7

LONG-TERM SERVICES AND SUPPORTS

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INTRODUCTION

Most of us go through our day-to-day tasks—from taking a shower, to getting dressed, to making breakfast—without a second thought about the effort required to accomplish them. However, for older adults who may experience significant disability due to injury or disease, these daily activities present challenges that may require ongoing assistance from family members, friends, or a formal care service provider. **Long-term services and supports** (LTSS; a term that generally has replaced the older phrase **long-term care** [LTC]) enable those who need continual help because of physical, cognitive, or developmental disabilities to accomplish the necessary tasks of daily living. This support can be provided in one's home or the home of a friend or relative, in a congregate housing complex, in an assisted living residence, or in a skilled nursing facility. The array of options available to elders with disability vary across the globe, as do the size and proportion of a nation's older population experiencing a long-term disability, due to a number of factors including life expectancy, socioeconomic status, environment, cultural norms and lifestyle, and the availability of health care. Despite these differences, virtually every nation in the world has older individuals with disabilities who need assistance with the basic tasks of daily living. A report by the U.S. Census Bureau (Kinsella & He, 2009) estimated that worldwide, the number of people over age 80—those most likely to need long-term services—will increase by 233% between 2008 and 2040. A recent study by the World Health Organization (WHO, 2018) reported that worldwide, the number of adults with significant difficulties in functioning is estimated to be between 110 million and 190 million and that disability rates are increasing because of population aging and an increase in chronic health conditions.

From: Global Aging: Comparative Perspectives on Aging and the Life Course, Second Edition
DOI: 10.1891/9780826162540.0007

Disability rates vary widely among countries, as do the long-term services designed to support the needs of individuals who require assistance. The need for long-term services is typically determined by a person's ability to carry out the common activities of daily living (ADLs). These activities include daily tasks such as dressing, bathing, transferring from bed, getting to the bathroom, and eating independently. Individuals who need help with these tasks are generally assumed to need long-term services. Definitions and level of support are dependent on a number of factors, such as governmental action and the culture of informal care. In attempting to understand the differences and similarities that exist among nations regarding LTSS, this chapter examines how countries are responding to the new and growing challenges of assisting older people with LTSS.

DEFINING LTSS

Prior to examining the different approaches used to deliver and finance long-term services, it is important to have a common understanding of what is meant by LTSS. As noted, individuals who require LTSS primarily need ongoing assistance with the basic daily tasks of living. In some instances, individuals may also have acute medical needs, but it is the personal tasks of life that define one's level of care needs each day. A typical case might involve an older person who experiences challenges in physical and/or mental abilities to the point where the individual can no longer function independently.

As an example, we look at Ruby, who is 88 years old and as a result of severe arthritis is now experiencing limitations in her ability to shop and cook, clean her apartment, and even to shower and dress independently. Ruby has three adult children, although only one of them, Dedree, lives nearby. Dedree tries to help as much as she can, but works full time at a large grocery store. Her days off vary, but she often works on the weekend. Her husband, Max, sells cars and typically works weekends and evenings. Dedree has two adult children who also have full-time jobs, though they do not work on the weekends. While Dedree's children can provide some support for Grandma Ruby, one of them just had a child and the other one is about to get married. Dedree provides as much support as she can, given her demanding job, but weekends are presenting a growing problem for the family. Ruby needs almost daily help to remain in her own apartment. A plan of care developed by Ruby's community social worker, who is often called a care manager, includes a personal care aide to assist with dressing, showering, and shopping; a daily home-delivered meal; a visit from a senior companion; and help from family members, which allows her to remain at home rather than move to a care facility. The big challenge is weekend care, because neither the personal care aide nor the home-delivered meal is available on weekends. Although it is a challenge, Dedree has worked out a schedule so that she, Max, or one of the children can stop by on each weekend day to provide assistance and a meal. This mixture of family support and formal services delivered at home is quite common in the

United States and other developed countries. In many communities throughout the world, however, LTSS typically are provided only informally, by family members or volunteers.

The type and amount of long-term assistance available to an elder with chronic care needs is the result of many factors, such as one's social and family environment, available technology, geographic locale, and level of care needs. Under some circumstances, because of the severity of disability or limited family or other informal supports, an older person with severe disability is unable to remain in his or her own home. In these instances, a person may need an apartment with supportive services, a residence with support and personal care services, or a facility that provides support, personal care, and skilled nursing services. The names of these facilities vary from country to country, although the institutions providing skilled long-term services typically are called **nursing homes**. Residential facilities' names vary widely by nation. An individual's circumstances can exacerbate or mitigate challenges of accomplishing the tasks of everyday living, but the need to provide ongoing LTSS is universal.

Since it is difficult in a brief discussion to capture their full variation across the globe, a typology of such LTSS is developed in this chapter to serve as a framework for categorizing national LTSS systems. Specific examples of how different countries handle LTSS tasks are presented to illustrate the range of approaches. These examples are used to help explain some of the complexities that arise when attempting to compare and contrast LTSS services on a global scale. Some of the LTSS policy issues common to many nations are described in the concluding discussion section of this chapter.

Typologies of LTSS

In order to better understand country approaches to long-term services, we have developed a model to categorize the nations of the world. As you can imagine, countries vary widely in their approaches to financing and providing long-term services. Our classification system builds on the work of earlier studies. Kraus et al. (2010) categorized 21 of the European Union (EU) LTSS systems using two distinct clustering strategies: One approach focused on service system characteristics, and the other focused on system use and financing. First, they examined the extent to which a nation's long-term services are *means-tested*—whether they are provided only to individuals without the money (means) to pay the cost themselves or to all equally as an **entitlement**. They also examined the availability of cash benefits, whether individuals had a choice of provider, the use of a quality assurance system, the amount of public expenditures for LTSS as a share of gross domestic product (GDP), and the amount of cost sharing required of service users. In this model, access to publicly funded long-term services can be viewed on a spectrum, from global entitlement to heavily means-tested. Based on these factors, the 22 EU countries were categorized into four groups (see Box 7.1 for listing of countries). The first cluster, including Denmark, Belgium, the Netherlands,

BOX 7.1

Countries Included in the Kraus et al. (2010) Typology

The following is an alphabetical list of the 22 European countries included in the Kraus et al. (2010) typology:

- Austria
- Belgium
- Bulgaria
- Czech Republic
- Denmark
- England
- Estonia
- Finland
- France
- Germany
- Hungary
- Italy
- Latvia
- Lithuania
- Netherlands
- Poland
- Portugal
- Romania
- Slovak Republic
- Slovenia
- Spain
- Sweden

Sweden, and France, was characterized as financially generous and having a well-developed LTSS system. Cluster 2 included such nations as Italy, England, and Spain, and was classified as having medium financial generosity and a moderately developed LTSS system. The countries placed in Clusters 3 (Bulgaria, Estonia, and the Czech Republic) and 4 (Hungary, Poland, and Romania) were classified as having a low amount of resources allocated to LTSS.

A second study, conducted by the Organisation for Economic Co-operation and Development (OECD), expanded on the Kraus typology (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011; see Box 7.2 for listing of OECD member countries included in their analysis). Their classification is based on the funding structure (universal, means-tested, or mixed) and provision of care provided by each nation's LTSS system. **Universal systems** provide publicly funded nursing and personal care to all eligible individuals (defined by their level of disability) regardless of income or assets. Within the universal category are three different funding structures: (a) **tax-based**, (b) **social long-term care insurance** (LTCI), and (c) **long-term services included as part of overall health coverage**. Under a means-tested financing structure, income and/or asset tests are used to determine eligibility for publicly funded LTSS. Means-tested systems are the least accessible and provide services and benefits only to those whose income falls below a defined threshold (sometimes called the poverty level). The third OECD category is a mix of the universal system and the means-tested system. These systems tend to vary greatly in eligibility criteria, individual cost, and services provided. In countries with limited formal service delivery, benefits often are limited to nursing-home care.

BOX 7.2

OECD Member Countries

The following is an alphabetical list of OECD member countries as of July 12, 2012 (OECD, n.d.):

- Australia
- Austria
- Belgium
- Canada
- Chile
- Czech Republic
- Denmark
- Estonia
- Finland
- France
- Germany
- Greece
- Hungary
- Iceland
- Ireland
- Israel
- Italy
- Japan
- South Korea
- Luxembourg
- Mexico
- The Netherlands
- New Zealand
- Norway
- Poland
- Portugal
- Slovak Republic
- Slovenia
- Spain
- Sweden
- Switzerland
- Turkey
- United Kingdom
- United States

OECD, Organisation for Economic Co-operation and Development.

A New Typology

Building on the previous work, a five-category typology has been created to classify national approaches to LTSS. As noted, a range of criteria can be considered when assessing and comparing LTSS systems at a global level. In addition to the previously identified factors of funding and definition of disability, the supply of LTSS and people's access to them are included. It is critical to combine the issues of financial and functional disability requirements with the supply, balance, and array of long-term services available. The factors from the two major earlier studies have been combined with additional delivery system indicators, such as the availability of residential care and the balance of formal and informal services. A description of the categories established and a list of selected countries that have been classified in each group are presented in Table 7.1.

GROUP 1

Nations in this grouping have publicly funded systems that provide universal LTSS coverage for older individuals. Using a range of funding sources, including a

TABLE 7.1 Typology of National Long-Term Care Services and Supports Systems

Group 1	Group 2	Group 3	Group 4	Group 5
Public insurance funding available for long-term care services	Mixture of public insurance and means-tested funding available	All funding for long-term services is means-tested	Funds are means-tested, but quite limited in availability	No public funds are available for long-term care services
HCBS widely available	HCBS widely available	HCBS commonly available	HCBS limited availability	HCBS not available
Institutional care widely available	Institutional care widely available	Institutional care widely available	Institutional care somewhat available	Institutional care rarely available
Housing with services widely available	Housing with services widely available	Housing with services available	Housing with services limited availability	Housing with services not available
Cash payments often available for long-term services	Cash payments generally available	Cash payments available on a limited basis	Cash payments not available	Cash payments not available
Informal care is one component of the system	Informal care is an important part of the system	Informal care is a critical element of the system	Very heavy reliance on informal care	Exclusive reliance on informal care
Examples: Germany, Japan, South Korea, the Netherlands	Examples: France, Ireland, Spain, Switzerland, Australia	Examples: United States, Estonia, Italy, Poland, Romania	Examples: China, Thailand, South Africa, India, Egypt, Mexico, Argentina, Brazil	Examples: Kenya, Nepal, Ghana, Bangladesh

HCBS, home and community-based services.

payroll tax, personal income tax, and general revenues (national, regional, and/or municipal), these countries have in common a long-term benefit covering both in-home and institutional services for their older populations. These countries have systematic approaches to identifying and determining levels of long-term disability and an array of service options. Their LTSS systems typically include a supportive service option linked to housing and self-directed and cash options for recipients. Although informal caregivers are involved as both unpaid and sometimes paid caregivers, the overall LTSS system of nations in this category is designed to balance the help provided by informal and formal providers. Examples of countries in this group include Germany, Japan, South Korea, and the Netherlands.

Germany

In 1995, Germany established a universal, non–means-tested, contribution-based system for funding LTC (*Pflegeversicherung*); benefits vary based on whether an individual chooses cash or care reimbursement and whether care is received at home or in an institutional setting. Due in part to an increase in the number of persons needing care and heavy criticism of the lack of support for those with cognitive impairments, from 2015 to 2017 the German LTCI system underwent a series of comprehensive reforms (*Pflegestärkungsgesetze [PSG])*. The system remains funded through employee payroll contributions with matching employer contributions (contributions for unemployed persons are paid by unemployment insurance) with pensioners paying the entire contribution out of pocket; however, the percentage of contribution has changed. Beginning January 1, 2017, the contribution rate is 2.55% (up from 1.95%) of an individual's gross income; for those aged 23 and older without children, there is an additional 0.25% contribution charge (Bäcker, 2016). Those who opt out of the public system can do so if they have higher incomes that meet a strict eligibility standard. However, individuals who opt out of the public system are mandated to purchase private LTCI that guarantees at least as much coverage and benefits as the public system. With the introduction of the "Pflege-Bahr" program in 2013, the government aims to increase participation in the private system (Nadash, Doty, & von Schwanenflügel, 2018).

The LTCI fund in Germany provides for home care (family members or nonprofessional private persons), home help service (professional staff or ambulatory help), and institutional care. Individuals who have a physical illness/disability, or a mental illness or other mental incapacity, who regularly need help with ADLs or household tasks for a period of at least 6 months are eligible for benefits. The amount of benefits received is determined by the care grade into which individuals are designated. Determination of care grade is done via an examination by a medical review board (*Medizinischer Dienst der Krankenversicherung [MDK]*) designated by the insurance fund. Based on the assessment of the review board, individuals are placed into one of five care grades (previously three care levels).

Prior to the comprehensive reforms, there was little or no acknowledgment of care needs for those with cognitive impairments, and the level of care received was based on the number of minutes of care a person required. For instance, under the previous system, to receive the basic level of care (care level I), an individual would require help with basic activities (e.g., personal hygiene, feeding, mobility) at least once a day and need help with household tasks several times per week (90 minutes of care per day, of which at least 45 minutes was dedicated to basic activities).

The reform of the LTCI system saw a fundamental change in the definition of "need of care." The previous focus on estimating the length of care need was replaced by a focus on determining an individual's degree of independence (their ability to *still* perform certain tasks); assessment orientation is now focused on resources instead of deficits; there is now a comprehensive consideration of care needs (including cognitive and psychiatric) instead of an emphasis on ADLs; the

idea of being dependent on assistance in order to perform specific activities was replaced by the idea that it is irrelevant whether the activity actually occurs (e.g., climbing stairs: the ability to do so is assessed even if no stairs are present in the person's environment); and the change from three care levels to five care grades (Link, 2018). Those receiving care prior to the reform were recategorized under the new care levels, so currently the German LTCI fund provides benefits for approximately 3.3 million people (Federal Ministry of Health, 2017).

Under the new evaluation criteria and expanded definition of care, assignment of care grades is based on six modules consisting of various items, which are weighted and combined for an overall care score (Link, 2018). The six modules (and their weights) are:

- Mobility (10%): for example, the ability to climb stairs or move around within the living area
- Cognitive and communicative abilities (15%): for example, temporal and spatial orientation and participating in a conversation
- Behavior patterns and psychiatric problems (15%): for example, night restlessness
- Self-care (40%): for example, washing, eating, and using the toilet
- Mastery of and dealing independently with illness or therapy-related requirements and burdens (20%): for example, taking medication or visiting the doctor
- Organization of everyday life and social contacts (15%): for example, occupying oneself and maintaining relations outside the immediate environment

Caregivers are also entitled to 6 months of leave and up to 24 months of part-time leave. The LTCI fund also contributes to pension insurance for family caregivers, defined as anyone providing care (at grade 2 or above) for at least 10 hours/week, 2 days/week and who is employed less than 30 hours (Nadash et al., 2018).

Although the LTCI system in Germany encourages care at home, nearly 27% of all individuals needing care reside in a care facility (Federal Ministry of Health, 2017). The fund covers nursing-related and medical care expenses and provides in-kind benefits for those receiving care in an institutional setting. As of May 2017, the average monthly copay for an individual receiving institutionalized care was 587€ (Federal Ministry of Health, 2017). Finally, to strengthen institutional care and improve quality, the comprehensive reforms provide for an increase in funding to support around 60,000 new professional caregivers.

Due to the relative newness of the program reforms, as of yet it is difficult to assess the success of the German LTCI system. However, it is clear that, despite political and financial challenges, the German system has been able to create and implement reforms in order to be able to provide some long-term service coverage for nearly all its citizens. Yet, with over 20% of the population aged 65 or older, a number projected to reach nearly 32% by 2050, it is unclear what new demands await the system and how Germany will face the challenges (Statistisches Bundesamt, 2015).

Japan

In April 2000, Japan implemented its national long-term insurance policy (*Kaigo Hoken Ho*), which provided a universal benefit for individuals aged 65 and older with severe disability (Yong & Saito, 2011). Since more than 23% of Japan's population was aged 65 and over in 2010 and projected to be as high as one-third by 2025 (Muramatsu & Akiyama, 2011), efforts to address the challenges of LTSS have attracted national support. The *Kaigo Hoken Ho* law relies on funds from general tax revenues, plan premiums, and copayments. Half of the program funds come from the government, either national, prefectural (prefectures are similar to states in the United States, provinces in Canada, shires in England, and departments in France), or local. The other half of funding comes from individuals, including: (a) Japanese adults between the ages of 40 and 64 who contribute through a payroll tax of 0.9%; (b) those older than age 65 who pay an income-based premium; and (c) copayment contributions by users who can afford them, equivalent to 10% of the total costs (Yong & Saito, 2011).

The LTCI covers all Japanese people aged 65 and older without regard to income. Individuals between the ages of 40 and 64 with severe disability also can qualify for LTCI benefits, but their disabilities must be caused by aging-related health conditions (e.g., early-onset dementia and cerebrovascular strokes) and require assistance with ADLs. Recipients can receive assistance at home through an array of in-home and community-based supports, including basic personal care assistance, rehabilitation and nursing services, and medical day care. The LTCI provides funding for medical equipment, such as an adjustable bed, and minor home renovation, such as a ramp (Yong & Saito, 2011). Institutional care also is covered under the LTCI fund. Nursing homes are placed into three major categories: those serving frail older people, those serving older people with high medical needs, and those focused on dementia care.

To determine eligibility for an LTCI benefit, the program relies on a structured assessment and eligibility determination process. After a person applies for or is referred to the program, a nurse or social worker employed by the municipality completes an in-home assessment of the individual's physical and mental functioning that also includes a report from the applicant's physician. The assessment information is electronically submitted, and the applicant is then placed into one of six levels of care. The assessment is then reviewed by a care needs certification board of health professionals who review the physician's report and the assessor's notes to make a final decision regarding the level of care. Eligible applicants are assigned a case manager, and service dollars are allocated based on the determined level of care. Although for planning purposes a dollar amount is associated with each specific level of care, the LTCI program does not allow a cash benefit to be paid directly to participants or their families. The case manager assists in developing, implementing, and monitoring the plan of care. The program has grown considerably since it was first introduced in 2000, when about 1.49 million users were covered. By 2010, the program was serving more than 4 million participants (about 14% of the age 65+ population;

Yong & Saito, 2011) and by 2016, the program was serving 5.11 million (Ministry of Health, Labour, and Welfare, 2016).

Reviewers of the implementation have identified a series of issues surrounding the LTCI experience (Yong & Saito, 2011). Utilization rates are higher than anticipated, with the proportion of individuals supported by the LTCI through in-home care increasing from 65% in 2000 to 75% in 2015 (Ministry of Health, Labour, and Welfare, 2016). Questions also have been raised about whether the age criterion of 65 and older is the optimum approach. In addition, the care-management component of the program in regard to the adequacy of the reimbursement rate and the independence of care managers is also an issue of concern. Finally, despite efforts to develop a national benefit, service and use patterns vary considerably across the country (Tsutsui & Muramatsu, 2005). In response to these concerns, additional revisions were made to the program in 2014. The revisions focus on two major areas; establishing a more effective community-based integrative system and making contributions to the plan more equitable. The program expanded its efforts to enhance coordination between in-home medical care and in-home long-term services and promoted efforts to serve those with dementia. The program also reinforced preventive services and attempted to more actively promote in-home services. Finally, the program worked on reducing premiums for low-income people and increased copayments for higher-income care recipients. As other countries develop efforts to respond to the LTSS needs of their citizenry, the experiences of Japan will be quite instructive in efforts to balance a comprehensive benefit with affordability.

GROUP 2

Nations included in this category have systems that rely on a mixture of public insurance and means-tested funding strategies, with a range of financing approaches. For example, some countries provide a universal benefit for certain long-term services, such as nursing-home care, but not for others, like assisted-living or in-home services. The nations in Group 2 typically have a wide array of institutional care options, community-based services, and specialized housing and supportive services. These countries typically have self-directed services available, and informal care is an important part of the system. Examples of countries in this group are Switzerland, Australia, Canada, Spain, Ireland, and France.

France

France's LTSS system includes a mix of universal and means-tested funding for a wide array of home and community-based services and institutional care. Until the 1990s, LTSS were traditionally a family or informal responsibility (Gannon & Davin, 2010). In 1997, France launched its first national LTSS program targeted at the age 60-and-older population (Le Bihan & Martin, 2013). The initial program was a care allowance to support frail older persons in need of ADL and instrumental activities of daily living (IADLs) assistance. After much criticism, this

initial system was replaced by the Allocation Personnalisée d'Autonomie (APA), which is still in place today (Kraus et al., 2010). The new system is based primarily on a cash benefit. The French system is overseen by the federal government (the main funding source), but divides further fiscal and organizational responsibilities among regional or local departments (subnational governments; Colombo et al., 2011). Eligibility for APA assistance is nationally based and requires that beneficiaries be age 60 or older and meet a high level of dependency for ADLs and IADLs (Kraus et al., 2010).

The **dependency assessment** consists of three steps: (a) a request from the older person in need, (b) an evaluation by an assessment team (medical doctor, nurse, and social worker) that defines the care package, and (c) a final agreement on the care package by the departmental (state) authorities (Kraus et al., 2010). France is one of only a few countries that require a medical doctor to be involved in the assessment and care-package development process (Colombo et al., 2011). The local departmental authorities are responsible for coordinating and partially financing the APA, and they grant final approval for the care package (Kraus et al., 2010).

The APA covers both home and community-based services and institution-based care, but at a progressively reduced rate (Kraus et al., 2010). Every disabled person aged 60 and older is eligible for APA benefits, but beneficiaries are compensated based on their income. Recipients at the highest income level (about 3.5% of participants) pay 90% of their LTSS costs out of pocket, while those at the lowest income level (23%) have no cost-sharing requirements (Doty, Nadash, & Racco, 2015). Recipients receive a cash benefit that is strictly designated to support expenses that fall under an approved care package. In the case of home and community-based services, as in Japan, beneficiaries are prohibited from hiring their spouses or partners and may engage only accredited and approved providers to deliver care (Colombo et al., 2011). For institutional care, the APA covers only personal and nursing costs and requires users or their families to pay for board and lodging themselves. If the nursing-home residents and their immediate families are destitute, they can apply for housing subsidies (that is separate from the APA LTC system) to cover their nursing-home meals and lodging. The average out-of-pocket expense is about 20% of income for home and community-based services and 35% for institutional care (Colombo et al., 2011).

A unique element of the French system is that it includes one of the largest private LTCI markets in Europe. As an example, there were 5.7 million policy holders in 2012, accounting for 11% of the adult population (Doty et al., 2015). Less than 2.5% of the U.S. adult population has private LTCI. The typical policy in France provides a lower benefit amount but is less costly than the typical policy in the United States. The French system also includes caregiver support programs and increased attention to dementia-related problems. The APA provides a variety of caregiver programs such as education, training, and respite care. However, France also provides caregivers with a relatively long (3 months) unpaid leave from work that employers cannot decline, although leave is only available for caregivers of a relative with at least an 80% autonomy loss (OECD, 2011a).

Ireland

Ireland's LTSS system also combines a universal and means-tested approach. The development of a formal LTSS system is relatively new for Ireland, which launched its first national Office for Older People in 2008 (Colombo et al., 2011). Ireland's LTSS system is organized and financed by the national government, through the health service executive (HSE). Historically, Ireland's LTSS expenditure had been one of the lowest among OECD nations (OECD, 2011b), though after LTSS were prioritized through a 10-year strategy that began in 2006, Ireland's LTSS expenditure is now closer to the OECD mean (OECD, 2017). However, the use of formal LTSS remains low, with only about 0.5% of older individuals living in institutions, compared, for example, with about 5% in the United States. This low utilization rate reflects the importance placed on informal and community-based care as well as the newness of the formal LTSS system in Ireland.

In 2009, Ireland initiated the **Fair Deal legislation,** which states everyone with care needs is eligible for personal care in institutions (this plan, unlike France's, covers room and board; Colombo et al., 2011). This plan was revised in 2013 and now requires that all participants contribute 80% of their incomes and 7.5% (5% prior to 2013) of their assets' value toward the cost of their care. However, because the formal LTSS system is relatively new, access is limited by resources and has resulted in targeting those most in need. There is a 3-year cap on asset-based contributions (for a total of 22%; prior to 2013, the cap was 15%), and in the case of a couple when only one of the individuals is residing in an institution, the personal contribution is based on only half of their assets (HSE, 2017).

Despite Ireland's relatively clear-cut LTSS plan, several issues surround eligibility and asset protection. Until 2006, there was no national standard for needs assessment, but Ireland is currently using a common assessment report. This report takes into account ADLs, currently provided medical, health, and personal social services, available family and community support, and personal wishes and preferences and is carried out by an HSE-appointed health care professional (HSE, 2017). A system similar to the U.S. public reverse mortgage program, called the Nursing Home Loan, has been developed. Despite a 3-year cap on asset testing, this program allows individuals to borrow on the equity in their homes to pay for institutional care. This type of program demonstrates the role that the government can play in converting nonmonetary assets into cash to pay for nursing-home care (Colombo et al., 2011).

According to an OECD (2011b) report, an informal care provision in most countries is highly dependent on the health status of the care recipient. Those who have greater ADL limitations are more likely to receive care in an institutional setting. This is not the case in Ireland, however, where no correlation is found between the health status of care recipients and their care setting. This is likely related to the strong traditional informal support system in Ireland as well as the many caregiver support programs. For example, Ireland's Home Care Package Scheme is not means-tested and was recently expanded to target high-risk patients awaiting discharge from the hospital (Noonan, 2014). In addition, an array of public

training, education, and counseling programs is available for caregivers. Ireland is one of a few nations that allow a long leave from work for caregivers (up to 1 year or more), but employers can refuse this on certain grounds (Courtin, Jemiai, & Mossialos, 2014). The Carer's Allowance (a means-tested government program) provides cash benefits to caregivers and acts like an income support program, replacing lost wages or caring expenses (Colombo et al., 2011). The Constant Attendance Allowance (a government program based on compulsory social insurance for employees) is considered more of an income support program than a formal caregiver payment and covers such expenses as travel and utilities (gas and electricity; Colombo et al., 2011). Beyond allowances, Ireland provides a respite-care grant that is tax-supported, non–means-tested, and available to all resident caregivers who provide full-time care (OECD, 2011b).

GROUP 3

Countries in this grouping offer a wide array of long-term services, including supportive housing, institutional care, and home and community-based services. Under this model, no public insurance is available to fund LTSS. Typically, a range of services is available to low-income persons meeting a high-disability and low-income threshold. Under the approach used in these countries, all LTSS are means-tested, and public financing does not begin until individuals have depleted their own resources. Self-directed care is available on a limited basis for some services for certain populations. Informal care is an integral part of this system, with an expectation that family will provide primary assistance prior to using governmental services. Examples of Group 3 countries include the United States, Italy, Poland, Romania, and Estonia.

United States

Because the United States continues to have policy debates and controversy about its overall approach to health care, it is not surprising that it has never designed an LTSS system. In fact, the major program for LTSS in the United States—Medicaid, adopted in 1965 as a health care program for the poor—did not even include most of the LTSS funded today. Neither the intermediate care nursing-home benefit (added in 1967) nor the home and community-based care benefit (added in 1981) was included in the original legislation. Medicaid accounts for almost 43% of all LTSS expenditures in the United States. It has very strict income and asset criteria and requires recipients to have severe disability. Under no exceptions can individuals receive Medicaid assistance for LTSS unless they meet the strict income and disability criteria.

Other sources of revenue for LTSS include Medicare, which now accounts for 22% of all expenditures; out-of-pocket payments by individuals (17%); individual private LTCI policies (6%); other private health insurance (5%); and other public entities (7%), such as the U.S. Department of Veterans Affairs (VA) and state-funded programs (Nguyen, 2017). The social insurance program covering health

care for older people, Medicare, provides a 100% nursing-home rehabilitation benefit for 20 days following a 3-day or longer stay in the hospital, and 80 additional days with a significant copay. Medicare also provides home health care coverage, but again, it is only delivered in conjunction with an acute care illness and not as a chronic care benefit.

The United States has an extensive array of formal services available to the approximately 6 million older adults with disability, including more than 16,000 nursing homes serving more than 1.5 million individuals. The income-tested Medicaid program supports approximately two-thirds of all nursing-home residents, although when residing in the community fewer than 8% of these individuals were eligible for the program (Stone, 2011). In the United States, the majority of nursing homes are for-profit (70%; Harris-Kojetin et al., 2016). Additionally, about 800,000 individuals receive home and community-based services provided through Medicaid-waiver programs operated at the state level (Eiken, Sredl, Burwell, & Amos, 2018). The so-called "waiver" programs were initiated in 1981, when the U.S. Congress passed legislation allowing states to waive Medicaid requirements that required Medicaid LTSS funds to be spent in institutional settings. A sizable private home-care market, estimated to be similar in scope to publicly supported services, also exists for individuals who do not meet the strict Medicaid eligibility criteria for income and severity of disability. Private-pay individuals, and in some states publicly funded participants, can self-direct their services, determining both the nature of assistance received and who will provide the necessary assistance. Tested in a research demonstration called the National Cash and Counseling Demonstration and Evaluation (Benjamin & Fennell, 2007), self-direction for Medicaid recipients is now being expanded across the United States (Sciegaj et al., 2016).

Housing with supportive services is also an important component of the U.S. LTSS system. In particular, the assisted-living option has expanded rapidly in recent years. Under this model, an individual with severe disability resides in a small apartment with a bathroom and a basic food-preparation area. Residents receive personal care, meals, and housekeeping services directly from the facility; however, home health care generally is provided through an agency as though the individuals were living in the community. More than 800,000 individuals now reside in assisted-living facilities across the United States. Although typically funded privately, in recent years, the means-tested Medicaid home and community-based waiver program has allowed public funds to be used for assisted living.

In many states a not-for-profit network of organizations, termed area agencies on aging, provide case management and coordination for in-home service networks. These agencies often complete eligibility assessments for LTSS settings and help ensure that the needed services are provided. Information provided by these agencies is available to all older persons, although most of the programs and services are earmarked for low-income individuals.

As a large country with a well-developed services system, annually the United States spends more than $339 billion on LTSS (Nguyen, 2017). The majority of the

nursing homes, assisted-living facilities, and home care agencies are proprietary in nature, and the U.S. delivery system is consistent with the market values of the nation. One of the major challenges faced by the U.S. LTSS system is the very high costs that are increasingly being shifted to the public Medicaid program, which is jointly funded by the federal and state governments. In many U.S. states, the costs of LTSS are becoming one of the highest expenditure categories in state government—rivaling the cost of education—and projections suggest that the current system will continue to represent a challenge to state budgets across the nation.

Estonia

Unlike many countries, due to out-migration, Estonia's population is actually decreasing. This makes LTSS for older adults (19% of the total population) even more of a challenge. The goal of LTSS in Estonia is to help individuals achieve the best possible quality of life, based on their needs and abilities—remaining at home for as long as possible (Paat & Merilain, 2010). LTSS in Estonia are mandated by the Social Welfare Act and are divided between local governments and the individuals needing care. Public health insurance pays for a significant portion of nursing care (financed via a payroll tax). Although LTSS are provided regardless of age, the amount of financial support or welfare services received is means-tested. Preference for funding is given to those who remain at home, with allowances for family caregivers provided by local municipalities (Colombo et al., 2011). Assurance of quality of care in institutional settings has been left to the local governments, which until recently have been criticized for not holding facilities to high standards. In many LTC institutions, there is a shortage of both beds and space and a lack of quality care (Paat & Merilain, 2010). Additional funds have been allocated to address this shortage, and in an attempt to identify effective methods by which to increase access to and coordination of LTSS, a preliminary case-management model was piloted in conjunction with the World Bank (Paat & Masson, 2018).

An interdisciplinary team of professionals conducts an assessment for LTSS eligibility. Specially trained case managers assess an individual's health and need for personal assistance, guidance, or supervision. Doctors assess an individual's need for nursing care and a local social worker examines an individual's need for welfare services. Estonia's health insurance fund pays for the initial assessment for care need and for nursing care. Service users can expect to pay a portion of institutional care, and home health care costs are divided between local governments and the service users (Paat & Merilain, 2010). However, there is no common nationally standardized needs assessment instrument. Thus, eligibility for publicly funded LTSS varies widely across municipalities (Paat & Masson, 2018).

Under the current Estonian system, service users can receive benefits from the state (in cash) or from the local government (either in cash or in-kind). In general, the state outlines the minimum requirements for service provisions. Local governments plan, implement, and supervise care services. Several different types of care are recognized by the state, but all are provided by local governments unless otherwise noted. Allowances are provided for care by relatives or informal nonfamily

caregivers. Home services (e.g., household chores) are provided either by the local government or by a private company (Colombo et al., 2011). Additional types of care include housing services (providing 24-hour accommodations), a personal assistant, adult day care, institutional care, strengthened support care (which has a goal of improving independence), and strengthened supervision care services (with a goal of maintaining quality of life in an institution; Paat & Merilain, 2010).

A number of challenges are recognized throughout the Estonian LTSS system. With little national oversight, quality of care remains a significant issue. Additionally, the current system is rather fragmented, with some funds and services provided by the state and some by local governments or private companies. Finally, although the goal of the LTSS system is to promote domiciliary care (housing and care combined), financial support is insufficient (€62 per month, on average; Paat & Masson, 2018). To address these concerns, a special task force was assembled with the aim of identifying long-term service policy solutions. The changes have two significant goals: (a) to integrate state and local services and (b) to reduce the care burden of informal caregivers. With a fragmented system providing less than ideal care, it is clear that the Estonian LTSS system will need to see substantial changes in the coming years in order to meet the needs of an aging population.

GROUP 4

Nations included in Group 4 have very limited public funds to support individuals in need of LTSS, but they have begun to see the development of some private service providers, particularly in the areas of nursing-home and in-home care. Older people in Group 4 countries who need such care must rely on family and friends for the majority of assistance received. Examples of countries in this group include Thailand, India, Mexico, Brazil, South Africa, and China. The demarcation of Groups 4 and 5 (discussed later) is not always easily discerned, because nations with extremely limited LTSS funds may appear to be more similar to nations in Group 5 than others in Group 4.

Brazil

To prepare for population aging and LTSS issues, in the 1990s Brazil created the National Policy for the Elderly (Política Nacional do Idoso [PNI]), which includes a list of actions to ensure social rights, autonomy, integration, and effective participation in society among the older population (Neumann & Albert, 2018). However, with a lack of resources and formal structure to enforce these directives, implementation is largely the responsibility of municipalities and families. One of the most noteworthy outcomes of the National Policy for the Elderly was to ensure that anyone aged 65 and older who cannot provide their own livelihood is eligible for a noncontributory pension equal to the monthly minimum wage of R$954 (Brazilian real, or US$300). The Brazilian pension system also includes a mandatory pay-as-you-go system for private-sector workers and a series of

separate mandatory systems for public workers—approximately 75% of the older adult population receives some social security benefit (Neumann & Albert, 2018). While often recognized as a leader among South American countries in pension reform, Brazil lacks a formal LTSS policy.

Established in 2006, the National Health Policy for the Elderly (Política Nacional de Saúde da Pessoa Idosa [PNSI]) provided national guidelines for active aging and the management of frailty, but failed to address a growing need for LTSS policy. Nursing homes are not common in Brazil; they provide care for only about 1% of the older population and mainly exist in large cities (Neumann & Albert, 2018). A few public nursing homes exist to serve older disabled individuals who have no family left and no means to pay for care (Garcez-Leme & Leme, 2014). Home and community-based supports are also limited. The Family Health Program (Programa Saúde da Família), which was originally designed to address maternal and child health, has expanded to incorporate chronic conditions. This program provides home visits to every household in 95% of municipalities and includes a multidisciplinary team of health workers (i.e., doctor, nurse, and community health workers), each of whom is responsible for 120 families in their defined area. However, the focus of this program is primary care, as training and resources for LTSS delivery are limited (Garcez-Leme & Leme, 2014).

China

With the largest older population in the world (more than 143 million people aged 65+), China faces monumental challenges as it addresses the LTSS needs of the nation. The aging population in China has increased from 3.6% of the total in 1964 to 10.5% in 2015; by 2050, the number of older people is expected to reach 349 million and account for one-quarter of China's population (He, Goodkind, & Kowal, 2016). Compounding China's challenges is the now well-known one-child policy that has contributed to China's fertility rate dropping from 2.9 in 1980 to 1.6 in 2012 (Das & N'Diaye, 2013).

Although it was not until the 1990s that institutional care became available in China, by 2006, the country had more than 39,500 institutions with about 1.5 million beds; by 2012, there were an estimated 45,000 nursing institutions; and by 2017, that number was estimated to be more than 144,000 (Flaherty et al., 2007; Xinhua, 2018; Zhan, Feng, Chen, & Feng, 2011). The definition of a nursing home in China is not the same as in the United States, with many of these facilities not providing any medical services; estimates vary, but probably about half provide no medical or nursing care. Further, about half of the "nursing-home" residents in China are reported to be able to take care of themselves, suggesting that for many residents this model of care is better described as "housing with supportive services." There are five types of institutions, varying by both the kind and level of disability and economic resources available (Chou, 2010). Institutions in rural areas tend to offer a lower level of care than urban facilities. These rural homes are also more likely than those in urban areas to be funded by the government (Wu, Mao, & Xu, 2008). These facilities appear to serve a range of residents, from those

with minimal impairment to those with high levels of disability (Chou, 2010). In addition to government funding, these institutions are paid by medical insurance and through private (out-of-pocket) expenditures. Based on concerns about quality of care, legislation was passed in 2013 to establish new regulations requiring nursing-home inspections and better protections for residents.

China appears to have a strong commitment to family and community support. The overwhelming majority of older Chinese adults with severe disability receive assistance in their own homes, either from family caregivers or through a live-in maid system, termed *bao mu*. For example, a study in Shanghai found that more than 90% of individuals with dementia were cared by families at home (Hua & Di, 2002). In fact, the Chinese Constitution states that "children who come of age have the duty to support and assist their parents" (Chu & Chi, 2008). Although family care is the dominant mode of LTC, China's recent demographic changes in combination with the one-child policy present considerable future challenges.

Formal community services are now being developed across China, with estimates identifying more than 900,000 community service centers (Chu & Chi, 2008). A study of community service centers in Shanghai found that these government-funded entities provided such services as shopping, home maintenance, counseling, and meals (Wu, Carter, Goins, & Cheng, 2005). These centers also help to arrange the *bao mu* (housemaid service) that generally provides personal care services, household chores, shopping, and accompanying seniors to medical visits. The vast majority of the *bao mu* workers are paid out of pocket by older people and their families (Wu et al., 2005).

China certainly recognizes the tremendous challenges it faces in the future. As part of its national strategic plan, the government has set a goal of establishing a comprehensive social care system as the foundation of its LTSS system, to be supported by institutional care (Zhang, 2011). As a result of this plan, a large number of new institutional beds have been added in the past 5 to 7 years. China has made strides in its efforts to develop a more comprehensive system of LTSS, but the tremendous growth in the size of the older population and the reduced fertility rate suggest considerable challenges ahead.

GROUP 5

Nations falling into this final grouping are generally very poor and have a very limited array of formal services available. For the most part, nursing homes do not exist in these countries, and very few in-home services are available. Generally, public funding for support services for older individuals with severe disability does not exist. Families provide the majority of LTSS, and these nations expect families will continue to be responsible for such care. Countries included in this category are Nepal, Kenya, Ghana, and Bangladesh.

Kenya

Until now, the discussion of LTSS around the globe has focused on countries with at least some formal system for providing such services and supports to older

adults. Kenya, unlike the countries previously discussed in this chapter, stands in stark contrast, having essentially no formalized LTSS system. Moreover, the long-established informal network of social support via family caregivers has undergone significant changes in recent years, leaving many older adults impoverished and with little familial support.

Historically in Kenya, as in most of the less economically developed countries, parents provide care for their children until grown, and in return children have a duty to provide care for their parents when they reach old age. However, a number of social and economic factors have caused a change in this arrangement. On the economic side, in order to explore new job opportunities and advancements, a relatively recent shift toward urban migration for younger adults—rather than remaining in rural farming communities—has left many older adults alone in rural areas to tend the family homestead. This is also happening in many other nations, including China, Thailand, and Vietnam.

The most notable social factor remains the HIV / AIDS epidemic, which currently affects approximately 4.8% of the Kenyan population (U.S. Central Intelligence Agency *World Factbook*, 2017). Palliative care and LTSS in sub-Saharan Africa are primarily associated with HIV and AIDS, leaving the needs of older adults largely neglected (WHO, 2017). Due to the rise in the number of individuals who contract this often-fatal disease, caring roles have become less clear, as many parents are forced to provide care for their adult children who have AIDS. It has been noted that although older adults derive satisfaction from their caregiving roles, many still lack adequate knowledge, skills, and resources for patient care (WHO, 2017). Additionally, due to the AIDS epidemic, the number of grandparents providing care for grandchildren also is increasing (Small, Aldwin, Kowal, & Chatterji, 2017). Economic, emotional, and physical strain often are associated with becoming, as an older adult, a full-time caregiver for young children.

Although formal social support is still relatively sparse in Kenya, a few organizations, like HelpAge International (through its local affiliate, HelpAge Kenya), supply economic assistance in some parts of the country to impoverished older adults who provide care for orphaned children (HelpAge International, 2018a). On a national level, the Ministry of Gender, Children, and Social Development (MGCSD) coordinates programs for older adults. In an effort to ease the burden on older adults, beginning in 2004 the Older Persons Cash Transfer (OPCT) Program—targeting individuals over age 65—established a way to provide older adults with essential funds for obtaining necessary provisions such as food, clothes, and adequate shelter (Mwaisaji, 2015). In July 2009, Kenya launched a program targeting impoverished older adults with its new pension scheme (HelpAge International, 2009a). Traditionally, the old-age pension in Kenya was tied to employment, with employee contributions to the social security fund accounting for about 5% of their earnings (Social Security Administration, 2017). This pension program, which eliminates the contributory element, makes Kenya one of the few countries in the region to have a noncontributory pension. Beginning in December 2009, older citizens (aged 65+) in 750 "extremely poor households" in 44

districts received 1500Ksh (Kenyan shillings; approximately US$19.40) per month (HelpAge International, 2009b). Payments are made through mobile phones, post offices, or electronic cards. The Kenyan government plans to extend this program to all persons aged 70 and older (HelpAge International, 2018b).

Several policy plans have included provisions for the needs of older persons, although all were broad, general goal statements and took few direct actions (Mbithi & Mutuku, 2010). From 2002 to 2008, the ninth National Development Plan designed programs to sensitize the public to the needs and rights of older individuals. Another example of national-level policy proposals, the Kenya National Policy on Aging, aimed to integrate the needs and concerns of older adults into national policy by ensuring that older people were "reorganized, respected, and empowered to actively and fully participate in society and development" (Mbithi & Mutuku, 2010). Unfortunately, little progress has been made toward implementation of any national policies related to LTSS for older adults in Kenya.

An opportunity exists for the government of Kenya to begin implementing the policies that have been outlined to provide care and funds for older citizens in need. HIV and AIDS education, as well as teaching proper caregiving techniques, would benefit Kenya's older population, providing predictable, adequate levels of support to improve their living, working, and aging conditions.

Nepal

Family members, rather than governmental agencies or nonprofit government funded organizations (nongovernmental organizations [NGOs]), provide LTSS in Nepal. Institutional care is practically nonexistent, with fewer than a handful of old-age homes in the entire country. Nepal has approximately 28.5 million people, with 5.5% of the population aged 65 and older. Yet, life expectancy at birth has been improving for both men and women in Nepal, increasing from age 41 in 1971 to age 69 in 2016, when for the first time life expectancy for women surpassed that of men. Approximately 83% of the older population reside with their children in rural areas (Pienta, Barber, & Axinn, 2001). A 1995 study, the Disabled People of Nepal Survey, reported that the prevalence of disability across all age groups was 4.6% (Basnyat, 2010).

Nepal has a small number of old-age homes, called *Briddha Ashram*. Funded by the government of Nepal, *Pashupati Briddha Ashram* is one of the oldest old-age homes and is situated near a famous temple, since Nepali people share a religious and cultural belief that after-death cremation near this temple ensures entry to heaven (Basnyat, 2010). Although the capacity of this shelter home is only 150 individuals, approximately 200 older people reside there. Recently, several additional shelter homes for older adults have opened. The *Nishaya Sewa Sadan* (shelter home for the helpless) is partially funded by the government and has 56 residents. It also receives contributions from residents and/or their families, and some funds are provided by additional sources such as voluntary contributions. Siddhi Memorial Old Age Home, a private, nonprofit facility funded by residents' family and friends and a German nonprofit organization, also opened in 2008.

This institution targets those older people who can make private out-of-pocket payments for care and appears to be the only such facility in Nepal.

People aged 65 and older currently constitute almost 6% of Nepal's population, but by 2030 this proportion is projected to double (He, Goodkind, & Kowal, 2016). With no formal community-based services and an institutional capacity of fewer than 1,000 beds nationwide, older persons with disability rely exclusively on family and friends for LTC needs. Although the country has a long-standing cultural tradition of filial piety, economic and social changes are now presenting major challenges to this approach. As the nation shifts to a more urban economy, as are China, Kenya, Thailand, and other countries, many of the younger family members are migrating to the cities, resulting in higher levels of unmet need for the older population. Because of a weak economy, the country has been unable to develop even a basic infrastructure for old-age pensions, and the development of LTSS does not seem to be a high priority. A study of Nepali political officials found that the majority of respondents were unaware of problems associated with LTSS, and they did not believe that the development of such services was an important role of the government (Basnyat, 2010).

CROSS-CUTTING ISSUES FOR AN AGING PLANET

The examples provided in this chapter indicate tremendous variations in the ability of countries to address the LTC needs of their citizens. Despite the many differences that exist among nations, at least four LTSS policy issues unite them.

Financing

Although it is clear that nations with higher per capita incomes (typically those in Groups 1–3) have developed a much more extensive array of LTSS, it is also evident that literally every one of these nations is facing challenges of long-term financing. Even highly resourced nations such as the United States, Japan, and Germany face substantial funding issues as they address the potential needs of their boomer populations. Although the older population in need of long-term services in the developed world is projected to more than double in the next 30 years, none of these countries has programs ready for the demographic growth they will experience between now and 2050. Some of the countries in Group 4 that now are experiencing rapid economic growth and an evolving LTSS system, such as China, India, and Thailand, also will face huge future challenges. These nations are still in the process of developing their LTSS infrastructure, but they will experience a faster growth rate of their older populations than the nations in Groups 1–3. Thus, these nations will be under pressure to quickly create an adequately financed system for their elders. Finally, it is the Group 5 nations that may be in for the biggest challenge. With no formal long-term service funding on the horizon, but a recognition that their aging populations will grow substantially, these

nations must develop both an infrastructure and financing mechanism quickly. However, many of these nations do not have basic pension plans in place, making it a remote likelihood that planning for long-term services will occur.

Support for Family

Regardless of a nation's resources, LTSS of older people are a family issue. Even for those nations with well-developed formal service systems, it is clear that informal supports are critical. However, a consistent theme heard in many countries is that demographic and social changes are placing more pressure on families. Whether it is the one-child policy of China, the migration patterns of rural Kenya and Nepal, or the dual-income worker structure in Europe and the United States, country after country is experiencing changes that are affecting the family's ability to provide assistance. Efforts to develop sound policies to support families in their role of assisting their elderly loved ones will be a universal challenge in years to come.

Need to Develop an Efficient and Effective LTSS System

No nation has yet figured out how to provide and pay for all types of LTSS in the most effective and efficient manner possible. Some countries have developed excellent supportive services in housing; others have created well-developed in-home care systems; still others have developed high-quality nursing homes or assisted-living communities. Certain nations are exploring the use of technology to improve service provision; others have developed effective and efficient systems to pay family members and friends for caregiving. Many interesting innovations are appearing, but countries have not done a good job of adopting the most successful approaches of other nations. The LTSS challenges that the world faces are monumental; in years to come, it will be necessary that countries share knowledge and take advantage of progress, similar to what has occurred in medical research and treatment.

Need for Prevention

A review of global demographic and social changes indicates that the number of older people with severe disability will more than double by 2040. Although such growth is a symbol of progress, suggesting many more people are surviving into old age and living longer with their disabilities, such changes will also place major financial pressures on all nations. Therefore, substantial efforts aimed at preventive actions will be necessary in four important areas. First, as mentioned in Chapter 1, Our Aging World, it must be recognized that aging occurs across a life course and that such issues as childhood obesity and malnutrition and access to adequate health care in early life will significantly affect rates of disability in later life. Second, we must continue to explore and encourage lifestyle changes, including exercise and social engagement, to help prevent or at least forestall disability in later life.

Small delays in disability will yield big economic and social benefits. Third, we must encourage environmental changes that can help older individuals optimize the livability of their home settings. Simply improving access to a toilet and the ease of use of a kitchen can make a significant difference in allowing a person to manage disability at home. Large-scale efforts such as the WHO Age Friendly Cities Project can have a large impact across the globe (WHO, 2007). Finally, technological development will be necessary. Whether it be more low-technology devices, such as water or door sensors (an electronic sensor that sounds an alarm when it detects running water or the opening of a door), or high-technology robots or floor sensors (actual devices built into the floor that monitor gait and assess fall risk), it is evident that technical innovation is needed to help meet the challenges of our aging populations.

CONCLUSION

Countries around the world have adopted a variety of fiscal and care system responses to their growing number of older adults who need assistance with the tasks of daily living. Based on the type of care provided and the financing structure, and in an effort to more clearly articulate the different approaches to LTSS, a typology of LTSS systems has been created, ranging from most to least comprehensive. For countries in Group 1, like Germany, care is widely available and publicly supported and funded. Group 2 countries, like France, have a mix of publicly funded and **means-tested LTSS**, and informal care is an important part of the system. For the United States, a country that falls into Group 3, most public funding is means-tested, and individuals are expected to be financially responsible for their own LTSS. In Group 4 countries like China, funding for care is means-tested and available only on a very limited basis, so Chinese elders rely heavily on informal family care. Finally, for countries like Kenya in Group 5, no public funds are available for LTSS; so very few care programs exist and older adults must rely almost exclusively on informal care and support networks. All nations must take steps to mitigate the challenges of an aging population by creating sustainable LTSS financing systems, finding better ways to support informal caregivers, sharing ideas for best-care practices, and focusing efforts on prevention.

DISCUSSION QUESTIONS

1. Who provides LTSS, and in what types of locations do individuals receive such assistance?
2. Is there a formal LTSS system in your country? How is it funded? Who is eligible to receive services?
3. What are the advantages and disadvantages of using means testing as a way for determining eligibility for publicly funded LTSS? How do these advantages and disadvantages compare to those for a universal system?

4. Should LTSS programs be designed specifically for, and only offered to, older people?
5. Can you see any overlap in the groupings included in the LTC typology? Are there countries that might fit in more than one category?
6. Of the countries you read about in this chapter, which two or three seem to have systems that make sense to you? Would their systems work in your country?

KEY WORDS

Activities of daily living
Dependency assessment
Entitlement
Fair Deal legislation
Home and community-based services
Housing with supportive services
Instrumental activities of daily living
Long-term care
Long-term services and supports
Means testing
Social long-term care insurance
Tax-based systems
Universal systems

REFERENCES

Bäcker, G. (2016). Reform of the long-term care insurance in Germany. *European Commission: ESPN Flash Report 2016/43.* Retrieved from https://ec.europa.eu/social/BlobServlet?docId=16074&langId=en

Basnyat, K. (2010). *Decision-makers' perception and knowledge about long-term care in Nepal: An exploratory study*. Master's Thesis, Miami University, Oxford, Ohio.

Benjamin, A. E., & Fennell, M. L. (2007). Putting the consumer first: An introduction and overview. *Health Services Research, 42*(1), 353–361.

Chou, R. J. (2010). Willingness to live in eldercare institutions among older adults in urban and rural China: A nationwide study. *Ageing & Society, 30*, 583–608. doi:10.1017/S0144686X09990596

Chu, L. W., & Chi, I. (2008). Nursing homes in China. *Journal of American Medical Directors Association, 9*, 237–243. doi:10.1016/j.jamda.2008.01.008

Colombo, F., Llena-Nozal, A., Mercier, J., & Tjadens, F. (2011). *Help wanted? Providing and paying for long-term care.* OECD Health Policy Studies, OECD Publishing. Retrieved from http://dx.doi.org/10.1787/9789264097759-en

Courtin, E., Jemiai, N., & Mossialos, E. (2014). Mapping support policies for informal carers across the European Union. *Health Policy, 118*(1), 84–94. doi:10.1016/j.healthpol.2014.07.013

Das, M., & N'Diaye, P. (2013). Chronicle of a Decline Foretold: Has China reached the Lewis Turning Point? IMF Working Paper 13/26, International Monetary Fund.

Doty, P., Nadash, P., & Racco, N. (2015). Long-term care financing: lessons from France. *The Milbank Quarterly, 93*(2), 359–391. doi:10.1111/1468-0009.12125

Eiken, S., Sredl, K., Burwell, B., & Amos, A. (2018). *Medicaid expenditures for long-term services and supports in FY 2016*. IAP: Medicaid Innovation Accelerator Program.

Federal Ministry of Health. (2017). Peer review on "Germany's latest reforms of the long-term care system" - Host Country Discussion Paper. *European Commission: DG Employment, Social Affairs and Inclusion.* Retrieved from http://ec.europa.eu/social/BlobServlet?docId=18962&langId=en

Flaherty, J. H., Liu, M. L., Ding, L., Dong, D., Ding, Q., Li, X., & Xiao, S. (2007). China: The aging giant. *Journal of the American Geriatrics Society, 55*, 1295–1300. doi:10.1111/j.1532-5415.2007.01273.x

Gannon, B., & Davin, B. (2010). Use of formal and informal care services among older people in Ireland and France. *European Journal of Health Economics, 11*, 499–511. doi:10.1007/s10198-010-0247-1

Garcez-Leme, E. L., & Leme, D. M. (2014). Costs of elderly health care in Brazil: Challenges and strategies. *Medical Express, 1*(1), 3–8. doi:10.5935/MedicalExpress.2014.01.02

Harris-Kojetin, L., Sengupta, M., Park-Lee, E., Valverde, R., Caffrey, C., Rome, V., & Lendon, J. (2016). Long-term care providers and services users in the United States: Data from the national study of long-term care providers, 2013-2014. *Vital & health statistics. Analytical and Epidemiological Studies, 38*, 1–105.

He, W., Goodkind, D., & Kowal, P. (2016). *An aging world: 2015*. U.S. Census Bureau, International Population Reports, P95-16-1. Washington, DC: U.S. Government Publishing Office. Retrieved from http://www.census.gov/library/publications/2016/demo/P95-16-1.html

HelpAge International. (2009a). Practical issues in ageing & development. *Ageing & Development*, *Issue 26*. Retrieved from https://www.helpage.org/silo/files/ageing-and-development-26.pdf

HelpAge International. (2009b). Practical issues in ageing & development. *Ageing & Development*, *Issue 27*.

HelpAge International. (2018a). Why we work in Kenya. Retrieved from http://www.helpage.org/where-we-work/africa/kenya

HelpAge International. (2018b). Kenya to launch universal pension scheme in January 2018. Retrieved from http://www.helpage.org/newsroom/latest-news/kenya-to-launch-universal-pension-scheme-in-january-2018

HSE. (2017). Nursing homes support scheme: Information booklet. Version No. 03/17. Retrieved from https://www.hse.ie/eng/fair-deal-scheme/applying-for-fair-deal/information-booklet.pdf

Hua, F., & Di, X. (2002). Case-study: China. In J. Brodsky, J. Habib, & M. Hirschfeld (Eds.), *The World Health Organization Collection on Long-Term Care: Long-Term Care in Developing Countries*. Geneva, Switzerland: World Health Organization.

Kinsella, K., & He, W. (2009). An aging world: 2008. In U.S. Census Bureau (Ed.), *International population reports P95/09-1.* Washington, DC: U.S. Government Printing Office. Retrieved from https://www.census.gov/prod/2009pubs/p95-09-1.pdf

Kraus, M., Riedel, M., Mot, E., Willeme, P., Rohrling, G., & Czypionka, T. (2010). *A typology of long-term care systems in Europe.* European Network of Economic Policy Research Institutes. Assessing Needs of Care in European Nations (ANCIEN).

Le Bihan, B., & Martin, C. (2013). Steps towards a long-term care policy in France: Specificities, process, and actors. In C. Ranci & E. Pavolini (Eds.), *Reforms in long-term care policies in Europe.* New York, NY: Springer Publishing Company.

Link, S. (2018). Long-term care reform in Germany—At long last. *Institute and Faculty of Actuaries.* Retrieved from https://www.actuaries.org.uk/documents/long-term-care-reform-germany-long-last

Mbithi, L. M., & Mutuku, M. (2010). *Social protection status in developing countries: The case of Kenya.* Draft paper prepared for ERD regional conference on promoting resilience through social protection in sub-Saharan Africa.

Ministry of Health, Labour and Welfare. (2016). Long-term care insurance system of Japan: Health and welfare Bureau for the elderly. Retrieved from https://www.mhlw.go.jp/english/policy/care-welfare/care-welfare-elderly/dl/ltcisj_e.pdf

Muramatsu, N., & Akiyama, H. (2011). Japan: Super-aging society preparing for the future. *The Gerontologist, 51*, 425–432. doi:10.1093/geront/gnr067

Mwaisaji. W., (2015). Scaling up cash transfer programs in Kenya. International Policy Center for Inclusive Growth, No. 286. ISSN: 2318-9118. Retrieved from https://www.ipc-undp.org/pub/eng/OP286_Scaling_up_Cash_Transfer_Programmes_in_Kenya.pdf

Nadash, P., Doty, P., & von Schwanenflügel, M. (2018). The German long-term care insurance program: evolution and recent developments. *The Gerontologist, 8, 58*(3), 588–597. doi:10.1093/geront/gnx018

Neumann, L. T. V., & Albert, S. M. (2018). Aging in Brazil. *The Gerontologist*, *58*(4), 611–617. doi:10.1093/geront/gyn019

Nguyen, V., (2017). Long-term support and services. *AARP Public Policy Institute: Fact sheet*. Retrieved from https://www.aarp.org/content/dam/aarp/ppi/2017-01/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf

Noonan, B., (2014). Understanding the reasons why patients delay seeking treatment for oral cancer symptoms from a primary health care professional: An integrative literature review. *European Journal of Oncology Nursing, 18*(1), 118–124. doi:10.1016/j.ejon.2013.07.005

OECD. (n.d.). Country List. Retrieved from https://www.oecd.org/about/members-and-partners

OECD. (2011a). France long-term care. In *Help wanted? Providing and paying for long-term care*. Paris, France: OECD Publishing. Retrieved from https://www.oecd.org/els/health-systems/help-wanted-9789264097759-en.htm

OECD. (2011b). Ireland long-term care. In *Help wanted? Providing and paying for long-term care*. Paris, France: OECD Publishing. Retrieved from https://www.oecd.org/els/health-systems/help-wanted-9789264097759-en.htm

OECD. (2017). Long-term care expenditure. In *Health at a Glance 2017: OECD indicators*. Paris: OECD Publishing. doi:10.1787/health_glance-2017-81-en

Paat, G. & Masso, M. (2018). ESPN thematic report on challenges in long-term care: Estonia 2018. *European Commission, Brussels*.

Paat, G., & Merilain, M. (2010). *Long-term care in Estonia*. European Network of Economic Policy Research Institutes. ENEPRI Research Report No. 75.

Pienta, A. M., Barber, J. S., & Axinn, W. G. (2001). Social change and adult children's attitudes toward support of elderly parents: Evidence from Nepal. *Hallym International Journal of Aging, 3*, 211–235. doi:10.1092/D5T7-2BMY-YP4W-T2NU

Statistisches Bundesamt. (2015). Pflegestatistik 2013. Pflege im Rahmen der Pflegeversicherung. Deutschlandergebnisse. Retrieved from https://www.destatis.de/DE/Publikationen/Thematisch/Gesundheit/Pflege/PflegeDeutschlandergebnisse5224001159004.pdf?__blob=publicationFile

Stone, R. (2011). *Long-term care for the elderly*. Washington, DC: The Urban Institute Press.

Sciegaj, M., Mahoney, K. J., Schwartz, A. J., Simon-Rusinowitz, L., Selkow, I., & Loughlin, D. M. (2016). An inventory of publicly funded participant-directed long-term services and supports programs in the United States. *Journal of Disability Policy Studies, 26*(4), 245–251. doi:10.1177/1044207314555810

Small, J., Aldwin, C., Kowal, P., & Chatterji, S. (2017). Aging and HIV-related caregiving in Sub-Saharan Africa: A social ecological approach. *The Gerontologist, 59*(3), e223–e240. doi:10.1093/geront/gnx159

Social Security Administration. (2017). *Social Security programs throughout the world: Africa, 2017* (SSA Publication No. 13-11804). Washington, DC: U.S. Government Printing Office.

Tsutsui, T., & Muramatsu, N. (2005). Care-needs certification in the long-term care insurance system of Japan. *Journal of the American Geriatrics Society, 53*, S22–S27. doi:10.1111/j.1532-5415.2005.53175.x

U.S. Central Intelligence Agency World Factbook. (2017). Kenya. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html

World Health Organization. (2007). *Global age-friendly cities: A guide*. Geneva, Switzerland: Author.

World Health Organization. (2017). *Towards long-term care systems in Sub-Saharan Africa*. WHO series on long-term care. Geneva, Switzerland: Author. Retrieved from https://www.who.int/ageing/long-term-care/WHO-LTC-series-subsaharan-africa.pdf?ua=1

World Health Organization. (2018). Ageing and Health fact sheet. Retrieved from https://www.who.int

Wu, B., Carter, M. W., Goins, R. T., & Cheng, C. (2005). Emerging services for community-based long-term care in urban China: A systematic analysis of Shanghai's community-based agencies. *Journal of Aging & Social Policy, 17*, 37–60. doi:10.1300/J031v17n04_03

Wu, B., Mao, Z., & Xu, Q. (2008). Institutional care for elders in rural China. *Journal of Aging & Social Policy, 20*, 218–239. doi:10.1080/08959420801977632

Xinhua. (2018). China's nursing homes more than triples in past five years. *Xinhuanet.* Retrieved from www.Xinhuanet.com

Yong, V., & Saito, Y. (2011). National long-term care insurance policy in Japan a decade after implementation: Some lessons for aging countries. *Ageing International, 37*(3), 271–284. doi:10.1007/s12126-011-9109-0

Zhan, H. J., Feng, Z., Chen, Z., & Feng, X. (2011). The role of the family in institutional long-term care: Cultural management of filial piety in China. *International Journal of Social Welfare, 20*, S212–S134. doi:10.1111/j.1468-2397.2011.00808.x

Zhang, Y. (2011). *China's long-term care strategy for the elderly*. EAI Background Brief No. 668. Singapore: East Asian Institute, National University of Singapore.