and payments to relatives. Under the AWBZ, residents can receive assistance, personal care, nursing care, and treatment at home. Furthermore, informal care givers can receive payments out of personal budgets which are used to either purchase formal care or pay for informal care. When cash payments are elected, the payments are 25% less than what would be paid for care-in-kind. While the AWBZ, as mentioned, covers much of the care at home for people needing LTC, domestic help and social services are covered separately by the Wmo. This law (the Wmo) covers such services as "home help, meals on wheels, home adjustments and transport."	There are several different types of services available in the Swedish long term care system. Available services include home care in regular housing, special housing or institutional care, day activities, home nursing care, meal services, safety alarms, and home adaptation. Along with these services, elderly and people with disabilities that cannot use regular public transport are provided with transportation assistance. In 2007, another type of "service" or "benefit" was created with the introduction of a tax deduction that allows all age groups to deduct 50% of the expenditure on household services or personal care purchased on the market up to 11,000 Euros/year. Rostgaard and Szebehly (2012) argue
Providers	*Public*	All care providers are private.	Before 1990, about 97% of providers of long term care were public. By 2013, only 77% were public.
	For-Profit	Providers can be both for-profit or not-for-profit.	In 2013, about 20% of providers were for-profit. This number has been steadily increasing because of political steps taken by the Swedish government. For example, the local government act of 1992 opened up the private market for long term care. Then, a tax rebate was introduced in 2007 that can be used for purchasing home care. In 2009, the Act on System of Choice facilitated the introduction of choice models in publicly funded homecare. This made it so that municipalities who adopted this program could not restrict the number of providers. Therefore, private providers could offer "topping-off" services. This act also allowed municipalities to introduce a voucher
	Not-For-Profit	Providers can be both for-profit or not-for-profit.	In 2013, 20% of providers were for-profit and 3% were non-profit.
Private Insurance		No	No

Selected
Long-Term Care Programs Internationally

		Netherlands	Sweden
Informal Care-Givers	*Overview*	The Netherlands has a high proportion of its population providing informal care; however, this care is less intensive than many other countries. Of the population 65 and older in the Netherlands, 28.8% receive some practical help from informal care-givers, but only 3.2% receive any personal help.	Sweden has a high proportion of its population providing informal care; however, this care is less intensive than in many other countries. In Sweden, 42% of people needing help with 1-2 tasks receive family care and this number, of older residents receiving informal care, has been increasing. From 2002/3-2009/10 help from non-cohabiting family members increased from 48 to 63 percent of non-institutionalized older people receiving informal help. Now, 8 out of 10 adults provide some care for an older person, and one study suggested that 31.1% of older adults (65+) receive informal practical help while 3.1% receive informal personal care.
	Support	There are cash benefits for informal care givers, but they play a small role within the LTC system.	National policy on support for family carers strongly stresses that family care must be provided voluntarily; however, there are systems of support such as cash payments to relatives. As of July, 2009, municipalities have been required to support informal caregivers in several ways, although these vary depending on the municipality. For example, there is a cash benefit that varies between SEK 1,000-3,000 per month provided to the care-recipient (to be given to the informal care-provider); however, this is not available (as of 2010) nationwide. Other support can come in the form of support groups, relief support, temporary residence for care recipients, volunteer services, and much more.
Satisfaction Rates		One study found that less than 30% of Dutch citizens were "dissatisfied with the performance of their LTC system." Of the European countries studied the lowest percent dissatisfaction was Denmark, with less than 25% dissatisfaction.	One study found that less than 30% of Swedish citizens were "dissatisfied with the performance of their LTC system." Sweden's satisfaction rate was in the top four countries studied, barely behind Denmark, France and Belgium

COUNTRY STUDIES

Country Brief: Canada

Overview

In Canada, there is no universal Long Term Care policy. It is not included within the Canada Health Act (CLHIA Report 2012). In reality, there is no uniform LTC policy in Canada, either. Rather, each province addresses the issue of LTC slightly differently. Before 1996, there were federal fund transfers to provinces to fund LTC; however, this program—called the Extended Health Care Services—was abolished. After the abolition of this program, federal transfers for LTC funding were stopped (Banerjee 2007).

Demographics

The population of Canada in 2015 was 35,851,770 people (World Bank Group). In 2012, about 14 percent of Canadians were over the age of 65; this number is expected to grow to 25% by the year 2036 (CLHIA Report 2012). "Statistics Canada" estimated (in CLHIA Report 2012) that the odds of needed long term care (LTC) is one in ten at 55, three in ten at 65, and five in ten at 75.

Although there is no universal LTC policy included within the Canada Health Act, the CLHIA Report (2012) states that many Canadians are not aware that the majority of LTC costs will be covered out of pocket—resulting in a lack of preparation by families and a lack of readiness to deal with the costs of caring for the elderly.

In Canada, about 7% of Canadians over 65 live in LTC facilities. Approximately 8% between 65 and 74 receive home care and this percentage increases to 20% for people aged 75-84. Finally, nearly half (42%) of all people over 84 receive home care for LTC (CLHIA Report 2012).

Eligibility

Although there is no universal program to provide LTC, there are often regional bodies that will determine the level of LTC need that residents require. Generally, most residents enter into the LTC spectrum through a "single entry point (that) . . . are often established and co-ordinated by Regional Health Authorities or other local bodies" (Banarjee 2007). Such health authorities often use a standardized assessment tool that attempts to measure one's health, ability to complete ADLs, and system of social support.

General Financing Scheme:

As explained, Canada has no universal LTC plan; however, some costs are subsidized by the government. For example, nursing home care is subsidized in all Canadian provinces (Stadnyk 2009). The amount that is paid for by the province—and the amount covered by the family—varies from province to province. Furthermore, there is often a "spending-down" requirement in which residents of long term care facilities are required to "spend-down" their assets in order to qualify for the government subsidy (Stadnyk 2009).

It is estimated that, over the next 35 years, LTC costs in Canada will total $1.2 trillion. This is approximately the same as the total amount of all public and private retirement assets. Furthermore, it is estimated that government programs will only cover $595 billion of these costs. The CLHIA Report (2012) claims that, in order to fully fund such a program, there would need to be a 6.4% increase of all personal and corporate taxes.

From 2006-2010, Canada spent 1.2% of its GDP on public LTC expenditure and it is expected to spend 1.9 and 2.5% of its GDP by 2060 (Maisonneuve and Martins 2013).

Benefits/Services Provided

Because there is no universal LTC system in Canada, the types of benefits and services provided vary largely across different provinces. Many provinces will cover some costs of home and institutional care; however, there is little federal oversight on what is done so such systems vary drastically across provinces.

Providers

In Canada, LTC is provided in several different sites: (1) hospitals, (2) LTC institutions/facilities and (3) in the home. The average daily cost of a hospital bed for LTC is $842. In a LTC facility, the average cost is $126 and at home the average cost is $42 per day (CLHIA Report 2012).

With its aging population, Canada is facing a shortage of institutional space to provide LTC. This problem—which can be seen as bed shortages and long wait times—will continue to grow as the population ages. For example, it is predicted that (if current trends continue) Canada will need over 800,000 LTC beds by 2047 to provide enough for all who need them, a 2.5x increase in the number of beds (CLHIA Report 2012). This represents an increase in the number of facilities by 6000, or about 170/year (starting in 2012). Canada is also facing a shortage of geriatric practitioners and nurses.

There are many different types of facilities in Canada—from government-run to not-for-profit to for-profit institutions. In 2006, a study found that 25.2% of LTC beds were in government owned facilities, 10.2% in religious, 23.9% in not-for-profit, and 40.7% in for-profit institutions (Berta et al 2006 referenced in Banerjee 2007). There is a large variation in the distribution of providers across provinces. For example, New Brunswick has no for-profit providers (Banarjee 2007).

Private Insurers

In 2010, about 385,000 residents of Canada were covered with LTC insurance (CLHIA Report 2012). This market is less developed than the private market in the US (which many argue is largely under-developed and ineffective).

In Canada, there are two types of insurance schemes that can be purchased. The first is similar to health insurance in the United States, in that it will reimburse for services needed up to a pre-determined amount. The second provides a monthly benefit when needed (CLHIA ACCAP)

Informal care-givers

Because there is no universal LTC policy, informal care plays a large role in the LTC scheme in Canada. In general, the majority of informal care-givers are children or spouses. There are about 2.7 million Canadians that are providing LTC (as of 2012) (CLHIA Report 2012). According to the CLHIA Report (2012) "They provide approximately 80 per cent of the care needs for people with chronic health issues and contribute and estimated economic value of $25 billion."

Informal care-givers are supported in several ways in the Canadian LTC system. First, Canadian benefits allow for informal care-givers to take up to 6 weeks of paid leave to care for a

loved one at the end of life. There are also tax benefits provided on an individual basis for informal care. There are also respite programs available for many Canadians; however, the CLHIA Report (2012) argues that the availability of such programs varies drastically across the different parts of the country.

Satisfaction Rates

Assessing Canadian's satisfaction with their long term care system would prove very difficult as it varies drastically across each providence. Studies were found for satisfaction surveys conducted in individual nursing homes—but no study assessing the satisfaction of Canadian residents with their LTC system was found.

Lessons Learned/Key Points

1. Canada has a universal health care program and many residents believe that this will extend to Long Term Care but it does not. This shows the importance of educating residents about their rights: about what is and is not included.
2. Evaluating Canada's system as a whole proves very difficult, and it may be more worthwhile to study one individual providence's system.

With the NYHA as the ideal, how close does this system come?

As Canada does not have a universal LTC system, it would not meet any of the requirements set up through the NYHA.

Country Brief: Denmark

Overview

In Denmark, the long term care (LTC) policy is part of the Consolidation Act on Social Services (CASS) (Schulz 2010). This program utilizes a state responsibility model in which each state (municipality) is in charge of providing care for the elderly that meets the country-wide expectation that all have free and equal access to the assistance that is offered. This care is financed through local taxes and through grants from the state (Schulz 2010).

Demographics

In 2016, the total population of Denmark was 5,707,251. Of this number, 1,411,281 people were over 60 years old (nearly 25% of the population). Furthermore, 243,758 people were over 80 years old, representing 4.3% of the population. In 2060, the total population is predicted to be 6,482,769 people. Of this, 1,985,447—or nearly 31% of the population—will be over 60 and 660,126 people—or nearly 10.18 percent—will be over 80 years old (Statistics Denmark 2016).

Much like the other countries studied in this analysis, Denmark is concerned with the shifting demographics of its population and the effect of such a shift on the LTC policy.

Eligibility

In Denmark, every lawful resident is eligible for care. The ability to access personal care, or to receive help with day to day activities is available regardless of wealth or age. Furthermore, there are no minimum requirements of impairment that must be met to receive such assistance. There is an individual assessment (Schulz 2010), but, even if it is determined a person needs as little as one hour of assistance per week the care will be provided.

Although Denmark does have a comprehensive system of assessment, the Ministry of Social Affairs left much of the responsibility to the municipalities. For example, since 1996 everyone aged 75 and older in Denmark has been entitled to "preventative visits" by a municipality-hired case manager. For these visits, the Ministry provided guidelines of what types of assessments must be done; however, the overall structure of such visits, is decided by the municipality (Schulz 2010). In general, the Barthel Index is used to assess functional impairment, but several different versions are used throughout Denmark (Maribo et al 2006).

When it is determined that a person needs formal care, they are then further assessed by a "home-care manager" who will decide which specific services are needed. Denmark is an interesting system in that there are no pre-defined categories of dependency. Rather, the person needing care can fall anywhere along a continuum of dependency depending on her particular needs. It is also important to note that the person being assessed has the right to appeal the decision if they do not agree with the final assessment (Schulz 2010).

Once this final assessment is completed—and the resident agrees with its conclusion—the municipal council prepares a plan that describes the "functions covered by the assessment, the object of the assistance, and the period during which assistance is to be provided" (Schulz 2010).

General Financing Scheme

In 2005, Denmark spent 1.95% of its GDP, about 4.055 billion Euros, on long term care according to Schulz (2010), and Rosgaard and Szebehely (2012) estimated that 1.7% of Denmark's GDP was spent on LTC in 2007. Maisonneuve and Martins (2013) estimate that, on average Denmark spent approximately 2.2% of its GDP on average between 2006-2010. These numbers vary slightly; however, it seems Denmark spends about 2% of their GDP on LTC.

The majority of the money that Denmark spends on LTC is spent on home care (4.044 billion Euros out of 4.055 billion Euros total in 2005). Only 11.2 million Euros were spent on nursing homes in 2005 (Schulz 2010).

The vast majority of this care is financed by taxes, but the municipalities can also receive grants and subsidies from the national government. These are often used to expand specific services such as dementia services (Schulz 2010). In general, Denmark's LTC services are largely funded by the national government through taxes and grants where Sweden's LTC services are funded by taxes to local authorities (Costa-Font et al 2015). Schulz claims, in her report on the LTC system in Denmark (for the Assessing Needs of Care in European Nations—ANCIEN—project), that user fees do exist but play a very small role in the overall funding (Schulz 2010). [Note: Denmark is also unique among Nordic countries in that it does not attach co-payments to health care except for with prescription drugs—other Nordic countries do use modest co-payment models (Olsen et al 2016)]. OECD Health Data showed that Denmark funds 89.6% of its LTC with taxes, and 10.4% with household out-of-pocket expenses (Costa-Font 2015). This number is very low compared to many countries, for example, Switzerland pays for nearly 58.4% of LTC costs out-of pocket; however, it is not the lowest. According to the OECD (2011 qtd in Costa-Font 2015), several countries have no out of pocket costs for LTC (See Figure 1)

Figure 1: Table from Costa-Font (2015)

Table I. Organisation for Economic Co-operation and Development (OECD) countries' sources of *ex ante* and *ex post* funding of long-term care

Country	Social security funds	Private insurance	Total *ex ante*	Tax funded	Household out-of-pocket expenses	Other	Total *ex post*
Switzerland	27.1	0.4	27.5	11.7	58.4	2.4	72.5
Portugal	51.4	1.1	52.6	2.0	45.4		47.4
Germany	54.7	1.7	56.4	12.5	30.4	1.4	44.3
Spain	10.2		10.2	61.7	28.1		89.8
Slovenia	57.1	0.5	57.6	18.3	24.0		42.4
Korea	30.7		30.7	46.2	17.8	5.3	69.3
Austria	0.7		0.7	81.1	17.1	1.0	99.3
Canada	0.4	0.4	0.8	81.6	16.8	1.6	100.0
Finland	7.6		7.6	77.2	14.2	2.0	93.4
Estonia	39.3	0.1	39.4	48.2	12.4	0.1	60.6
Norway				89.3	10.7		100.0
Denmark				89.6	10.4		100.0
Australia		0.3	0.3	88.9	8.5	2.3	99.7
Japan	44.8	4.0	48.7	44.2	7.1		51.3
New Zealand		1.3	1.3	92.0	4.4	2.3	98.7
Hungary	30.2	0.9	31.0	60.1	2.4	6.4	68.9
Sweden				99.2	0.8		100.0
France	54.4	1	54.8	44.8	0.4		45.2
Poland	49.2		49.2	43.1	0.3	7.4	50.8
Belgium	58.7	9.8	68.5	31.4	0.2	0.0	31.5
Iceland	60.6		60.6	39.4			39.4
Czech Republic	69.5		69.5	30.5			30.5
Netherlands	90.4		90.4	9.5		0.2	9.7

Source: OECD Health Data, 2011.

Benefits/Services Provided

Within Denmark's LTC system, there has been an "explicit policy priority" given to community care over residential care. For example, no new nursing homes have been constructed since 1987. Instead, a variety of "dwellings" have been adapted to meet the needs of older adults (Schulz 2010). The results of these types of policies can be seen in the spending of Denmark on LTC with nearly 99.7% of the funding going towards home care (calculated using statistics in above section).

In general, people are eligible for several different types of services including home nursing, home care, and practical help (Schulz 2010). Home nursing refers to the medical care that a resident needs such as wound care. This is provided by a professional nurse in home (after being prescribed by a physician). Health services include those services that promote health and rehabilitation. Finally, practical help refers to personal care services, such as help with ADLs, and domestic tasks, such as meal preparation. These can be provided by many different professionals such as paraprofessionals, personal care workers, and housekeepers (Brodsky et al 2003 used in Schulz 2010). Intensive informal care, according to Schulz, is not common; however, it can be supported with cash payments: "under specific circumstances the carer of a closely connected person can be employed by the municipality for up to six months" (Schulz 2010).

In Denmark in 2009, 18% of people 65 and older receive home care services. When combined with residential services, about 23% of 65+ receive some form of services (Schulz 2010). When comparing these numbers to Sweden, there are several interesting trends. First, although Sweden spends more money, there is a higher percentage of elderly in Denmark covered (23% versus 16%) (Rostgaard and Szebehely 2012). One reason for this may be that it is more common to receive small amounts of help in Denmark than Sweden. In Denmark, 11% of the elderly population receives less than, or equal to, two hours of home care each week. In Sweden, this number is only 3.6% (Rostgaard and Szebehely 2012).

It is also important to note that, much like in Sweden, Denmark has introduced policies to incentivize the purchase of market-based home care services. For example, a scheme in Denmark allows people over 65 to take a 30% tax subsidy to be used to purchase assistance with domestic chores. The maximum subsidy is set at 3,200 euros per year per household. [At the time of Rostgaard and Szebehely's publication, there was no data about the uptake of such a service (2012)]. Still, Rostgaard and Szebehely make a clear distinction between the policy changes in Sweden and Denmark, claiming that "During the 1990s and 2000s, Denmark has maintained the high social investments in the (free) public care system, whilst Sweden to an increasingly degree has targeted home care at those who are most frail" (2012). This has led, they argue to the development of a "relatively generous public service [model] where home care resources are spread to both those with extensive personal care needs and those only in need of help with domestic chores" (2012) in Denmark. "In Sweden, coverage of public home care has declined steadily since the early 1980s, now mainly targeting those with the greatest personal care needs" (Rostgaard and Szebehely 2012).

Providers

Throughout the years, Denmark has maintained high social investments in its public care system and, for this reason, the public sector is the main provider of LTC. Still, the government—as shown in the tax subsidy program referenced above—has taken steps to incentivize the development of competitive private agencies (Schulz 2010) making it possible to receive publically funded home care provided by for-profit (private) providers (Rostgaard and Szebehely 2012). Additionally, volunteer work is supported (Council of Europe 2008 qtd in Schulz 2010). According

to Schulz (2010), the individual has the ability to choose the provider of home care services. Roughly 100,000 people are employed within the Danish LTC system (Clausen et al 2011). At the moment, Denmark is facing shortages in the number of employees available. To address this, there is a push to allow more people to qualify as "providers" to meet the needs of the LTC system (Swartz 2013).

Private Insurers

I have found no references to private LTC insurance in Denmark.

Informal care-givers

Denmark has a high proportion of its population providing informal care; however, this care is less intensive than the care provided via informal mechanisms than in many other countries, as shown in the Rodriguez et al. (2012) graph (used in Szebehely Jan. 2015). While they may provide small amounts of help, family members in Denmark do not consider themselves "care-givers." There may be several factors that contribute to this. First, Denmark has invested heavily in its LTC system resulting in a system that could be described as de-familialising: "leaving women (and men) with the *option* of whether or not to provide care" (Rostgaard and Szebehely 2012). Because of this, family members may choose to assist, but do not have to provide care out of necessity (Rostgaard and Szebehely—2012—argue that this is in contrast to the system in Sweden today). Another factor that may contribute is that 72% of Danes would prefer to receive formal long term care rather than informal care (Eurobarometer 2007/Rostgaard & Szebehely 2012).

Rostgaard and Szebehely's study (2012) was able to estimate the amount of people that are receiving informal care. They found that only 16% of people needing help with 1-2 tasks receive help from their family in Denmark—compared to 42% in Sweden. For people with more involved cases, the percentage was much higher: at 45.9% in Denmark and 53.2% in Sweden. Overall, Mot et al. (2012) estimate that 29.2% of elders (65+) receive practical help from their families, and only 4.3% receive personal care help.

As previously mentioned, there are cash payments available for family carers; however, this is not commonly used in Denmark.

Satisfaction Rates

A 2007 Eurobarometer study attempted to gauge the population's satisfaction with European long term care programs. When Danish citizens were asked if they, or a loved one, received appropriate long-term care when it was needed 54% answered "yes, totally," 29% said "yes, but only partly," and 16% said "no"—with 1% not choosing. When asked "In the future do you think that you would be provided with the appropriate help and long-term care if you were to need it?" 72% of Danes surveyed answered yes, putting Denmark near the EU average of 71% (the highest being Greece with 89% and the lowest being the UK with 61%).

When asked who would finance regular help and long-term care if needed 76% of Danes answered "public authorities or social security," putting them well over the European Union average of 32%. In fact, they were the highest scorer on this question—reflecting the large investment that Denmark has made (Eurobarometer 2007). Overall, this study found that less than 25% of Danish citizens were "dissatisfied with the performance of their LTC system," the lowest percentage of all European countries studied for this policy project (and all other countries shown in the graph) (data represented graphically in Ranci and Pavolini 2013).

Lessons Learned/Key Points

1. Denmark has a population that is about 25% of the population of NYS but it still elects to divide the responsibility for such a system to the municipalities. How will the LTC responsibilities be divided under NYHA? Will assessments be made standard, or will they be determined at regional levels?
2. There is no lower limit of services provided and there are no pre-defined categories of need. Denmark's system seems to be very individualized.
3. Seniors are entitled to two "preventative visits" per year in which they are assessed. Would this be possible? It may help ensure that people who are not regularly interfacing with the health system do not fall through the cracks.
4. There is a well-defined appeals system if people are not happy with the results of their assessment.
5. Denmark pays very little out of pocket and is able to provide very broad services. Of course, they also have very high taxes.
6. 99% of funding in this LTC system goes to home care. In fact, Denmark seems to be "fading out" nursing homes. Is this a transition that we want to incentivize with the NYHA LTC project?
7. Volunteer work is valued in the Danish LTC system. Is this something that could be incentivized in the NYHA program (through schools etc.)?
8. There is a very high satisfaction rating with this system. This could be due to many factors, but is definitely worth investigating further. That being said, the level of taxes needed to obtain a system such as the one set up by Denmark may be much higher than what many in the US would be comfortable with.

With the NYHA as the ideal, how close does this system come?

In lines with the NYHA, every resident is eligible. There is no means-testing for eligibility for this plan. NYHA calls for no premium/other charges for health care. While it is unclear if this would apply to the long term care model (specifically with regards to co-payments), the Danish model is very close to meeting this standard, but there are some out of pocket fees. The NYHA also calls for comprehensive care which is clearly offered in the Danish LTC program.

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Country Brief: England (with notes on UK)

Overview

While England has a long term care system, it should be considered a "safety-net" program—similar to Medicaid—not a universal LTC system (Gleckman 2010). The program consists of two main parts: (1) long term nursing, and (2) social care. The nursing care is provided under the National Health Service (NHS), and is available to all residents (without means testing). On the other hand, social care under the LTC system is attached to means-testing. Furthermore, such social care services are directed towards residents that live alone (without the possibility of informal care) (Comas-Herrera et al 2010). This is true for the majority of the United Kingdoms; however, in Scotland, both social care and nursing services are paid for publically without means-testing for eligibility (Comas-Herrera et al 2010) (Gleckman 2010).

Demographics

The population of the United Kingdom in 2015 was 65,138,230 people (World Bank Group). In 2015, about 18 percent of people living in the United Kingdom were over the age of 65 (World Bank Group). By 2040, it is expected that 24.2% of the population in the UK will be over 65 (Ageuk 2016). Currently, the fastest growing population in the UK is the oldest demographic: 85 and over. From 1985 to 2010, this demographic increased from representing 1% of the population to 2%; by 2035, it is expected to represent 5% of the population (Office for National Statistics 2012).

Eligibility

There are two types of testing to determine eligibility in the UK LTC system (excluding nursing services and Scotland). First, the needs of the resident are assessed. Second, the means of the resident are evaluated (including both finances and availability of informal care).

The assessment of the "needs" of the resident is completed by local authorities. While there is no, sanctioned, national definition of need, there are criteria that were implemented by the "Fair Access to Care initiative." This is a national framework that defines four different levels of need eligibility: low, moderate, substantial, and critical (Comas-Herrera et al 2010). This national framework was implemented to ensure that residents with similar levels of needs would provide care that aimed at achieving similar outcomes; however, it does not necessitate that these residents receive the same amount of care in different localities. Local councils are still able to decide what services will be provided for the different eligibility bands. Furthermore, they have the option of setting up "sub-bands" as well.

Recently, the UK completed a study (much like Germany and Japan) to determine what type of universal assessment could be used. Unlike in Germany and Japan, the UK decided that they would not need to develop an entirely new test. Rather, six different tools were identified that could be used as part of a single assessment process (Büscher 2011).

Once a person has undergone assessment, and it has been determined that they need care, the resident will be subjected to a means test. This is done to determine whether or not the LTC services will be paid for (in full or partly) by the local authority. In general, this means-test looks not only at available finances or assets, but also at the availability of informal care (Comas-Herrera et al

2010). It is important to note, also, that both income and assets are assessed when means-testing eligibility is completed.

For nursing care, which is provided by the NHS, there is no means-testing eligibility because it is classified as health care, for which there is a universal entitlement. Furthermore, there is no means-testing for either nursing care or social support in Scotland (this was determined after recommendations by the Royal Commission to remove means testing from both nursing and social services).

General Financing Scheme:

LTC in the UK is funded via several different mechanisms. First, health services that are provided by the NHS are funded by the central government with money supplied through general taxes and national insurance contributions (Comas-Herrera et al 2010) (Gleckman 2010).

The social services, on the other hand, have several different sources of funding. First, for those who are eligible to receive publically funded social services, funds flow through the local authorities. These funds are derived through local taxes and via a central government grant but quite often, user fees are attached to the services. A large portion of social services are purchased privately (as public provision of such services are means-tested) (Gleckman 2010).

The local authorities play an important role in purchasing services, and services are purchased from public, voluntary and private providers. For non-institutional care, the local authority can negotiate their own fees with providers. For institutional services, such fees are set by the central government (Comas-Herrera et al 2010).

On average, from 2006-2010, public expenditure on LTC was 0.9% (Maissonneuve and Martins 2013) (Comas-Herrera et al 2010).

Benefits/Services Provided

There are several different formal services offered within the UK LTC system including community health services, independent care homes, nursing homes, home care, and day-care services. As previously described, nursing care is provided regardless of one's financial availability. Along with accessing services provided in kind for nursing care, it is also possible to qualify what is termed an "attendance allowance." This is a type of cash benefit provided to those who need frequent attention during the day (or night) for help with "bodily functions" or supervision during the day (or night) to ensure the safety of the resident—or others. There is also a "carer's allowance" offered to those who provide informal care.

Another service that can be utilized is called the "individual budget," which is a form of "cash-benefit" that can be accessed instead of receiving publically-funded social services. It is often used by individuals to purchase services such as a personal assistant. Studies assessing the benefits of an "individual budget" have found that those who receive the budget feel much more in control of their daily lives than those who receive services-in-kind. On the other hand, they generally report lower psychological well-being when receiving the individual budget. This may be because of the psychological stress felt by those who have to plan and manage such a budget (Comos-Herrera et al 2010).

The government plays a role in not only providing these services, but also regulating them. In 2008, a merger between the CSCI—which covered social care services—and the Healthcare commission—which oversaw healthcare services—created the Care Quality Commission. This

commission's goal is to regulate, monitor and improve the different services that are provided. To do so, they register and inspect services and also set minimum standards (Comas-Herrera et al 2010).

Providers

Services are provided across all sectors: public, private—for-profit, not-for profit. There is also care that is provided informally by relatives and friends. Furthermore, new jobs have been created now that local authorities are required to provide cash benefits as people who receive cash look to hire services such as personal assistants. Brokerage services have also been started in order to help people who receive cash benefits navigate and hire services.

As mentioned, the Care Quality Commission oversees and regulates the different providers. Part of this regulation is monitoring and evaluating service providers. In 2008, the CSCI (the part of the Care Quality Commission focusing on social services) rated 80% of services in the "voluntary" sector as good or excellent. 79% of the services run by the local councils were rated as good/excellent and 66% of services in the private sector received this rating. 73% of home care agencies received ratings of good or excellent in 2008 (CSCI 2008 referenced in Comas-Herrera et al 2010).

Private Insurers

The role of private insurers in the UK is minimal (Comas-Herrera et al 2010).

Informal care-givers

The UK's LTC system heavily relies on informal (unpaid) care. This care is provided by different sources, but most commonly it is provided by a spouse or child. It is estimated that 85% of all elderly with a disability living in private homes receive some form of informal care (in England)—amounting to about 1.8 million receiving such care (Comas-Herrera et al 2010). It is interesting to note that the UK's system (except Scotland), the means-testing used for eligibility is not carer-blind. What this means is that the availability of informal care is considered when the assessors are determining whether or not one will receive publically funded social service care.

Within the UK system, there is financial support for the informal care-giver. This support—termed the Carer's allowance—is a cash benefit that is paid to informal care-givers who work long hours. In general, about 62 euros/week is paid to informal care-givers who provide 35+ hours of care, earn less than 110 Euros/week, are not in full-time education, and look after someone who qualifies for disability benefits (Comas-Herrera et al 2010). An interesting distinction has been made about the UK's carer's allowance: it is not meant to act as payment for informal care, but rather as a compensation for the loss of earnings a care-giver sees.

Much like in the United States, this reliance on informal care could become problematic as the demographics of the country shift. For example, by 2041, it is expected that there will be a care gap of 250,000 informal care-givers (Pickard et al 2008 referenced in Comas-Herrerra et al 2010). This represents a potential problem for the UK LTC system, and is one that future reforms may aim to address.

Satisfaction Rates

A 2007 Eurobarometer study attempted to gauge the population's satisfaction with European long term care programs. When UK citizens were asked if they, or a loved one, received appropriate long-term care when it was needed 49% answered "yes, totally," 36% said "yes, but only partly," and 13% said "no"—with 2% not choosing. When asked "In the future do you think that

you would be provided with the appropriate help and long-term care if you were to need it?" 61% of those in the UK surveyed answered yes, putting the UK well below the EU average of 71%. In fact, this was the lowest of all countries surveyed.

When asked who would finance regular help and long-term care if needed, only 37% answered "public authorities or social security," putting them in line with the European Union average of 32%. For comparison, though, the highest scorer on this question was Denmark with 76% answering "public authorities or social security" (Eurobarometer 2007). Overall, this study found that about 40% of UK citizens were "dissatisfied with the performance of their LTC system," near the middle of European countries studied (data represented graphically in Ranci and Pavolini 2013).

Lessons Learned/Key Points

1. The UK does not have a universal LTC system (Scotland comes much closer). Rather, it is more of a "safety-net" program, similar to Medicaid.
2. The UK LTC system relies strongly on informal care. This will be (and arguably, already is) problematic as the demographics of the UK shift in the years to come—creating a supply shortage.
3. In the UK, means-testing refers to income, assets, and the availability of informal care. This means-testing is not carer-blind.
4. Once the UK implemented cash payments for social services, new positions within the LTC sector were created: such as the personal assistant. This type of position could be useful within NYHA as many in the UK choose to use it and it is (presumably) cheaper than nursing services.
5. Cash payments are fairly popular in the UK. Studies have shown that they make seniors feel more in control of their daily lives. On the other hand, the psychological well-being of these seniors was measured to be lower (perhaps because of the stress of having to manage the cash payment).
6. The way that informal care is paid within the UK system is unique. Rather than paying the care-givers for their services, they are paid a "carer's allowance" which is supposed to somewhat offset losses. It is a very low sum (about 80 dollars per week).

With the NYHA as the ideal, how close does this system come?

The UK's LTC system functions more like Medicaid than the proposed NYHA. It is far from a universal system—functioning more as a safety-net—and therefore would not meet the ideal set by the NYHA.

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Country Brief: France

Overview

France's most recent (and current) long term care (LTC) policy, called the APA (personalized allowance for autonomy), was created in July of 2001 (the first allowance was approved in 1997). It had three main goals: (1) increase the amount of recipients by removing means-testing and removing an estate tax, (2) raise the number of recipients by allowing "medium-dependent persons" to access the program, and (3) avoid local differences by developing and defining a "national financial scale" (Joel et al 2010). In 2004, the CNSA—another plan—was introduced to increase the national funding of the APA. The French program financed through general tax revenues only and is able to fund about 70% of care (Chevreul and Brigham 2013). Part of this is because the French system cuts benefits to high income seniors (Gleckman 2010).

Demographics

In 2015, the total population of France was 66,808,385 people, with 19% of them over 65 years old—up from 12% in 1960 (World Bank Group 2016). In 2013, approximately 8% of the population is over 75 years old; this number will increase to 15.6% in 2050 (Chevreul and Brigham 2013). In 2060, the total population is predicted to reach 73,600,000 people. Of this, nearly 33% of the population will be over 65 years old (Insee). In 2020 the population over 80 will reach about 4 million, and in 2040 it is expected to reach 70 million (Joel et al 2010).

Eligibility

According to French law, elderly people whose health and/or well-being necessitates follow-up and assistance with activities of daily living (ADLs) are eligible for LTC. Elderly people, according to French law, refers to people over 60 years. In France, a scale called the AGGIR scale is used to assess the level of care that is needed. This scale assigns individuals to one of six degree of dependency based on the amount of difficulty that the individual has with ADLs. Of these six degrees, only the people who belong to Gir1-Gir4 (Gir1 is the most dependent category) receive the main allowance for autonomy (the APA) (Joel et al. 2010). With regards to most physical determinants of dependency, this assessment tool is responsive; however, it does not do a great job assessing "the degree of psychological dependence . . . at the onset of the disease" (Joel et al 2010).

Although the benefit is not means-tested, the amount is reduced progressively with increased income. It is reduced (from the full benefit) from 0% to 80% (meaning 100% of the full benefit to 20% of the full benefit) (Joel et al 2010). So while the system could be said to be universal, it is largely aimed at people with low income.

In general, there is a three-step assessment process. First, the elderly resident submits a request. Then, he/she is evaluated by a social and health team. This team will define the care package with a plan that combines three different types of help including housework, personal services and equipment. Once this is made, the social worker (or other evaluator) will give the elderly resident the contact information of the organizations and people providing such services (Joel et al 2010). Finally, there will be a final agreement made by departmental authorities. Because France hopes to maintain freedom of choice, the resident (or family) has the responsibility of choosing the provider and contacting them. A case study by Joel et al (2010) showed that this procedure can potentially lead to confusion for seniors.

General Financing Scheme

Because of the complex structure of the French LTC plan, and the many different sources of funding, finance flows are complex. In general, the French LTC plan is paid for by three different methods: (1) taxes, (2) contributions through social insurance, and (3) families. Furthermore, there is also private insurance available in France (Joel et al 2010).

In 2007, the total LTC cost is estimated at 25 Billion Euros (Sénat 2008 qtd in Joel et al 2010). 19 billion of this was paid for by public funds (60% through general health insurance, 20% by local governments, 15% by the CNSA[1], and 2% by the central government through mechanisms such as tax exemptions). From 2006-2010, the public expenditure on the LTC plan was estimated to be 1.1% (Maisonneuve and Martins 2013). Overall, the French spent 1.73% of the GDP on LTC in 2010 (Chevreul and Brigham 2013), or about 30.8 billion dollars.

The way the public expenditure is spent differs in institutions versus home care. In institutions, the overall fee is paid for in three ways. First, the nursing care is paid for by health insurance, dependency is partially covered by APA (for care services such as ADLs), and the lodging fees are paid for by the families. Lodging fees can vary drastically, from 12,000 to 29,000 Euros per year. Home care is paid for with several different sources. The APA pays a portion (about 4.5 billion Euros in 2007) (Espagnol 2008 qtd in Joel et al 2010) along with the retirement social insurance (about .3 billion Euros in 2007). There are also housing benefits from family social insurance, but these are for everyone, not just seniors who need assistance with ADLs. Home nursing care is paid for by the health social insurance program (about 1 billion Euros in 2006) (Fenina and Goeffroy 2007 qtd in Joel et al 2010) while health care is provided by the health insurance plan. The health insurance plan pays for about 60% of the total cost of LTC in France (Joel et al 2010).

Cost sharing is an important source of funding for the French system, which has a coverage depth of about 70% (Chevreul and Brigham 2013). In general, this cost sharing is determined through an "assistance principle." People making below a threshold of 695 euros per month do not contribute at all to the funding but a copayment is used for those who make more (Bihan et al 2013). For the most dependent residents, costs can vary from 1,500 to 4,000 Euros per month in the home, and 1,300 to 2,000 Euros in institutions with monthly fees. In 2007, Families paid approximately 650 million Euros in co-payments. On average, an APA benefit amounts to 490 Euros per month (Prevot 2009 qtd in Joel et al 2010). The average cost-sharing amount is 88 Euros, or about 18% of the benefit (Joel et al 2010).

In institutions, families spent approximately 6 billion Euros in 2007 including lodging and fees. Along with lodging costs (estimated at 1000 Euros per month on average), a family will, on average pay approximately 100 Euros per month in fees (Joel et al 2010).

Benefits/Services Provided

[1] The CNSA, or the National Solidarity Fund for Autonomy, was created in 2004. It is "responsible for providing financial support and funding for support services to persons who can no longer function independently" (Joel et al 2010). It flows through two different sources. First, it contributes about one-third of the total cost for local authorities' expenses on APA, and it also contributes to the Disability Compensation Benefit (PCH) which is allocated for people under 60 with disabilities. It is mainly funded through social insurance contributions by employers (Joel et al 2010). In essence, it is another mechanism that was introduced after the APA to strengthen LTC coverage.

In France, LTC is defined using the OECD definition: "The term 'long-term care services' refers to the organisation and delivery of a broad range of services and assistance to people who are dependent on help for basic ADL" (Joel et al. 2010). This care, in France, falls in between the health care and social care sectors. In 1975, the medico-social sector was created as an umbrella term to refer to disability and dependency services. In general, this medico-social sector refers to chronic impairments, while the medical/health care sector focuses on acute problems (Bourjac 2007 qtd in Joel et al 2010).

Many services are available in France. These services "include nursing and residential homes, hospital, home nursing care services, home care services, day care centres and support for informal carers" (Joel et al 2010). About 10% of elderly residents (and about two-thirds of those with dependency) live in nursing homes showing that, in general, home-based services are preferred (both by the residents and by government policies).

As described earlier, the French LTC plan is structured around individualized assessments/plans for seniors of LTC providers.

Along with quality and pricing regulations, such authorities focus on providing the framework for integration of social and medical services. To do so, two different structures have been set up: (1) the Local centre for information and coordination (CLIC) and (2) the Gerontological Health Network. The CLICs are supposed to coordinate information about access to different benefits while the Gerontological Health Network is meant to evaluate care needs and ensure continuity of the care that is received. Essentially, CLICs focus on local benefits, the Gerontological Health Network focuses on organization of the whole health sector. While this attempt has been admirable, Joel et al (2010) argue that "the different attempts to coordinate stakeholders have made the LTC system more complex).

Providers

The French LTC system relies on a network of both formal and informal care providers. Formal care providers fall into two categories: home-based and institution-based. Home-based care can be either home nursing care services or home care services, while institution-based can be hospitals/long-term care units, nursing homes, and residential homes.

Another oversight provided by the French government is the licensing of nursing homes. In France, legal status (EHPAD) can be obtained by nursing homes after completing an agreement called the convention tripartite. This contract, between the local government, the regional government, and the nursing home is essentially a quality certificate for nursing homes (Joel et al 2010). About 70% of nursing homes obtain this certification.

Currently, France seems to be approaching a shortage of nursing home beds. In general, the number of places (not beds) per thousand residents is decreasing (from 166/1000 in 1996 to 127/1000 in 2008). Furthermore, in 2010, the occupancy rate was about 97% (Joel et al 2010).

Consultant reports about the trends in provider types in France indicated that, within the institutional sector, there is a trend towards privatization and concentration (Joel et al 2010 reference Ernst and Young 2008 and Candesic 2007); however, the majority of structures are still public. Overall, about 60% of beds were public in 2007, with 26% being private non-profit and 14% being for-profit (Joel et al 2010). This for-profit sector; however, was noted to be growing, and most likely represents a larger share now, nearly ten years later.

Home care is provided by two types of providers: paramedical staff to provide nursing care and social staff for home care (although sometimes the line between these two types of services is

difficult to define). The majority of care-givers are nurse aides (providing 80% of the visits). About 30% of the home nursing care services are provided by public organizations while the other two-thirds are provided by non-profit (private) associations (Joel et al 2010).

Private Insurers

Proportionally, the French private insurance market is the largest market. A total of 2.1 billion Euros was spent on this market in 2007 (Bihan et al 2013).

Informal care-givers

In France, about 22.5% of elderly residents (over 65 years old) receive informal practical help—from people who do not live with them (relatives or friends) while 7.3% receive informal personal care (Mot et al 2012). These informal care-givers include family (about 85%), friends and neighbors. Overall, about 66% are women (Joel et al 2010). It was estimated (in 2001) that there about 3.5 million of such informal care-givers (Joel et al 2010).

Policy trends have aimed to recognize, and ameliorate, the toll on such care-givers, of which, about 42% declare having negative consequences—both psychological and physical (Joel et al 2010). There have been two different attempts to support such workers. In 2007, a law was passed to allow carers to take up to three months off of work without losing retirement rights. Another measure was to invest in day-care services. Unlike many programs, there is no payment to relatives in this program (Swartz 2013).

Joel et al (2010) claim that there are several different measures that could improve the situation for informal care-givers: (1) creation of a status for informal care-givers under the law, (2) creation of "informal care-givers' notebook" that notifies them of their rights, and (3) the possibility for payment of informal care-givers. These measures are being debated in France.

Satisfaction Rates

A 2007 Eurobarometer study attempted to gauge the population's satisfaction with European long term care programs. When French citizens were asked if they, or a loved one, received appropriate long-term care when it was needed 60% answered "yes, totally," 27% said "yes, but only partly," and 11% said "no"—with 2% not choosing. When asked "In the future do you think that you would be provided with the appropriate help and long-term care if you were to need it?" 76% of the French people surveyed answered yes, putting France above the EU average of 71% (the highest being Greece with 89% and the lowest being the UK with 61%).

When asked who would finance regular help and long-term care if needed 46% of French answered "public authorities or social security," putting them slightly over the European Union average of 32%, and much lower than the 76% of Danes with this answer. (Eurobarometer 2007). Overall, this study found that about 25% of French citizens were "dissatisfied with the performance of their LTC system," the second lowest percentage of all European countries studied for this policy project (and all other countries shown in the graph) (data represented graphically in Ranci and Pavolini 2013). Both France and Denmark had similar overall (dis)satisfaction ratings despite having very different programs and financing mechanisms.

Lessons Learned/Key Points

1. The French system is a good example of a LTC policy implemented in phases. This implementation (step-by-step) has created a very complex system with funding coming from many different directions. This should be an advantage that NYHA has, being implemented in one fell swoop (concurrently with the health insurance plan). Still, it is

important that we attempt to predict future problems that may arise (such as changing demographics) and plan accordingly as each step seems to add a level of bureaucracy and complexity to the system.

2. While this system is technically universal, it was clearly designed for people with low income.
3. The quasi-waiver system that is in place in the French LTC program could create unnecessary work for the beneficiary or family (who have to navigate the market of providers to choose); however, it may also provide the benefit of allowing beneficiaries to choose their own providers and services.
4. As seen in the French system, defining LTC versus health care (for elderly with chronic illnesses) could be difficult. Will it be necessary to define what will come out of the NYHA health insurance portion versus the long term care portion? Or will long term care be seamlessly integrated, making the differentiation of the two unnecessary? I imagine it will be necessary for our purposes to determine how much the LTC portion of the bill will cost.
5. The French system allows for an individualized service plan, but does so within pre-formed categories of need. It may be worthwhile investigating the pros and cons of this type of system versus the system in Denmark that has no pre-set categories.
6. The government, as seen in the French plan, can play an important role in quality assurance. The French have an interesting way of doing this with nursing homes, by providing nursing homes that complete the "tripartite" agreement a special license (stamp of quality). This may be a way for NYHA to tackle the question of what should be done with private (for-profit) nursing homes. For example, New York State could set a minimum level of standards of quality, and basic financial guidelines for nursing homes. Then, each region could develop their own standards/pricing guidelines and negotiate with nursing homes. Nursing homes could elect not to participate; however, they would then not be certified by the state (and perhaps could face penalties). It is also important to note that even with this type of oversight, the French private sector is still able to thrive and grow.
7. France has a thriving private insurance market (most likely because of the large amounts of co-pays). If co-pays are not necessary, the private insurance market in the US will clearly become unnecessary. Do we need to consider job training and other costs for the employees of these long term insurance markets that will be displaced?
8. France is currently trying to address the issue of informal care-givers. This is an issue that NYHA will clearly have to address. The authors of the review of the French LTC policy recommended three topics to think about: (1) a definition of informal care-givers should be created, (2) these care-givers must have specific rights, and must be informed of such rights, and (3) the question of whether or not they will be paid must be answered.
9. Despite being structured in a very different manner, the overall (dis)satisfaction rate with France's LTC policy is very close to that of Denmark. It will be worth investigating what types of factors contribute most to these rates.

With the NYHA as the ideal, how close does this system come?

In lines with the NYHA, every resident (over 60) is eligible. There is no means-testing for eligibility for this plan; however, there is means-testing for cost sharing. While the program is technically universal, it is clearly set up to provide care mostly for low income individuals. NYHA calls for no premium/other charges for health care. While it is unclear if this would apply to the long

term care model (specifically with regards to co-payments), the French model would not meet this model, as it has rather high amounts of cost-sharing. The NYHA also calls for comprehensive care which is provided by the French system.

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Country Brief: Germany

Overview

Implemented in 1995 (Büscher 2011), Germany's long term care system is based on a mandatory central government social insurance model (Gleckman 2010) (Swartz 2013).

Demographics

In 2014, the population of Germany was 81,197,537 (Statisches Bundesamt 2016). By age group, the population in 2013 was 18% 0-19 years old, 61% 20-64 years old, 15% 65-79, and 5% over 80 years old. In 2060, the population is expected—as it is in most countries—to age. The populations of 0-19 years old and 20-64 years old are supposed to drop to 16% and 51% respectively while the populations of 65-79 year olds and people over 80 are expected to increase to 20% and 13% respectively (Statistisches Bundesamt 2016). By 2050, Germany's share of people over 80 years old—at 15%—will be the second highest in the OECD (Colombo and Murakami 2013).

This aging population will put new pressures on the country in the form of increased social and health care costs. For example, it is estimated that approximately 7.2% of the German population aged 65 and older suffers from dementia. As the population ages, the number of people suffering from this disease is expected to double to 2.4 million by the year 2050 (Schwarzkopf et al 2012). German studies have shown that caring for patients with dementia is expensive, costing on average 12,300 Euros (approx. $13,630) per patient to the German social security system. On the other hand, patients without dementia cost about 4,000 Euros/patient (approx. $4,430) to the social security system (Schwarzopf et al 2012). Noting the increased economic burden that an aging population represents, Germany has been grappling with ways to improve the financial sustainability of their long term care program.

Eligibility

The German long term care social insurance program is not means tested for eligibility, although cost-sharing contributions are means-tested (Swartz 2013). The system by which German citizens are determined to be qualified for the program is undergoing reform at the moment. In the past, a person was considered eligible if they were unable to perform regular activities of daily living (ADLs) because of physical or mental illness or disability for at least six months. Under this system, there were three levels of severity. The first level of severity meant that the person needed assistance with at least 2 ADLs per day and one domestic task several times per week amounting to at least 90 minutes of care per day. Level 2 meant that the person needed assistance with ADLs 3 times each day and needed domestic care assistance several times per week, amounting to 180 minutes of care needed each day. Level 3, the most severe level, was reserved for people who needed assistance with ADLs all day and domestic assistance several times each week, totaling at least 300 minutes of care per day. Such assessments were conducted by the Medical Board of the sickness insurances (Büscher 2011). On this current system, approximately 10% of the population older than 65 has been deemed eligible (Tamiya et al 2011).

Recently, it was recognized that determining eligibility based solely on ADLs or time of care needed was a rather archaic system. For this reason, there was a study conducted in order to search for new LTC eligibility criteria. The study recommended developing a new tool to assess eligibility because all other eligibility tools currently in use fall short. The new tool was labeled the NBA. It was published in Germany in February 2008 and later tested and evaluated. In this tool, eight modules were developed: mobility, cognitive and communication abilities, self-care, ability to deal

with illness-/therapy-related demands and stress, managing everyday life and social contacts, activities outside the house and household maintenance. These modules are weighted differently in the final calculation. Based on this calculation, the person could fall into one of 5 degrees of dependency (Büscher 2011). This exact system was not adopted; however, the system eventually proposed by the German Federal Cabinet has many similarities.

On August 12, 2015 the Federal Cabinet passed a bill to strengthen long term care in Germany. This bill includes an additional 5-Billion-Euro investment—starting in 2017—that is projected to allow for stable contributions to the social insurance plan until 2022. Furthermore, a new evaluation system was implemented. While it is not the same as the NBA plan described in Büscher 2011, many similarities are noted. The main difference is that, instead of eight, the proposed plan only measures six areas: mobility, cognitive and communicative abilities, behavior and psychological problems, self reliance, coping w/ and independent handling of demands and pressures caused by illness or the need for therapy, organizing everyday life and social contacts. Ultimately, like suggested in the NBA, five categories of need have been created (Federal Ministry of Health 2015).

General Financing Scheme

The German long term care system aims to provide for about 50% of the costs of long term care services relying heavily on a premium payroll tax (Gleckman 2010) (Swartz 2013). The system does contain a cost-sharing component—with the amount of cost-sharing to be contributed determined by means-testing.

Overall, there are several different sources of funding for long term care in Germany. As summarized by Mot et al., the largest payer of care is the mandatory long term care social insurance, paying for 51.9% of overall costs. Public authorities and general taxation pay for 10% of the overall cost. The statutory health insurance pays for 8.1% of long-term care. Statutory injury insurance pays for .7%—bringing the total contribution from mandatory insurance schemes to 60.7%—private insurance pays for 1.9%, and employers pay for 2.2%. The final 25% of costs are paid for by private households (Mot et al. 2012). A slightly different model of costs suggests that long term care costs are paid for by the following methods: 56.8% by social insurance, 1.7% by private long term care insurance, 8.3% by social assistance, 1.9% by welfare for war victims, and 31.3% out of pocket (Mot et al 2012). While the overall numbers are slightly different, both studies suggest that the social insurance model is able to pay for between 50 and 60 percent of total costs and families are required to pay for about 25 to 30 percent of the costs.

Overall, it is estimated that public expenditure on long term care costs was approximately .9% of the total GDP between 2006 and 2010 (Maisonneuve and Martins 2013). In 2005, total expenditure on long term care amounted to 1.28% of the GDP (Schulz 2010). The social long term care insurance fund spent approximately 18.34 billion Euros (approx. $20.31 billion) in 2007. The highest single expenditure of this money was allocated to full-time institutional care, with 8.83 billion Euros (approx. $9.78 billion) dedicated in 2007 (Schulz 2010).

Benefits/Services Provided

Within the German system, there are three options for benefits. The first option is a cash benefit. Secondly, care can be contracted directly with the insurance, and thirdly, a beneficiary could receive a combination of these two options (Gleckman 2010). Social insurance will pay for both nursing home care and care-in-kind home services.

Based on the severity of a person's situation, different needs are determined, and thus, different benefits are provided. These severity levels are based on the eligibility tests, as described earlier. Depending on the type of benefit selected—cash, institutional care, or home care—the cost of benefit within each level of severity changes. Based on the old (currently being changed) eligibility requirements, the benefits provided for each service in each severity level are as follows: level 1 severity receives 225 Euros for cash, 440 Euros for care-in-kind, and 1023 Euros for Nursing home; level 2 severity receives 430 Euros cash, 1040 Euros for home care, and 1279 Euros for institutional stays; level 3 severity receives 685 Euros cash, 1510 Euros in home, and 1510 Euros for institutional care (these payments represent monthly expenditures (Büscher 2011).

Starting in 2017, these amounts will change to reflect the new eligibility testing system. There will be five categories instead of three. For this new system, the amounts of assistance in the form of non-residential cash benefits, non-residential benefits in kind for home care, and benefits for residential care in Euros per month for the 5 categories will be as follows: level 1—125, NA, 125; level 2—316, 689, 770; level 3—545, 1298, 1262; level 4—728, 1612, 1775; level 5—901, 1995, 2005 (Federal Ministry of Health 2015).

In 2009, about 2.34 million people were eligible for benefits (Büscher 2011). Of these slightly over two million people, 1.62 million were cared for in their homes (nearly 70%) and 717,000 were cared for in nursing homes. 1.07 million people (of the 1.62 million cared for in the home) were cared for by informal care givers and elected to receive a cash benefit. 63.9% of those receiving cash benefits fell into level 1 severity, 28.4% were level 2 severity and 7.7% were level 3. The remaining 550,000 people were using professional home care services, with 54.5% in level 1 severity, 33.9% in level 2, and 11.6% in level 3. Of the aforementioned 717,000 patients in nursing homes, 36.8% received the level 1 benefit, 41.2% were level 2, and 20.5% were level 3 (Büscher 2011).

For institutional care, room and board—or hotel costs—are not paid for by the social security long term care system (Gleckman 2010); however, these costs are individually bargained between the LTC fund and the facilities. Then, they are paid fully out-of-pocket by the resident or family unless the user cannot complete payments. In such situations, they are eligible for public assistance (Yoshida and Kawahara 2014).

Providers

In Germany, long term care is provided mainly by private, not for profit organizations; however, there are municipally run and private, for-profit institutional facilities (Yoshida and Kawahara 2014).

In institutions, Germany has approximately 26 long term care workers per 1000 people over 65 years of age. For home-care, there are approximately 12 long term care workers per 1000 people. Both of these numbers are from 2009 (Colombo and Murakami 2013)

Private Insurers

As mentioned previously, there is a private insurance option in Germany. This is chosen by approximately 9 million people (Gleckman 2010). This private insurance model is provided for high income individuals who choose to opt out of the social insurance model—note that carrying long term care insurance is mandatory within the German system so opting out of the social insurance can only be done if private insurance is purchased. Approximately 9% of the total German population chooses to do this (Mot et al 2012).

Informal care-givers

As discussed in the "benefits/services provided" section, informal care-givers are incentivized within the German system by the provision of cash benefits. Under the recent expansion of the German long term care system, caregivers are being further incentivized. For example, caregivers will now be paid pension contributions if they provide over ten hours of care per week. Furthermore, coverage in unemployment insurance for such providers will be expanded (Federal Ministry of Health 2015).

Mot et al. claim that the German system relies heavily on informal care, with 37.1% of people over 65 receiving practical help and 9% receiving personal care from informal caregivers (2012). Note that practical help refers to household assistance while personal care refers to assistance with ADLs.

Satisfaction Rates

A 2007 Eurobarometer study attempted to gauge the population's satisfaction with European long term care programs. When German citizens were asked if they, or a loved one, received appropriate long-term care when it was needed 58% answered "yes, totally," 32% said "yes, but only partly," and 8% said "no"—with 2% not choosing. When asked "In the future do you think that you would be provided with the appropriate help and long-term care if you were to need it?" 74% of Germans surveyed answered yes, putting Germany in the middle of the countries surveyed (the highest being Greece with 89% and the lowest being the UK with 61%). Of the European countries reviewed for this long term care policy project, Sweden was the most likely to answer yes, with 84%—falling behind only Greece and Belgium. (Eurobarometer 2007). When asked who would finance regular help and long-term care if needed 43% of Germans answered "public authorities or social security," putting them well over the European Union average of 32%, but far from the highest scorer, Denmark, with 76% (Eurobarometer 2007). Overall, this study found that about 40% of German citizens were "dissatisfied with the performance of their LTC system." Of the European countries studied for this policy project, the lowest percent dissatisfaction was Denmark, with less than 25% dissatisfaction. Overall, however, Germany's satisfaction rate was near the top third of countries studied (data represented graphically in Ranci and Pavolini 2013).

Lessons Learned/Key Points

1. Germany's system is not based on general tax revenues, rather it is based on a social insurance model. This does not fit with the NYHA proposal.
2. Germany's median age in 2050 will be older than that of the United States. Therefore, it will be useful to watch how Germany prepares itself for their aging population. Like many other countries, this demographic shift and the expected costs that come along with it are worrying for the country; however, Germany has recently elected to expand long term care coverage. Along with this expansion of coverage, Germany looks to be attempting to further incentivize informal care in order to reduce costs on the social insurance system.
    a. People suffering with dementia cost the social insurance system approximately three times as much as people without dementia in the German system. Therefore, it will be important to think about how to design care that may be able to better control such costs.
3. Germany, like many other countries, have recognized that quantifying ADLs or total time of care needed are archaic systems for judging eligibility. Therefore, they have decided to invest in the development of a new system to determine eligibility. It will be worthwhile to compare the model used in New York and compare it to the models being created in

countries such as Germany to ensure that there are not factors that are overlooked in the New York model.

4. Germany's system is universal in that it covers everyone; however, it does not cover all costs. Rather, it aims to cover about 50% of costs with a means-tested cost sharing system implemented to cover the rest (out of pocket spending amounting to approximately 30%). It will be important to consider how "comprehensive" the proposed long term care policy looks to be for the NYHA and to understand that Germany, and many other countries, do not aim to cover close to 100% of costs.
5. Germany provides a cash benefit in order to incentivize informal care. This has both pros and cons. On one hand, the cash benefit provided is generally less than the amount paid by the social insurance to hire formal care (in home or institutionalized). Because of this, however, it should be questioned whether or not the amount provided is fair. Do people truly understand the actual cost of care well enough to know if they should accept a cash payment? Furthermore, the idea of incentivizing informal care can be seen as both a pro or con, and often depends on cultural values. While it may incentivize "close-knit families" who care for their elders, it may also put pressure on family members to leave their job to care for their parents, in-laws or relatives. If this is the case, it is worth considering who provides care? Is it generally men or women? What age? And what affect would this have on our economic system by incentivizing people to "leave the workforce" (note: there is a lot of research on this being done in Sweden). Finally, do we have enough now, and will we have enough, informal care-givers to rely on them? Germany's system, according to Mot et al. (2012), relies heavily on informal care. As the population gets relatively older, and the relative number of available care-givers decreases, will this create a problem for the long term care system?
6. While room and board costs are not supplied, they are negotiated by the system overseeing the long term care system. This could help to regulate these costs by providing the negotiating power that individual "consumers" would not have.
7. In Germany, there is a small percent (9%) of the population that chooses to opt out of the social insurance system and purchase private insurance. This private insurance only pays for about 2% of Germany's overall LTC costs. The United States also has a small, private, LTC insurance sector at the moment. It is important to think about how the NYHA long term care policy will handle this sector? Should there be a private sector at all, or does that simply allow for different standards of care for wealthy and poor patients? (note: once again, there is a lot of research about privatization being done in Sweden).

With the NYHA as the ideal, how close does this system come?

In lines with the NYHA, every resident is eligible. There is no means-testing for eligibility for this plan; however, the amount of cost-sharing does depend on means. NYHA calls for no premium/other charges for health care. While it is unclear if this would apply to the long term care model (specifically with regards to co-payments), the German model does not meet this standard because of the existence of co-payments. The NYHA also calls for comprehensive care. While the German system provides many benefits, it only covers approximately 50-60% of long term care costs. About 30% of costs are still paid for out-of-pocket by beneficiaries and families.

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Country Brief: Japan

Overview

Japan's long term care (LTC) system is a social insurance program that was created in 2000 (Gleckman 2010) (Tamiya et al 2011). It became the third pillar of social security joining healthcare and pensions (Olvares-Tirado and Tamiya 2014). This LTC insurance program had five goals: increasing the level of independence of adults, reducing the burden of care on families, aligning benefits provided with the premiums paid, an integrated system of long term and medical care, and lowering the number of elderly residents who were hospitalized (Gleckman 2010).

Japan has struggled with the question of how to best provide care for many years. In 1963, Japan began to pour public financing into nursing homes and, by the early 1970s, medical care was secured for older people free of charge, even for hospital stays (co-payments for older adults were abolished). With the abolition of these co-payments, there was a surge of "social admissions." The 1989 enactment of the "Gold Plan/Ten Year Strategy for Health and Welfare of the Elderly" aimed to address this increase by both doubling the number of institutional beds and tripling the services provided in the home and community over a ten-year period. In 1997, the LTC insurance program was created and it was finally implemented in 2000 to address problems that existed with the Gold Plan. It was created with heavy influence from both the German and Scandinavian approaches. For example, it was determined that "evidence from Europe indicates that nations that provide only services have a more egalitarian or progressive pattern of care provision than do nations that rely on cash allowances" (Tamiya et al 2011). The structure of the system was designed based on a triennial cycle in which, every three years, municipal leadership is required to create a new work plan for the LTC plan. Furthermore, every three years, national reassessment is completed. It is also important to note that the Japanese LTC program is designed specifically for older adults and does not cover people with disabilities. Tamiya et al argue that this is because of the focus on a service-only approach which must be designed with a specific population in mind (2011).

Demographics

In 2013, the total population of Japan was 127 million people (World Bank Group 2016). In 2010, over 29 million residents of Japan were over 65 years old—putting that demographic at 23% of the total population. This number is expected to increase to 40% by 2050. Furthermore, Japan currently has the highest health life expectancy at birth (HALE) (Tamiya et al 2011). Recently, the population of people older than 80 topped 10 million in Japan, or 7.9 percent of the total population (Sakamoto 2015) and is expected to increase.

Unlike many countries, Japan's population is not growing. In fact, in 2011, 2012, 2013, and 2014 Japan's population fell (Hongo 2015). As the current population of Japan ages, and the population stagnates/declines, the average age is going to continue to increase.

Eligibility

In Japan, there is no means testing for the LTC insurance. It is a universal program that is not dependent on the financial situation of the family or senior (Tamiya et al 2011) (Swartz 2013).

Eligibility for specific services is, instead, based on a needs assessment that will determine what services an individual will qualify for. Then, the recipients will choose what services they want to obtain and which providers they wish to utilize.

In general, the needs assessment process is similar to that of Germany; however, it is much less restrictive. Tamiya et al (2011) argue that the reason for the relative lack of restriction with this program arose for political reasons. As explained above, the LTC Insurance program came on the heels of the Japan Gold Plan (or ten-year plan). Under this Gold Plan, there was a major shift from long-term institutionalized care to home-based, and community-based, programs[1] that began to cover many seniors. For this reason, when the new LTC Insurance program was introduced, it had to be taken into account that there were many people already receiving services (and such services could not—politically—be rolled back). This led to a relatively less restrictive needs assessment in which about 17% of the population over 65 years old has been deemed eligible[2] (Tamiya et al 2011). The assessment tool that was created, and is currently in use, was based on a study conducted by Tsutsui et al (1995) (referenced in Olivares-Tirado and Tamiya 2014); however, like in Germany, Japan has conducted a study about what LTC eligibility tool would be most effective and it was suggested that a new tool should be developed (Büscher 2011). The tool that was originally implemented established 6 levels of care, although in 2006 one more level was added (Olivares-Tirado and Tamiya 2014).

After assessments are completed, and certified, the assistance level and the monthly benefits are communicated to the applicant—typically within 30 days of applying (Tsutsui and Muramatsu 2007 ref. in Olivares-Tirado and Tamiya 2014). This certification is then good for 6 months, at which point a renewal or change in status must be requested.

General Financing Scheme

Japan's LTC insurance program is technically considered a social insurance; however, about 45% of funding comes through taxes. Another 45% comes through social contributions and 10% comes from co-payments (Olivares-Tirado and Tamiya 2014) (Tamya et al 2011). This mixed funding is similar to the Medicaid program in the United States (Gleckman 2010). Also, in 2005, there was a reform implemented to improve the sustainability of the program. This reform made it so that middle and high income users were no longer subsidized for hotel costs in institutional facilities (private nursing home hotel costs are also non-subsidized) (Yoshida and Kawahara 2014).

[1] With the introduction of the Gold Plan, there was a rapid growth of the formal care sector. During this time costs increased annually by about 10-15% (Campbell and Ikegami 2000 referenced in Olivares-Tirado and Tamiya 2014).

[2] The rather loose restrictions on eligibility within the Japanese LTC insurance program make Japan an interesting case study to review the concept of the "woodwork effect" (aka "moral hazard"). This is the idea that the expansion of the eligibility of services will bring a huge rush of people who were previously not seeking services (perhaps because they were relying on informal care). Whether or not this is a justified concern is unclear based on the European experience. Although Japan's LTC costs are higher than expected, it has also been noted that about 20 percent of people who could receive benefits do not participate. Furthermore, only half of the beneficiaries use their full benefits (Gleckman 2010) (Gleckman 2007). It is shown, however, that the number of people using their LTC benefits are increasing as people continue to learn about the program. For example, in 2000 the total number of beneficiaries amounted to only 6.9% of the elderly population. By 2008, it was 13.5% of that population. The LTC expenditure also increased by 5% annually from 2007-2011. To address such concerns, there were reforms made in 2005 (reforms discussed throughout the brief) (Olivares-Tirado and Tamiya 2014).

The LTC insurance budget is managed on a three-year cycle by the municipalities. Every three years, the municipalities are required to present a plan for balancing the budget over the three-year Program Management Period (PMP). LTC prices, on the other hand, are set by the central government and are essentially held constant. Once the expenditure forecasts are estimated, the revenue scheme is designed. There are several different sources of income considered in setting the scheme. The first is through general taxation, which supplies funds in four different ways: (1) the central government will cover 20% through the Long-term Care Benefits Subsidy, (2) the central government will administer an additional grant to allocate 5% of the national total of all benefits to adjust for discrepancies in municipalities finances[3] (this is called the Adjustment Subsidy—AS), (3) local entities called prefectures cover 12.5% of the benefits, and (4) another 12.5% is paid for by intra-municipal transfers. The rest of the money is supplied by social insurance premiums. One type of premium is paid by residents over 65 to cover any remaining revenue needs (set by each municipality and based on income). Secondary premiums are paid by people aged 40-64 and are collected as a public health insurance premium surcharge (they are a payroll tax paid 50/50 between employers and employees). They cover 31% of LTC insurance benefits and function as a way to equalize revenues because they are pooled nationally and distributed in a way that favors municipalities with low secondary insured shares (Olivares-Tirado and Tamiya 2014) (Gleckman 2010). Finally, there is a 10% co-payment for services (Olivares-Tirado and Tamiya 2014)

For the primary social insurance tax, there are national guidelines that describe a six-tiered income bracket system with adjustment coefficients (50%, 50%, 75%, 100%, 125%, 150%) so that the 4th tier is the standard rate (which is devised by each municipality so that the budget for the three year PMP is balanced). These rates can vary greatly but the median for the 2010-2012 PMP was 48000 Yen (or 476.03 USD) annually (Olivares-Tirado and Tamiya 2014).

From 2006-2010, the public expenditure on the LTC insurance program was .7% of the GDP (Maisonneuve and Martins 2013). Overall, 1.2% of the GDP is dedicated to LTC, which is much lower than many other countries despite Japan's relatively old age. Still, the LTC expenditure is expected to increase rapidly over the next 40 years, and could even reach as high as 4.4% of the GDP in 2050 (based on an OECD projection) (Colombo and Murakami 2013).

Benefits/Services Provided

Unlike many LTC programs, the Japanese program provides service benefits only. There are no cash payments in this system (Gleckman 2010) (Tamiya et al. 2011). There was extensive debate about whether or not to include cash benefits as part of the program while it was being devised; however, it was concluded that they should not be included. One major reason for their omission could be Japan's focus on decreasing the burden on family carers, and allowing such carers—mostly daughters—to enter the workforce.

In theory, once the benefit is determined through the assessment, the beneficiary is free to choose services on their own. In practice, however, there is typically a care-manager that make care plans "according to each applicant's certified care needs level, living environment, and requests from the user and family" (Olivares-Tirado and Tamiya 2014). The role of the care-giver is a key position within the Japanese LTC Insurance program. This person is a professional with 5 years of clinical experience at least who possesses a health/welfare license. They are integral to the success of the program as they are relied upon to coordinate services by many providers across a large geographical

[3] These are distributed depending on the percentage of people over 75 and the average income of people over 65 in each municipality (Olivares-Tirado and Tamiya 2014)

area—and to do so within a strict budget. The recipient of the insurance has the choice to make requests or—if necessary—change the care manager every six months (Olivares-Tirado and Tamiya 2014).

There are many services that can be utilized within this system. They range from care prevention services to at-home or institutional care. In the home, care services include practical and personal care, nursing, bathing, rehabilitation services along with funds to purchase needed equipment. There are also community services provided such as commuting and day care services. There are several types of institutional care settings such as the nursing home, geriatric intermediate care centers, and LTC health centers. The latter two are for patients who are stable but need extensive rehabilitation or nursing.

Providers

Within the healthcare system in Japan, there is a principle called the "non-profit principle" forbidding investor-owned hospitals and clinics. This principle does not apply to services in LTC program. Therefore, there are many different providers (Olivares-Tirado and Tamiya 2014). In general, most institutional care is provided by private, non-profit (Gleckman 2010) providers, although there are some municipal institutional facilities and some private, for-profit, nursing homes (Yoshida and Kawahara 2014). Most home care is for-profit (Gleckman 2010) with 55.1% of 20,885 businesses that provided home care in 2008 being for-profit entities.

Private Insurers

I did not find any discussion of private insurance.

Informal care-givers

One of the main goals of the Japanese LTC program is to reduce the burden on family givers. In fact, this has been given as one reason not to include cash payments (as it may put pressure on family carers—mostly women—to stay home and provide care). One of the goals of this was to increase the amount that family members who were providing care would be able to work. The success of the LTC Insurance program in meeting this goal was investigated by Tamiya et al (2011).

Overall, Tamiya and colleagues (2011) found that the average time that family carers spent caring dropped significantly after the introduction of this program (by .81 hours/day)[4]. After the introduction of the program, time spent on caring for high income individuals dropped by 1.36 hours, for middle income by .81 hours, but for low income individuals the drop was insignificant. A similar trend was shown with regards to the increase in employment, with high income carers working on average 4.57 hours/week more after the introduction of the LTC insurance program. For middle and low income individuals the amount of time spent working showed no significant change (although they were slightly more likely to be employed). Tamiya et al suggested several possible explanations for this trend (that the LTC Insurance program met its goal—reducing the burden on carers and allowing them to work—with high income, but not low income, individuals). One explanation could be that the opportunity cost of providing informal care for high income

[4] Tamiya et al (2011) also showed that the household costs of caring for an elder decreased by 5% for all income groups after the introduction of the insurance plan.

residents is much higher than for low income individuals because of their higher salary. Furthermore, care leave is often offered to full-time workers with high income, so they are able to have the flexibility needed to still provide small amounts of care.

Satisfaction Rates[5]

In a summary of answers from 11,181 people in 9 different prefectures in Japan, it was found that 86% of LTC insurance users are "satisfied" or "nearly satisfied." Only 5% are "slightly dissatisfied" or "dissatisfied." It was found that only 17% of users believed that the fee was "too expensive" (and 21% believed it was "slightly expensive") and about 21% felt that they had a "heavy emotional burden" because of the premium (Ministry of Health 2002).

Lessons Learned/Key Points

1. What are the benefits of providing services only, and no cash benefits?
    a. It was argued that providing services only has been shown to be more egalitarian than also providing a cash stipend as high income individuals could add to the cash stipend and purchase more expensive (potentially better quality) services. This, then, could create two distinct levels of care.
    b. Cash benefits may put pressure on informal care-givers to continue providing care even if they would like to re-enter the workforce. The Tamiya et al study is interesting to consider here, as it was shown that Japan's system (with no cash benefits) did allow high income informal care givers to work more each week, but low and middle income caregivers saw no appreciable difference. Would it then be better, for these low and middle income families, to have a cash benefit at least?
    c. It was also argued that providing "services-only" makes it hard to address multiple subgroups (such as the elderly and people with disabilities) with the same program as they have very different needs. On the other hand, there is a large amount of variation in services needed from one senior to another, so I am not sure how much of a factor this really is.
2. Japan has very loose qualifications for services. Tamiya et al argue this is because there were some people already covered under previous plans and so they had to ensure they would be continued. While we do not face this problem with NYHA, it is important that we intelligently design eligibility requirements as it is almost impossible (politically) to draw back services. Japan is now struggling with a potential massive increase in cost (1.2% to 4.4% of GDP) and will have to make difficult decisions about how to cut costs without rolling back services.
3. Once an assessment is made and a plan is certified, the beneficiary has to recertify every 6 months. Denmark had a similar, twice yearly, preventative visit mandate. This would be good to consider as the amount of need required may rapidly change and, having this sort of structure in place, may prevent people with worsening conditions from going unchecked.
4. There was not a huge woodwork effect noted in the literature, especially because many people did not fully utilize their benefits. It is predicted, however, that as people continue to learn about the program, a larger percentage will be taking full advantage of it (leading to increased costs).

[5] Not included in the Eurobarometer survey (2007)

5. There is a lot of focus in the financing scheme on ensuring that there are not geographical discrepancies in the amount of funding each municipality gets to fund its LTC insurance.
6. There are clear regulations put in place for case managers. It may be worth devising a set of regulations for NYHA LTC case managers (versus the case managers who deal with populations not needing LTC).
7. Prices are negotiated and set by the central government. There are many private, for-profit providers in Japan's system. It may be worth investigating what types of regulations Japan uses to ensure quality (and prevent these companies from cutting corners to increase profit). For example, would it be possible to introduce a "medical loss ratio" for LTC?

With the NYHA as the ideal, how close does this system come?

In lines with the NYHA, every resident is eligible regardless of financial need. There is no means-testing for eligibility for this plan; however, there is means-testing for hotel costs for institutional care. NYHA calls for no premium/other charges for health care. While it is unclear if this would apply to the long term care model (specifically with regards to co-payments), the Japanese model has 10% cost-sharing for services. The NYHA also calls for comprehensive care which is provided by the Japanese system.

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Country Brief: Netherlands

Overview

In 1968, the Exceptional Medical Expansion Act created a long-term care insurance system called the AWBZ (Gleckman 2010) (Mot et al 2010). This plan is universal and publically funded (Szebehely Jan. 2015). Over the past (nearly) 50 years, the Dutch system has undergone several reforms including, most recently, a major overhaul in 2015. This brief will describe, in detail, the Dutch LTC policy in place before 2015 because of the wealth of data regarding this earlier system. This will prove useful when comparing it to the New York Health Act (NYHA). A brief summary of the reforms made in 2015 will be included as well.

Under the Dutch system, the AWBZ aims to cover all chronic care, for both the elderly and people with disabilities. It covers care at home and in institutions such as "personal care, nursing, assistance, treatment and stay in an institution" (Mot et al 2010). Before 2007, the AWBZ also covered domestic help; however, a reform in 2007 shifted the provision of this care to the Wmo (Law on Social Support), with the goal of lowering the cost of the AWBZ (Gleckman 2010). This has created a division in the provision of services: the AWBZ is funded by social security premiums, taxes and co-payments and overseen by the central government while the Wmo is funded by a non-earmarked budget for home help that is received by local councils.

The most recent reform, in 2015, represented the most substantial overhaul of the system since its creation in 1968. This reform aimed to address concerns that the costs of the AWBZ were becoming too high as they continued to increase. The provisions afforded by the AWBZ have now been distributed amongst four laws (three old, one new). Home nursing was added to the Health Insurance Act (Zvw), social care and support was added to the Wmo, and preventative and mental health care for children was added to the Youth Act. A new law, the Wlz (Long Term Care Act), was created to cover the costs of residential care. By renegotiating the amount of services provided, this reform hopes to realize massive savings; however, the feasibility of such savings have come under question (Van Ginnekan and Kroneman 2015).

Demographics

In 2016, the population of the Netherlands was 16,979,729 with a median age of 42.9 years (Worldometers 2016). Of these nearly 17 million residents, 18% were over 65 in 2015 (World Bank Group). In 2011, about 4% of the population was over the age of 80 (similar to the OECD average) (OECD 2013). The Netherlands expect to see a continual increase in the age of its society, with predictions suggesting that in 2050, 24.5% of the population will be over 65 years old and nearly 10% of the population will be over 80 years old (Mot et al 2010).

Eligibility

The Dutch LTC system is universal. There are no means testing for eligibility of services; however, cost sharing is determined via means-testing (Swartz 2013). Therefore, eligibility for the AWBZ is determined by assessing the needs of the resident. This needs assessment is conducted by the CIZ (the Centre for Care Assessment), an independent organization with no financial incentives. The role of the CIZ is to determine if a resident should be deemed eligible for AWBZ because of

either a "somatic, psycho-geriatric or mental disorder or limitation" or "an intellectual, physical, or sensory disability" (Mot et al 2010).

The assessment process of the CIZ is referred to as the funnel model. It is completed in a step-wise fashion. First, the CIZ analyzes the situation of the resident: not only are disorders and any disabilities evaluated at this step, the circumstances—availability of usual and informal care and the existing use of programs like welfare and care provisions—are also investigated. During the second step the CIZ attempts to determine how best to solve the care problems of the resident. It does by looking to see if care can be provided outside of the AWBZ by usual family care (usual care is expected by the government, but there is a limit set on what is deemed "usual"), other publicly funded programs, or general provisions that are available to all residents. Thirdly, the role of voluntary care is investigated. If informal care exceeds "usual" care an entitlement exists; however, if the informal caregivers want to continue giving care, and the recipient want to continue receiving it, the potential entitlement under AWBZ may be adjusted downwards. Next, during the fourth step, the CIZ decides whether home or institutional care is preferable. Once these four steps are completed, a final decision on the entitlement is determined (it can be appealed by the resident as well) (Mot et al 2010). In 2008, 600,000 people were determined to be eligible and receive benefits. Of these, two-thirds were elderly, one-fifth were people with disabilities, and the remaining were patients with mental illness (Gleckman 2010).

In 2007, domestic home help was removed from the AWBZ in an attempt to control costs. Instead, it would be covered by the Wmo and overseen by local councils. Therefore, the need of domestic home help is determined by this local council. Unlike the CIZ, the local council has an incentive to contain costs. Furthermore, the local council has a fair amount of freedom in determining means of assessing eligibility. It would be possible, for example, for the local council to decide that high income individuals—who can afford domestic care on their own—do not qualify for Wmo help. While the local councils have financial incentives to keep Wmo costs down, democratic pressure, theoretically, keeps them from being too strict with the elderly and chronically ill (Mot et al 2010).

General Financing Scheme:

The AWBZ is funded largely by income-related premiums that constitute a social security contribution. These premiums are paid by all citizens over 15 years old with a taxable income. In 2008, the premium was a 12.5% tax for any income above 47,400 dollars (Gleckman 2010). Approximately 68% of LTC costs under the AWBZ are funded in this manner. Twenty-four percent of the costs are covered with taxes and the remaining nine percent of costs are covered with user charges (Mot et al 2012). User charges, outside of institutions, are paid via a 12.60 Euro/hour co-payment. An income-dependent maximum is set. For example, for a person with a yearly income of 40,000 Euros, the maximum user fee is 307.83 Euros per four weeks, or about 4000 euros per year. In an institution, there are two different phases of cost-sharing: low for the first six months, and high after. While there are different levels set based on income, at the very least, a single resident must have remaining in their income at least 276.41 Euros per month to spend freely. Cost sharing is set up with this limit in mind (Mot et al 2010).

The Wmo receive a non-earmarked budget for home help. In 2007, the total budget for all municipalities combined was 1.2 billion Euros (a 150 million Euro surplus was maintained). (Mot et al 2010). For the Wmo, cost sharing is set by the local council. It must not exceed the maximum set

under the AWBZ; however, the local council is free to change the parameters of such cost sharing within these limits.

In 2008, the LTC system in the Netherlands cost approximately 20 Billion Euros (Gleckman 2010). In 2010, the total spending on the LTC system represented about 3.7% of the GDP, the highest of all OECD countries (OECD 2013). From 2006-2010, public expenditure on the LTC system represented 2.3% of the GDP (Maisonneuve and Martins 2013).

Benefits/Services Provided

The AWBZ funds several types of services: including home-based services, institutional care, cash allowances for individuals, and payments to relatives (Swartz 2013). Under the AWBZ, residents can receive assistance, personal care, nursing care, and treatment at home. Furthermore, informal care givers can receive payments out of personal budgets which are used to either purchase formal care or pay for informal care (Mot et al 2010). When cash payments are elected, the payments are 25% less than what would be paid for care-in-kind (Mot et al 2010).

Within this system, institutional care plays a relatively important role compared to other European LTC systems. In 2007, about 164,000 elderly patients used institutional care either in nursing homes or elderly homes. Before 2009, two categories of institutional care existed: nursing home care and residential care. In 2009, however, there was a reform that created ten different products that could fall under institutional care. These products could be packaged in a "severity-of-care" package (or ZZP) which can range in its severity. Although residents pay a co-payment for services (income-dependent), hotel costs (room and board) are included in the package. While the co-payment may be high enough for high income individuals that they end up paying for room and board anyways, this represents a difference from many LTC policies in which such hotel costs are managed separately (Mot et al 2010).

While the AWBZ, as mentioned, covers much of the care at home for people needing LTC, domestic help and social services are covered separately by the Wmo. This law covers such services as "home help, meals on wheels, home adjustments and transport" (Mot et al 2010).

In the Dutch LTC system, the quality of services provided is regulated by the law (two laws, in fact: the KWZ and the Wet BIG). These laws strictly regulate institutional care, but home-based services are much less regulated with regards to quality (there are laws that monitor competition and prices) (Mot et al 2010). For home-based services, competition is expected to ensure high quality services.

The separation of LTC services represented by the AWBZ and the Wmo (and the separation of medical care as well) has created problems with integration and coordination in the Dutch LTC system. People needing services will most likely have to negotiate multiple systems, all with different rules. Furthermore, this lack of integration poses problems for improvement and reform: "for example, it is not in the financial interest of the local council to invest heavily in independent living for the elderly, as the council will bear the costs of this policy, while the benefits will appear in the form of lower AWBZ expenditures" (Mot et al 2010). While merging such systems could address this problem, it may present problems of its own by creating a system that grows too large by attempting to do too much.

Providers

In the Netherlands, all care providers are private. They can be either for-profit or not-for-profit. The Dutch Healthcare inspectorate (IGZ) monitors the quality of care provided while the Dutch Healthcare Authority (NZA) regulates the market (Tinker et al 2013).

One famous provider in the Netherlands has shown a very innovative way to address the issue of dementia and Alzheimer's Disease called Hogeway, a contained "dementia village" in which seniors with dementia are able to live and function independently in a village resembling a normal town (Planos 2014). This "village" has received a lot of international attention, with LTC experts flocking to the town to see what principles could be applied to other systems.

Private Insurers

The high level of risk coverage afforded by the AWBZ makes private insurance obsolete (Mot et al 2012).

Informal care-givers

The Netherlands has a high proportion of its population providing informal care; however, this care is less intensive than many other countries (represented graphically by Rodriguez et al 2012 in Szebehely Jan. 2015). Of the population 65 and older in the Netherlands, 28.8% receive some practical help from informal care-givers, but only 3.2% receive any personal help (help with ADLs). Furthermore, the role of cash benefits—although they do exist—plays a small role and is becoming smaller in order to contain costs (Mot et al 2012).

Satisfaction Rates

A 2007 Eurobarometer study attempted to gauge the population's satisfaction with European long term care programs. When Dutch citizens were asked if they, or a loved one, received appropriate long-term care when it was needed 58% answered "yes, totally," 35% said "yes, but only partly," and 4% said "no"—with 4% not choosing. When asked "In the future do you think that you would be provided with the appropriate help and long-term care if you were to need it?" 72% of respondents from the Netherlands surveyed answered yes, putting the Netherlands near the middle of the countries surveyed (the highest being Greece with 89% and the lowest being the UK with 61%). The EU average was 71%.

When asked who would finance regular help and long-term care if needed 51% answered "public authorities or social security," putting them well over the European Union average of 32%, but still far from the highest scorer, Denmark, with 76% (Eurobarometer 2007). Overall, this study found that less than 30% of Dutch citizens were "dissatisfied with the performance of their LTC system." The lowest was Denmark, with less than 25% dissatisfaction. Overall, however, the Netherland's satisfaction rate was in the top six of the countries studied (data represented graphically in Ranci and Pavolini 2013).

2015 Reform

As described, the Dutch LTC system underwent reform in 2007 by shifting domestic care from the AWBZ to the Wmo. This was the first step of the reform and was implemented with the hopes of urging more individual (and municipality) responsibility for LTC. This reform drastically cut the budget for such home care services as a response to continually rising costs (Maarse and Jeurissen 2016). In 2015, another reform was implemented, realizing a comprehensive restructuring of the Dutch LTC system. In this reform the AWBZ was demolished, and its services were spread amongst four programs. Home nursing was added to the Health Insurance Act (Zvw), social care and support was added to the Wmo, and preventative and mental health care for children was added to the Youth Act. A new law, the Wlz (Long Term Care Act), was created to cover the costs of residential care (Van Ginnekan and Kroneman 2015).

This reform has several goals. First, the reform aims to de-medicalize the Dutch LTC system by having social support be supplied by informal caregivers and through community models. Secondly, the reforms aim to decrease the amount residential, institutionalized, care delivered. Such care will now only be available if absolutely necessary. Thirdly, the responsibility for the oversight of non-residential care has been shifted from the central government to local municipalities and insurance schemes. Along with these goals, expenditure cuts were introduced to try and address the seemingly unsustainable inflation of LTC costs (Maarse and Jeurissen 2016).

As would be expected, this reform has been controversial as it drastically changes the organization (and access to) the LTC system. Still, LTC will continue to be largely publicly funded and the benefits provided will continue to be generous (Maarse and Jeurissen 2016).

Lessons Learned/Key Points

1. The Dutch system was created in 1968. It has undergone many reforms over this period to adapt to the changing needs of society. Recently, in 2015, it was necessary to overhaul the system which was not created with a rapidly aging society in mind.
2. There is a relative lack of integration in this system. This creates problems with both patient navigation and improvement of the system (because of conflicts of interest among the individual programs that comprise the LTC system). Such examples could be used to demonstrate the advantages of integrating LTC with medical coverage under NYHA.
3. The needs assessment in the Dutch system is conducted by CIZ, an independent assessor. The use of an independent assessor (who is in no way connected to the LTC budget) allows for unbiased assessments.
4. CIZ has a whole step of its assessment plan dedicated to exploring options outside of the LTC plan. This could be a useful step in reducing costs to the LTC plan, assuming outside sources are commonly utilized. If not, this may simply add another bureaucratic step.
5. Cash payments are 25% less than what would be paid for care-in-kind. This could be a good way to save costs, although, the existence of cash benefits may increase the woodwork effect: offsetting any savings.
6. The Hogeway Dementia Village is a world famous residence for people living with dementia. Any successful LTC system must allow for innovation, as we have yet to determine what the best way to care for the elderly is. Therefore, the NYHA must find a balance between stifling creativity with over-regulation and permitting poor quality services because of a lack of oversight.

7. The 2015 reform aims to drastically decrease the expenditure on the LTC system (the costliest among OECD nations) while still allowing for the provision of extensive benefits. It will be interesting to follow these reforms and see how successful they are in doing so.

With the NYHA as the ideal, how close does this system come?

Pre 2015 Reform: In lines with the NYHA, every resident is eligible. There is no means-testing for eligibility for this plan; however, the cost sharing does depend on means-testing. It is important to note that domestic care is provided by local councils and eligibility is determined by these groups. There is little oversight from the central government for these groups, so it is feasible that a local council could decide that domestic services should not be provided to high income individuals who could afford to pay for them. NYHA calls for no premium/other charges for health care. While it is unclear if this would apply to the long term care model (specifically with regards to co-payments), the Dutch model does not meet this standard because of the existence of co-payments. The NYHA also calls for comprehensive care which seems to be provided within the Dutch system although reforms seem to be making services more difficult to access.

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Country Brief: Sweden

Overview

In 1957, the Social Services Act was introduced in Sweden. This act gave the Swedish municipalities responsibility for providing home care to elderly or disabled citizens (Fukushima et al 2010). The Social Services Act has evolved into the long term care structure that exists today in which municipalities are in charge of providing many services for elderly citizens (Bergstraesser 2015). Sweden's long term care system is universal and publically funded (Szebehely Jan. 2015). There are three different authorities in charge of managing this system: the central government, the county councils, and the local authorities.

Demographics

In 2015, the population of Sweden was 9,798,871 (Worldbank 2016). In 2011, the percent of the population over 65 was 19 and the percent between 80 and 100 years old was about 5% (approx. 500,000 people). This is expected to increase to 25% and about 6.3% (approx. 600,000 people) respectively by 2060 (Statistics Sweden 2012). At the moment, this 19% over 65 years makes Sweden the country with the highest number of elderly citizens in the world—as of 2011 (Bergstraesser 2015).

The recognition of this aging population has led to worry about increasing costs; however, studies disagree on how this increase in age will change costs. Some studies have suggested that the increased costs—even to LTC—have less to do with the actual age of the population, and can be captured better by looking at the Time-to-Death (TTD), or the probability of dying within 2 years. In a recent study in Sweden (Karlsson and Klohn 2013), on the other hand, it was shown that LTC expenditures for the older population can be explained somewhat by TTD; however, the demographics and "age structure" of the country remain more important when attempting to determine LTC costs. Furthermore, the percentage of the population that falls within the "oldest" category is a very important determinant of the costs of LTC.

This same study looked to predict the costs of LTC expenditure. It was found that expenditures can be expected to increase from SEK 11 thousand per capita (per year) to 20 thousand per capita over the next one hundred years—in 2060, the cost is projected to be around 17 thousand per capita (Karlsson and Klohn 2013) (Note: SEK 1000 is equivalent to approx. 115.99 USD).

Eligibility

In Sweden, any person with impediments who has permanent residency in Sweden is eligible for care. The amount of care given is determined by an assessment of needs. As of 2010, there was no general guidance provided by central authorities about how to assess for needs. Therefore, the method varied depending on the local authority. Several different models were used including, but not limited to, the Katz ADL index, the Residential Assessment Instrument, and the Geriatric depression scale (Fukushima et al 2010).

General Financing Scheme:

In 2006, the total expenditure on LTC for Swedish residents over 65 was SEK 168 billion (approx. 19.5 billion USD). This corresponds to about 3.5% of the total GDP of Sweden. (Fukushima et al 2010). Note that, compared to many of the other countries studied in this LTC Policy project, this number is slightly high. This may be related to the abnormally high percentage of Swedish residents aged over 65.

In the Swedish system, the majority of funds covering the long term care system in Sweden come from a municipal tax. This provides for about 85% of the cost. Another 10% of the cost comes from national taxes (Szebehely and Trydegard 2012). The remaining 4-5% of the cost is paid for by service fees. (Karlsson and Klohn 2013).

The central government sets a maximum monthly fee for long-term care which is related to the financial situation of the citizen (Fukushima et al 2010). This came from the max-fee reform in 2002 that made it so the maximum fee was 180 Euro/month (Rostgaard and Szebehely 2012). In 2011, another reform set the maximum fee at 184 Euros (Szebehely and Trydegard 2012).

Spending for elder care has decreased over time in Sweden. From 1990-2000, it reduced in relation to the number of people over 80 by 14%. From 2000-2009 it reduced in absolute terms by 6% (Szebehely & Trydegard 2012). This can only partially be explained by improved health. Szebehely argues that this is due to the current trend of refamilization and privatization in the Swedish model.

Benefits/Services Provided

There are several different types of services available in the Swedish long term care system. Available services include home care in regular housing, special housing or institutional care, day activities, home nursing care, meal services, safety alarms, and home adaptation. Along with these services, elderly and people with disabilities that cannot use regular public transport are provided with transportation assistance. (Fukushima et al 2010). In 2006, nearly one hundred thousand people (over the age of 64) received care in institutions in Sweden. Nearly two hundred thousand people (178,282) in the same age group received home care (Fukushima et al 2010). In general, the trend in Sweden seems to be towards home care, and away from institutional care—as the number in institutions reduced by approx. 12% from 2001 and the number receiving home care increased by approx. 12% over the same time period (Fukushima et al 2010). In 2005, 57,300 people received meal delivery services and 64,700 received assistance with home adaptations. In 2004, 372,900 received transportation services. And in 2006, 157,169 people had safety alarms installed (Fukushima et al 2010).

These numbers change from year to year, but one study in 2008 showed that about 15.6% of the population over 65 years old received some form of services (with 6.4% of these being in the form of institutional care and 9.2% in the form of home-care). This home-care was broken down further to show that 3.6%—of the total 9.2%—(of the total population over 65) received less than or equal to 2 hours of care per week; 4.7% received between 2 and 20 hours; 0.9% received greater than 20 hours per week (Rostgaard and Szebehely 2012).

Home care in Sweden consists of providing household tasks, personal care, social support, (Szebehely & Trydegard 2012) (Szebehely, April 2013) and help with medication and rehabilitation. On average, 7hrs/wk of care is provided, but the intensity varies from once a month to several times a day/night. About three quarters of the workers providing such care have some form of formal training (Szebehley April 2013). Residential (institutional) care covers 5% of people 65+, with 80%

of residents being older than 80 years old. Furthermore, approx. two-thirds of residents suffer from cognitive impairment and/or dementia (Szebehely April 2013).

In 2007, another type of "service" or "benefit" was created with the introduction of a tax deduction that allows all age groups to deduct 50% of the expenditure on household services or personal care purchased on the market up to 11,000 Euros/year. Rostgaard and Szebehly (2012) argue that this may function as an incentive for better-off groups of elders to leave the home care services and increasingly turn to the market instead—pointing towards an increased "privatization" of Swedish care (to be discussed in the next section).

The percent of people receiving care in Sweden has been decreasing since 1970. This can only partially be explained by improved health. Home care declined in the 1980s and 1990s because of stricter guidelines, increased user fees—the max was in 2002, before the reform—and organizational changes. Residential care use has declined in the 2000s. Szebehely argues that this is due to three trends in Sweden's system: re-familization, privatization and marketization (Szebehely Jan 2015).

Providers

Over time, there has been an increase in purchasing privately provided help as the amount of care provided through public program declines. The percent of privately funded providers has, therefore, increased. Before 1990, about 97% of providers of long term care were public. By 2013, only 77% were public (table in Meagher & Szebehely 2013 qtd in Szebehely Jan. 2015). In 2013, 20% of providers were for-profit and 3% were non-profit (Meagher & Szebehly 2013 qtd in Szebehely Jan. 2015) (Szebehely April 2013). In Stockholm, 73% of nursing homes and 61% of homecare hours are provided by for-profit providers (Szebehely April 2013).

Szebehely argues that the decline of public services is (1) increasing the help from family among elderly with fewer resources, (2) increasing privately purchased services among elderly with more resources, and (3) increasing the help by daughters rather than sons affecting the lives of 'working daughters.'

In 2013, about 20% of providers were for-profit. This number has been steadily increasing because of political steps taken by the Swedish government. For example, the local government act of 1992 opened up the private market for long term care. Then, a tax rebate was introduced in 2007 that can be used for purchasing home care. In 2009, the Act on System of Choice facilitated the introduction of choice models in publicly funded homecare. This made it so that municipalities who adopted this program could not restrict the number of providers. Therefore, private providers could offer "topping-off" services (Szebehely Jan. 2015). This act also allowed municipalities to introduce a voucher system so the individual could choose among authorized providers. In this system, private and public providers receive the same reimbursement and users pay the same fee, so it is supposed to allow competition with regards to quality. In Oct. 2010, more that half of the municipalities introduced such a choice (Szebehely & Trydegard 2012).

This increasing privatization of the market has led to several worries (especially for Szebehely and colleagues). For example, since its introduction in 2007, the use of the tax deduction has increased in all income groups; however, it is claimed considerably more often by older persons with higher income (Statistics Sweden, 2013b qtd. in Ulmanen & Szebehely 2014). Szebehely worries that this could lead towards the creation of two levels of care—one for the wealthy, and a second for the remainder of the population. Secondly, the private sector is highly concentrated, with only two corporations making up half of the private eldercare market (Meagher & Szebehely 2010 qtd in

Szebehely & Trydegard 2012). In general, Szebehely worries that the trends seen in the Swedish long term care system are starting to create a public sector that is used mostly by groups with less education and income. Therefore, she worries that the quality of care in this system may begin to fall, and Sweden will end up with a two-tiered system of quality.

Along with this shift towards privatization, Sweden is currently attempting to allow more people to qualify as "providers" in order to meet the increasing needs of the aging population (Swartz 2013).

Private Insurers

While there are many private providers within the Swedish system, I did not find any discussion of Private insurers.

Informal care-givers

Sweden has a high proportion of its population providing informal care; however, this care is less intensive than in many other countries as shown in Redriguez et al (2012). In Sweden, 42% of people needing help with 1-2 tasks receive family care (Rostgaard & Szebehely 2012) and this number, of older residents receiving informal care, has been increasing. From 2002/3-2009/10 help from non-cohabiting family members increased from 48 to 63 percent of non-institutionalized older people receiving informal help (Ulmanen & Szebehely 2014). Now, 8 out of 10 adults provide some care for an older person (Szebehely Jan 2015), and one study suggested that 31.1% of older adults (65+) receive informal practical help while 3.1% receive informal personal care (Mot et al 2012).

In general, women are more likely to provide more familial support than men. Women spend, on average, 7 hrs/wk caring for an elder and men spend approximately 5 hrs/wk. Not surprisingly, this affects the amount that they are able to work. 17% of women and 10% of men have reduced their working hours, stopped working, or retired earlier than planned for due to caring for an elder (Szebehely Jan. 2015).

National policy on support for family carers strongly stresses that family care must be provided voluntarily (Ulmanen & Szebehely 2014); however, there are systems of support such as cash payments to relatives (Swartz 2013). As of July, 2009, municipalities have been required to support informal caregivers in several ways, although these vary depending on the municipality. For example, there is a cash benefit that varies between SEK 1,000-3,000 ($116-$349) per month provided to the care-recipient (to be given to the informal care-provider); however, this is not available (as of 2010) nationwide (Fukushima et al 2010). Other support can come in the form of support groups, relief support, temporary residence for care recipients, volunteer services, and much more (Fukushima et al 2010).

Eurobarometer surveys have shown that, despite the increase in informal care (and the trend towards familization) 80% of Swedes would prefer formal care to informal care (Eurobarometer 2007 and Rostgaard & Szebehely 2012).

Satisfaction Rates

According to questionnaire studies, “most care recipients are very satisfied with the quality of care provided to the elderly today” and “the main dissatisfaction concerns the lack of social activities in LTC” (Fukushima 2010).

A 2007 Eurobarometer study attempted to gauge the population’s satisfaction with European long term care programs. When Swedish citizens were asked if they, or a loved one, received appropriate long-term care when it was needed 59% answered “yes, totally,” 33% said “yes,

but only partly," and 5% said "no"—with 3% not choosing. When asked "In the future do you think that you would be provided with the appropriate help and long-term care if you were to need it?" 84% of Swedes surveyed answered yes, putting Sweden near the top of the countries surveyed (the highest being Greece with 89% and the lowest being the UK with 61%). Of the European countries reviewed for this long term care policy project, Sweden was actually the most likely to answer yes, with 84%—falling behind only Greece and Belgium. (Eurobarometer 2007).

When asked who would finance regular help and long-term care if needed 60% of Swedes answered "public authorities or social security," putting them well over the European Union average of 32%, but still far from the highest scorer, Denmark, with 76% (Eurobarometer 2007). Overall, this study found that less than 30% of German citizens were "dissatisfied with the performance of their LTC system." Of the European countries studied for this policy project, the highest percent dissatisfaction was Finland, with about 50% dissatisfaction. The lowest was Denmark, with less than 25% dissatisfaction. Overall, however, Sweden's satisfaction rate was in the top four countries studied, barely behind Denmark, France and Belgium (data represented graphically in Ranci and Pavolini 2013).

Lessons Learned/Key Points

1. Within the Swedish system, there is a lot of responsibility that is left to the municipalities and local governance structures. How much responsibility (and freedom) do we want to leave to be decided by regional structures/governance boards within the NYHA LTC plan.
2. It is hard to predict how the aging population will directly impact costs, as you not only have to consider that there will be more elderly (at any given time). They will also be living longer. This is an important consideration for cost prediction; however, it is not clear what the best way to predict it is. Studies disagree on the extent that the actual increased life span affects costs (versus time-to-death measures).
3. Should we recommend one universal test for eligibility? (Or perhaps one for elderly residents and another for people with disabilities). Sweden's system leaves this up to local bodies, and this—I imagine—could create massive regional differences in eligibility requirements.
4. Sweden spends—relatively—a lot on its LTC plan (at 3.5% of the GDP). It would be worth further investigating why this is. Is it because they, on average, are older than most other countries? Is it because they provide a very extensive set of services? Is it another factor?
5. In Sweden, the max-fee is income-graded. This may be a potential route for determining cost sharing—as opposed to a percent fee.
6. Sweden provides a very expansive set of services including improving homes (to make them safer for elderly), day-care services, and personal safety alarms. Such services (that may not, generally, be considered part of LTC costs) could help allow people to live longer, healthier, happier lives (in their own homes).
7. The 2007 reform introduced a voucher-like system of tax rebates to allow for direct purchasing of care off of the private market. This seems to be, in a way, Sweden's form of the "opt-out" system that Germany has. The important question, though, is does this really serve any purpose, improve care, or increase satisfaction? Or is it, rather, a politically motivated move?
8. We should be realistic about what we can and cannot provide when we devise our LTC plan for NYHA so that we don't have to draw back services over time. Sweden seems to be in a position where they have offered so much for so long and now, as the population is getting older, they are scrambling to figure out ways to continue to offer such services and still be

able to afford the LTC plan. I would think that this plays a role in the shifts that Szebehely discusses (privatization, re-familization, marketization).

9. How much do we want to incentivize informal care? While it could save costs it may fail to alleviate the pressure that many people (especially women) are facing in taking care of the elderly. We also should consider that it seems to be a world-wide trend that most of this informal care is provided by women, and that, for this reason, incentivizing it may put added pressure on women to leave the workplace. (In Sweden, 17% of women—versus 10% of men—have had to reduce work hours, stop working, or retire in order to take care of an elder).
10. In Sweden, studies have found that 80% of Swedes prefer formal, professional, care versus informal care. Would this number be the same in the US with the bad reputation that many formal care providers—such as nursing homes—have?

With the NYHA as the ideal, how close does this system come?

In lines with the NYHA, every resident is eligible. There is no means-testing for eligibility for this plan; however, the maximum fee does depend on means. NYHA calls for no premium/other charges for health care. While it is unclear if this would apply to the long term care model (specifically with regards to co-payments), the Sweden model does not quite meet this standard because of the existence of co-payments. The Sweden system, however, does have a very small amount of costs being paid out of pocket (about 4-5%) versus about 30% in Germany. The NYHA also calls for comprehensive care. The Swedish system seems to offer a very extensive set of services.

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