Long-Term Care Laws in Five Developed Countries

A Review

World Health Organization
2000
Long-Term Care Laws
In
Five Developed Countries

A Review

Jenny Brodsky, Jack Habib, Ilana Mizrahi

JDC – BROOKDALE INSTITUTE OF GERONTOLOGY AND
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# TABLE OF CONTENTS

ACKNOWLEDGMENTS .......................................................................................................... vii

EXECUTIVE SUMMARY ..................................................................................................... 1

A. INTRODUCTION .............................................................................................................. 4
   Summary Table: A Review of Long-Term Care Laws in Five Developed Countries .... 8

B. DESCRIPTION OF THE PROGRAMMES ....................................................................... 15
   1. Framework ................................................................................................................ 15
   2. The Nature of the Insuring Agency and the Degree of Integration with other Components of the Service System ........................................................................ 15
   3. Eligibility Criteria ..................................................................................................... 16
      Age
      Health and functional status
      Availability of informal care
      Income test
      Additional eligibility criteria
   4. Eligibility Assessment ............................................................................................... 19
      Assessment tools
      Levels of need defining eligibility
      Responsibility for assessment
      Professionals making the assessment
   5. Benefits ..................................................................................................................... 20
      How services are provided
      Unrestricted cash benefits versus in-kind services
      The main services covered
      Level of benefits
      Informal support
   6. Programme Operation ............................................................................................... 26
      Auspices of service providers and availability of services
      Responsibility for care planning
      Quality assurance
   7. Finance ...................................................................................................................... 29
      Special premium (employee/employer contributions)
      General taxation
      Co-payments
   8. Coverage ................................................................................................................... 30
   9. Cost ............................................................................................................................ 31
      Substitution of community for institutional care, and of long-term care for acute hospitalization

C. SUMMARY AND EMERGING ISSUES ....................................................................... 35
D. A REVIEW OF LONG-TERM CARE IN FIVE COUNTRIES........................................39

1. Austria........................................................................................................39
2. Germany ......................................................................................................44
3. The Netherlands ..........................................................................................55
4. Israel ...........................................................................................................64
5. Japan ..........................................................................................................75

E. REFERENCES...............................................................................................85

General ...........................................................................................................85
Austria .............................................................................................................86
Germany ..........................................................................................................87
The Netherlands ...............................................................................................90
Israel ...............................................................................................................93
Japan ..............................................................................................................96
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Dr. Miriam J. Hirschfeld  
Special Adviser to the Executive Director  
Long-Term Care  
Noncommunicable Diseases and Mental Health  
Geneva,  
November 2000
EXECUTIVE SUMMARY

Providing long-term care for the disabled is a major and growing challenge of modern society. It is estimated that 9.9% of the total population of high human development countries are disabled (that is, have a functional limitation), as defined by the International Classification of Impairments, Disabilities and Handicaps (ICIDH) (Metts, 2000). The World Health Organization has calculated a general indicator of healthy life expectancy, based on Disability Adjusted Life Expectancy (DALE), which shows that overall, about seven years of life are lost to disability though this loss is slightly less for richer regions. The share of life expectancy which is lost to disability ranges from less than 9% in the healthiest regions to more than 14% in the least healthy (World Health Report, 2000). There are no equivalent comparable international data on the prevalence of disability in performing the activities of daily living. Data for Germany indicate that in 1992, approximately 4.6% of the total population were dependent on assistance (with different degrees of disability) (Schneekloth, 1996). Since disability increases with age, the rapid aging of societies is leading to a rapid increase in the numbers of disabled, and this increase does not appear to be offset by improvements in age-specific health status (Jacobzone et al., 1999).

The provision of long-term care is affected by the availability of the family as a source of support, because in most countries, care is still predominantly a family task - mainly performed by women. The increasing proportion of women in the labour market and the declining ratio between those needing care and those who are potential caregivers are raising questions about the family's ability to care for the elderly and disabled.

While all developed countries provide long-term care services, only five of them have implemented long-term care systems based on legislation and entitlement principles - a very recent development. Traditionally, long-term care has been provided on the basis of budget-limited programmes and income testing, not as part of an insurance scheme.

In this paper, we analyse and compare the long-term care laws of five countries: Austria, Germany, Israel, Japan, and the Netherlands.

These countries have placed long-term care at the forefront of their national political agendas. At the same time, in designing and implementing long-term care laws, each of the countries sought a balance between meeting needs and containing costs. We analyse the alternatives available to each country and the choices they ultimately made. We compare their choices, based on a conceptual framework (presented in a summary table on pages 6-12), which helped us identify the major structural features of each law and highlight the critical design issues and factors relevant to their resolution. These include the target population and eligibility criteria, the type of benefit (cash allowances, services in kind, or both) and services offered (community care, institutional care, or both), as well as the range of services and level of benefits, and the organizational structure and responsible insuring agency (i.e. whether long-term and acute care are organizationally and financially linked or discrete).

Major Lessons

A number of general lessons emerge from the experience of these countries.

A basic design issue that is clear from the variation among the laws is the extent to which needs should be addressed, i.e. the level of benefits offered. Underlying this determination is society's view of the appropriate and expected roles of the disabled person and the family.

Beyond introducing an entitlement, all of these countries have made significant changes in their long-term care policies. They have thus made a significant commitment to:
1. Allocate greater resources to long-term care.

2. Develop systems of long-term care that integrate home and institutional care, social and health services, and the care of the disabled across the life span.

3. Shift the balance between community and institutional care by making considerably greater resources available for community services.

4. Allocate central funding for long-term care, so that access to services is less determined by local resources and priorities.

5. Empower consumers by providing greater choice among types of service and service providers.

6. Encourage families to continue caring for disabled and elderly relatives by sharing with them the responsibility and the burden of care.

The five countries have employed several broad strategies that are worthy of consideration:

1. The availability of services is a key prerequisite for both the successful provision of services in kind and effective use of cash benefits. Concern about the availability of services was common in all these countries. A common strategy they have used to expand service availability is to encourage for-profit agencies to enter the long-term care market.

2. While increasing the range of service providers, competition has been restricted to quality and does not include price (which is mostly fixed). This reflects an effort to avoid the emergence of separate services for the rich and the poor, and to control costs.

3. The countries use a range of methods to limit costs. They set minimum disability levels for eligibility and maximum benefit levels and they require co-payments. In addition, Israel uses a means test (albeit a liberal one) and the Netherlands takes into account family support. This illustrates that there are a range of alternative mechanisms to contain costs of entitlement programmes that do not have budget limits.

4. The basic strategy adopted by most of the countries is to provide coverage of a greater number of people rather than providing more intensive services to a smaller group. This clearly implies that there is no commitment to meet full needs, even when no other source of care is available. The case of the Netherlands is different: it does not set limits to the total benefits of the recipient, but limits the maximum amount of specific services (home nursing). It also considers the availability of family support when determining the amount of services to be provided. The Netherlands thus combines an entitlement with a discretionary process of assessing eligibility.

While the broad strategies adopted by these countries are noteworthy, important components of their systems clearly require much further attention and development:

- Significant efforts have been made to standardize and ensure objectivity in eligibility assessment. However, given the importance of the assessment tools, we were surprised to find little reference to efforts to evaluate their reliability. The number of eligibility levels varies significantly across the countries and this requires more analysis and evaluation.

- The extent and nature of the efforts to ensure quality and prevent abuse also vary significantly across the countries, and there is a general feeling that a much greater effort is required to develop effective and efficient ways to ensure quality. The question of what quality assurance means when cash assistance is provided has not been adequately addressed conceptually.
• The countries experiment with a range of ways to choose between in-kind and cash benefits and try various approaches to combining the two. Our analysis points to the importance of better defining each of these options. For example, in-kind services can be provided with more or less allowance of consumer choice and autonomy. In addition, some countries use the term cash benefits even when use of the cash is restricted to purchase of services. The restriction to purchase of services may or may not include paying relatives. Thus countries' experiences suggest a variety of options to consider. However, the outcomes of their experiences are subject to many interpretations, and many questions remain unanswered. This is clearly an issue that requires much further study.

• Providing financial assistance, whether in cash or in kind, is not sufficient to assure that a disabled person will access the most appropriate services. The need to find better ways to coordinate access to fragmented service delivery systems, and the need to provide information and counseling are major challenges in all the countries.

• There is also a need to study different options of contracting and subcontracting services and their implications for cost, quality, equity, accessibility and acceptability.

• The entitlement programmes we have analysed do not always represent the only source of public assistance for long-term care. The countries offer services that can provide supplementary assistance for those eligible under the law, as well as services to those who are not eligible. However, the countries do not always offer a clear view of how the entitlement programme and non-entitlement sources of help are integrated. It is therefore important to address the long-term care system in a more comprehensive way.

• One of the basic concerns of those who question or oppose the entitlement approach is concern that costs will be much beyond projected levels and will be subject to constant increase. In Germany this problem has not materialized, but in Israel it has become a major concern. Unfortunately the data available on the various systems are not sufficient to address the issue in a comprehensive way.

In summary, major aspects of implementation require further attention, including quality assurance mechanisms, counseling for clients and family caregivers on the availability and choice of services, and the development of satisfactory coordination mechanisms among the various components of the health and social service systems and between acute and long-term care. In some countries, there is also a need to invest more in service infrastructure and human resource development.

The lack of adequate systems for monitoring implementation and evaluating outcomes limits our ability to learn from the experiences of these countries. As these programmes develop, there is a need for systematic evaluation of their experiences, so that lessons can be learnt and shared with other countries.

There is also a need to study the relative advantages and disadvantages of insurance-based options and other options of providing long-term care.
A. INTRODUCTION

Providing long-term care for the disabled is a major and growing challenge of modern society. Disabilities may result from physical, mental or sensory impairment. There is, however, a lack of data on the number and proportion of disabled people in need of long-term care. Using disability data collected by the United Nations Statistical Office (UNSO) and general population data collected by the United Nations Development Programme (UNDP), Metts (1999) estimates that 9.9% of the total population of high human development countries1 are disabled (that is, have a functional limitation), as defined by the International Classification of Impairments, Disabilities and Handicaps ICIDH, (WHO, 1980; 1999). 2

A conventional measure of the general health status of the population is life expectancy. However, this measure does not provide an indication of the burden of disease and disability. The World Health Organization has calculated a general indicator of healthy life expectancy, based on Disability Adjusted Life Expectancy (DALE), which takes into account the time lived with a disability. Analysis of the relation between DALE and life expectancy indicates that overall, about seven years of life are lost to disability, though this loss is slightly less for richer regions. The share of life expectancy which is lost to disability ranges from less than 9% in the healthiest regions to more than 14% in the least healthy (WHO, 2000).

The severity of a disability associated with a given impairment for any given person is a complex function of the impact of the impairment on the person's functional capability and the impact of social and environmental factors (Metts, 2000). There are no international data for estimating the prevalence of disability in performing instrumental activities of daily living (IADL), such as cleaning, preparing food, shopping, etc. However, data on the prevalence of disability in performance of activities of daily living (ADL) exists for Germany. In 1992, a representative survey of the population living in private households in that country indicated that about 1.5% of the total population was disabled in ADL. About 71% of the 1.5% were age 65 or older (representing 6.9% of those age 65 or older, and 16.8% of those age 80 or over), while 29% were under age 65 (Schneckloth, 1996). Furthermore, about 2.5% of the total population were disabled in IADL. Altogether around 4% of the population living in private households (with different degrees of disability) were dependent on assistance. Taking into consideration the number of persons receiving care in institutions, approximately 4.6% of the total population were dependent on assistance. Since disability increases with age, the rapid aging of societies is leading to a rapid increase in the numbers of disabled, and this increase seems not to be offset by improvements in age-specific health status (Jacobzone et al., 1999).

The provision of long-term care is affected by the availability of the family as a source of support since in most countries, care is still predominantly a family task – mainly performed by women. The increasing proportion of women in the labour market and the

1 Countries are annually categorized by UNDP as either High Human Development, Medium Human Development, or Low Human Development, using a Human Development Index that measures a country's average achievements in three dimensions of human development: longevity, knowledge, and standard of living (United Nations Development Programme, Human Development Report 1997).
declining ratio between those needing care and those who are potential caregivers (the “daughter generation”) are raising questions about the family’s ability to care for the elderly and disabled.

Countries throughout the world are struggling to develop long-term care systems and policies that will meet the basic needs of the disabled elderly, ensure the most appropriate and effective care in the least restrictive environment, contain costs, and find an appropriate balance between the role of the family and that of the state.

All developed countries have established long-term care programmes under the auspices of health and welfare services. “Long-term care” is defined broadly and varies by country. Usually, it includes some combination of health, social, housing, transportation and support services for people with physical, mental or cognitive limitations who wish to live as independently as possible. In most countries, home and community services are preferred over institutional care, and are seen as supplementing family support of the disabled.

While all developed countries provide long-term care services, only five of them have implemented long-term care systems based on legislation and entitlement principles: Austria, Germany, Israel, Japan, and the Netherlands. And even in these countries long-term care systems are a very recent development. Traditionally, long-term care has been provided on the basis of budget-limited programmes and income testing, not as part of an insurance scheme.

This paper examines the long-term care laws of Austria, Germany, Israel, Japan, and the Netherlands. In designing and implementing long-term care laws, each of these countries has sought a balance between meeting needs and containing costs. Thus they have addressed design issues such as what target population to choose; how to assess eligibility and who is to do it; what benefits to grant; who provides services; and how to finance the system. In this document, we analyse the alternatives available to each country and the choices they ultimately made. We compare their choices, based on a conceptual framework that helped us identify the major structural features of each law, the similarities and differences among the laws, and the issues of concern to policy makers in each country – such as cash benefits versus in-kind services, the integration of acute and long-term care, and the balance between the role of the family and the state. We discuss these issues as they are reflected in the experience of each of the countries reviewed.

It is important to note that it is often difficult to draw clear conclusions from country experience because there is little systematic evaluation of the implementation of long-term care laws and relatively little data on outcomes.

This paper does not address the broader issue of the relative advantages and disadvantages of insurance-based systems but focuses on the major trends emerging from the experience of countries that have implemented a long-term care insurance scheme.

Tables 1 and 2 present the basic demographic background and general health indicators of the five countries, and Table 3 summarizes the major components of the long-term care laws in these countries. On the basis of this table, in Section B, we provide a comparative analysis of the laws, highlighting the critical design issues and factors relevant to their resolution. Section C summarizes the major similarities and differences in the long-term care systems of the five countries, as well as some of the issues and lessons arising from the countries’ experience. Finally, in Section D, we provide an overview of the background and development of the long-term care law in each of the countries, and discuss each country’s experience with implementation.
Table 1: Selected demographic characteristics of the five countries:

<table>
<thead>
<tr>
<th></th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population in 1999 (millions)</td>
<td>8.11</td>
<td>82.6</td>
<td>15.8</td>
<td>5.7</td>
<td>126.3</td>
</tr>
<tr>
<td>Population aged 65+ in 1999 (millions)</td>
<td>1.2</td>
<td>13.2</td>
<td>2.1</td>
<td>0.58</td>
<td>20.8</td>
</tr>
<tr>
<td>% of 65+ in 1999</td>
<td>15.4</td>
<td>15.9</td>
<td>13.6</td>
<td>9.9</td>
<td>16.5</td>
</tr>
<tr>
<td>% of 65+ in 2025</td>
<td>21.5</td>
<td>23.4</td>
<td>23.0</td>
<td>14.0</td>
<td>26.7</td>
</tr>
<tr>
<td>% of 75+ in 1999</td>
<td>6.9</td>
<td>6.8</td>
<td>6.0</td>
<td>4.4</td>
<td>6.6</td>
</tr>
<tr>
<td>% of 75+ in 2025</td>
<td>10.6</td>
<td>11.0</td>
<td>10.8</td>
<td>5.9</td>
<td>14.9</td>
</tr>
<tr>
<td>Parent support ratio [% in 1999]</td>
<td>19.2</td>
<td>18.2</td>
<td>18.4</td>
<td>20.1</td>
<td>17.1</td>
</tr>
<tr>
<td>Parent support ratio [% in 2025]</td>
<td>27.7</td>
<td>31.7</td>
<td>25.4</td>
<td>20.7</td>
<td>44.0</td>
</tr>
</tbody>
</table>

As may be seen in Table 1, in Austria, Germany and Japan about 16% of the population are 65 or over, while in Israel only about 10% are. All countries will experience rapid aging by 2025. The parent-support ratio provides an indication of the pressure of caregiving responsibilities. The percentage of those 75 or over is between 6-6.9%, except in Israel. By the year 2025 it will reach about 11% in Austria, Germany, and the Netherlands, and a notable 14.9% in Japan. The differences in the parent support ratio were relatively small in 1999, about 1 person over 80 to every 5 persons in the prime caregiving ages (age 50-64). This ratio will increase rapidly in all countries except Israel. The most significant increase will be in Japan.

Table 2 shows general health indicators in the five countries. They are all among those with the highest life expectancy in the world; Japan has the longest life expectancy, as well as the longest healthy life expectancy (74.5 years). Analysis of the relationship between disability-adjusted life expectancy and life expectancy shows that the number of years lost to disability for men ranges from 5.4 years in the Netherlands to 7.1 years in Israel, and for women, from 6.0 years in Austria to 8.3 years in Israel. The proportion of life expectancy lost to disability for men ranges from 7.2% in the Netherlands to 9.3% in Israel, and for women, from 7.4% in Austria to 10.4% in Israel (WHO, 2000).

---

3 Parent support ratio: the ratio of those ages 80 and over per 100 persons age 50-64. Source: International Data Base, 2000; United Nations, 1998; World Health Statistics Annual, 1996
<table>
<thead>
<tr>
<th></th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life Expectancy at Birth (in years):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>74.4</td>
<td>73.7</td>
<td>75.0</td>
<td>76.2</td>
<td>77.6</td>
</tr>
<tr>
<td>Females</td>
<td>80.4</td>
<td>80.1</td>
<td>81.1</td>
<td>79.9</td>
<td>84.3</td>
</tr>
<tr>
<td><strong>Disability-adjusted Life Expectancy at Birth (in years)</strong>:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>71.6</td>
<td>70.4</td>
<td>72.0</td>
<td>70.4</td>
<td>74.5</td>
</tr>
<tr>
<td>Males</td>
<td>68.8</td>
<td>67.4</td>
<td>69.6</td>
<td>69.2</td>
<td>71.9</td>
</tr>
<tr>
<td>Females</td>
<td>74.4</td>
<td>73.5</td>
<td>74.4</td>
<td>71.6</td>
<td>77.2</td>
</tr>
<tr>
<td><strong>Expectation of Disability at Birth (in years):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>5.6</td>
<td>6.3</td>
<td>5.4</td>
<td>7.1</td>
<td>5.7</td>
</tr>
<tr>
<td>Females</td>
<td>6.0</td>
<td>6.6</td>
<td>6.7</td>
<td>8.3</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Percentage of Lifespan Lived with Disability:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>7.5</td>
<td>8.6</td>
<td>7.2</td>
<td>9.3</td>
<td>7.3</td>
</tr>
<tr>
<td>Females</td>
<td>7.4</td>
<td>8.3</td>
<td>8.2</td>
<td>10.4</td>
<td>8.4</td>
</tr>
</tbody>
</table>

The following summary table highlights the major structural features of the five long-term care laws. It represents the conceptual framework which enables us to compare nine key variables: the framework of the law, the nature of the law and the insuring agency, eligibility criteria, eligibility assessment, benefits, programme operation, finance, coverage and cost.

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4 WHO calculated an indicator of disability-adjusted life expectancy (DALE), which summarizes the expected number of years to be lived in full health. To calculate DALE, the years of ill health are weighted according to severity and subtracted from overall life expectancy.
### Summary Table: A Review of Long-Term Care Laws in Five Developed Countries

<table>
<thead>
<tr>
<th>I. Framework</th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Long-term care services provided by statutory programme based on personal entitlement</td>
<td>Yes; two programmes&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes; three programmes&lt;sup&gt;6&lt;/sup&gt;</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Programme name</td>
<td>Bundespflege-Geldgesetz</td>
<td>Pflegeversicherung</td>
<td>Algemene Wet Bijzondere Ziektekosten (AWBZ)</td>
<td>Chok Bituach Stiyud</td>
<td>Kaigo Hoken</td>
</tr>
<tr>
<td>(The Federal Long-Term Care Allowance Act; The Provincial Long-Term Care Act)</td>
<td>(Long-Term Care Insurance Law, or Social Dependency Insurance Programme)</td>
<td>(The Exceptional Medical Expenses Act)</td>
<td>(Community Long-Term Care Insurance (CLTCI) Law)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Date of initial implementation</td>
<td>January 1, 1994</td>
<td>April 1, 1995 (community care)</td>
<td>January 1, 1968</td>
<td>April 1, 1988</td>
<td>April 1, 2000</td>
</tr>
<tr>
<td></td>
<td>Expanded to include institutional care July 1, 1996</td>
<td></td>
<td>Changes over time in kinds of services covered&lt;sup&gt;7&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>5</sup> Austria has enacted two laws: The Federal Long-term Care Law, which covers people who are entitled to social security pensions (90% of the population), and the Provincial Long-Term Care Law, which covers 10% of the population.

<sup>6</sup> Description refers to the Community Long-Term Care Insurance Law, which covers the elderly; others needing long-term care are covered by the Attendance Allowance Law (age 18-64) and the Disabled Child Law (age 0-17).

<sup>7</sup> Having initially served mainly as a means of funding long-term or high-cost care in various types of institutions (e.g. nursing homes), its provision has been extended over the years to cover more elements of health care, many of which are neither prolonged nor expensive (Health Insurance in the Netherlands, 1998). In 1989, home care services were included and in 1997 residential homes were included.
### Summary Table: continuation

<table>
<thead>
<tr>
<th>II. The Nature of the Programme and the Insuring Agency</th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Special/part of health or social insurance</td>
<td>Special programme</td>
<td>Special programme</td>
<td>Special programme</td>
<td>Special programme</td>
<td>Special programme</td>
</tr>
<tr>
<td>2. The insuring agency</td>
<td>Ministry of Labour, Health and Social Affairs</td>
<td>Care funds linked to sickness funds</td>
<td>Ministry of Health, Welfare and Sport(^8)</td>
<td>National Insurance Institute (Social Security)</td>
<td>Municipal Government</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Eligibility Criteria</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>Three and over</td>
<td>All ages</td>
<td>All ages</td>
<td>Women 60+, men 65+</td>
</tr>
<tr>
<td>2. Health, functional status</td>
<td>Disability in ADL, IADL (forecast need for care for at least six months); need for at least 50 hours assistance per month (the blind/severely visually impaired, deaf, wheelchair-bound are automatically entitled)</td>
<td>Disability in two or more ADL (forecast need for care for at least six months); need for at least 1½ hours assistance per day</td>
<td>Health problems, functional disability</td>
<td>Disability in ADL and/or need for constant supervision</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Availability and extent of family assistance</td>
<td>Not considered</td>
<td>Not considered</td>
<td>Considered</td>
<td>Not considered</td>
</tr>
</tbody>
</table>

---

\(^8\) The AWBZ is managed through health insurers: the health insurance funds, or private health insurance companies approved by the government. The government is responsible since insurance organizations cannot take financial risk to cover AWBZ.

\(^9\) The minimum level of disability includes people who are able to sustain an independent daily life. Services are aimed at improving the current situation and preventing the deterioration of underlying conditions. Services include periodic home visits to provide guidance to family caregivers and health counseling (Okamoto, 2000).
### Summary Table: continuation

<table>
<thead>
<tr>
<th>4. Means test</th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Yes; for full benefit-income not higher than average wage for single person, and 1.5 for couple(^{10})</td>
<td>None</td>
</tr>
</tbody>
</table>

| 5. Other criteria | None | None | Psycho-social; condition of the home and environs; type and level of formal care provided | Living alone (adds points toward eligibility)\(^{11}\) | None |

### IV. Eligibility Assessment

<table>
<thead>
<tr>
<th>1. Assessment tools</th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured; uniform nationwide</td>
<td>Structured; variation among provinces</td>
<td>Discretionary; uniform protocol being prepared</td>
<td>Structured; uniform nationwide</td>
<td>Structured; uniform nationwide</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Levels of eligibility</th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seven levels, by hours of care per month (50-180 hours)</td>
<td>Three levels, by hours of care per day (1 ½-5 hours)</td>
<td>Tailor-made care</td>
<td>Two levels, by hours of care per day (2½-6½ hours)</td>
<td>Six levels, by hours of care per day (25 minutes to 110 minutes)(^{12})</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Responsibility for assessment</th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insuring agent</td>
<td>Medical board(^{13})</td>
<td>Regional assessment boards (RIO)</td>
<td>National Insurance Institute(^{14})</td>
<td>Municipality(^{15})</td>
<td></td>
</tr>
</tbody>
</table>

---

\(^{10}\) For a person with children – an additional income amount equivalent to half the average wage is added for each child. Half of the benefit is provided when income is above the average wage, but not higher than 1.5 the average wage for a single person and 2.25 times the average wage for a couple. Those with higher incomes are not eligible.

\(^{11}\) Living alone adds points only if the applicant needs assistance in ADL for at least two hours.

\(^{12}\) The minutes are derived from a care time study in institutional settings (Ikegami, 2000).

\(^{13}\) Care funds conduct the assessment for eligibility through the sickness funds, medical service, and reimburse the sickness funds for the use of the service.

\(^{14}\) The National Insurance Institute pays independent public health nurses per assessment.

\(^{15}\) The municipality pays independent care managers for eligibility assessment.
### Summary Table: continuation

<table>
<thead>
<tr>
<th></th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Professionals making assessment</td>
<td>Physicians</td>
<td>Physicians or nurses</td>
<td>Multi-disciplinary team (social workers, nurses, physicians)(^{16})</td>
<td>Nurses</td>
<td>Care manager (from various professions)</td>
</tr>
<tr>
<td>V. Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Cash allowance (unrestricted/restricted(^{17}), in-kind services, or combination of both)</td>
<td>Cash allowance (unrestricted)</td>
<td>Both (in-kind services and unrestricted cash allowance): value of cash allowance is lower than that of in-kind services (45%-53% of benefit depending on disability level)</td>
<td>In-kind services (restricted cash allowance being used experimentally)</td>
<td>In-kind services (cash – 80% of the benefit – offered only in the absence of services)</td>
<td>In-kind services</td>
</tr>
<tr>
<td>2. Main services covered:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Institutional care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Home care(^{17})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Day care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beneficiary’s Choice, in all categories</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respite care, night centres, assistive devices</td>
<td>Assistive devices, Home nursing, Respite care Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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\(^{16}\) RIO employs professional staff for the assessment. Expertise is not explicitly stated in the regulations; therefore, several professions may perform the assessment. To assist in specialized assessment, expert consultation may be required (e.g. in case of suspected dementia).

\(^{17}\) Unrestricted cash allowances enable beneficiaries to use the funds as they see fit, while restricted cash allowances may be used only to purchase services.
### Summary Table: continuation

<table>
<thead>
<tr>
<th></th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Level of benefits per month (estimated in US$)</td>
<td>Between $160 and $1,686 (cash allowance) (as of 1998)(^\text{18})</td>
<td>Community care: In-kind services between $375 and $1,400 (or $1,875 in hardship cases); cash allowance: between $200 and $650 (as of 1999) Institutional care: in-kind services; Between $1,000 and $1,400 (or $1,650 in hardship cases) (as of 1999)(^\text{19})</td>
<td>Not specified – no formal limit on total benefit, maximum limit in specific services (such as 3 hours per day for home nursing)</td>
<td>Between $360 and $540 (for in-kind services) (as of 1999)(^\text{20})</td>
<td>Between $560 and $3,260 (for in-kind services) (as of 2000)(^\text{21})</td>
</tr>
</tbody>
</table>

### VI. Programme Operation

<table>
<thead>
<tr>
<th></th>
<th>Government; NGOs; for-profit organizations</th>
<th>Government; NGOs; for-profit organizations</th>
<th>Government; NGOs; for-profit organizations</th>
<th>NGOs, for-profit organizations</th>
<th>Government; NGOs; for-profit organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Auspices of service providers(^\text{22})</td>
<td>Beneficiary(^\text{23})</td>
<td>Medical board/Beneficiary(^\text{23})</td>
<td>Beneficiary/Service provider</td>
<td>Regional committee</td>
<td>Care manager/Beneficiary</td>
</tr>
</tbody>
</table>

\(^{18}\) Calculated by the authors according to exchange rates: ATS 12.5=$1.00.

\(^{19}\) Calculated by the authors according to exchange rates: DM 2=$1.

\(^{20}\) Calculated by the authors according to exchange rates: NIS 4.1=$1.

\(^{21}\) Calculated by the authors according to exchange rates: ¥ 109.8=$1.

\(^{22}\) Government includes national or municipal.

\(^{23}\) However, the actual care planning is made by a senior care-worker of the provider agency.
<table>
<thead>
<tr>
<th>VII. Finance</th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sources of Finance:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Special payment/premium</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>- General taxation</td>
<td>Yes (100%)</td>
<td>No</td>
<td>Yes</td>
<td>Yes (20%)</td>
<td>Yes (50%)</td>
</tr>
<tr>
<td>- Co-payment</td>
<td>Yes (for institutional care)</td>
<td>Yes (for institutional care)</td>
<td>Yes (for all services)</td>
<td>No</td>
<td>Yes (for all services)</td>
</tr>
<tr>
<td>2. Premium cost$^{24}$</td>
<td>Not relevant</td>
<td>1.7% of gross wages, upper limit contribution - DM 6375 (former West Germany) DM5400 (former East Germany) – equal contribution of employer and employee$^{25}$; retirees share cost with pension fund</td>
<td>9.6% of taxable income between NFL 8,600 and NFL 47,000; above this wage, annum flat payment; majority paid by employer, remainder paid by employee</td>
<td>0.16% payroll tax shared by employee (0.1%) employer (0.06%); pensioners do not pay</td>
<td>0.9% supplement to health insurance premium for employees aged 40-64, shared equally with employers; $26 (average) per month; for persons aged 65+, deducted from pensions</td>
</tr>
</tbody>
</table>

$^{24}$ Premium contributions for the self-employed may be different, and the premium for those who are not employed may be covered by other funds.

$^{25}$ The contributions of the employers are recompensed by the designation of a paid holiday as a working day.
### Summary Table: continuation

<table>
<thead>
<tr>
<th>VIII. Coverage</th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of recipients</td>
<td>324,000 recipients (1998)</td>
<td>1.8 million recipients (1999)</td>
<td>recipients 88,000 (1999)</td>
<td>Just began implementation (estimated number for 2000 is 1.35 million elderly (6.2% of the elderly)</td>
<td></td>
</tr>
<tr>
<td>2. Percentage of benefit recipients</td>
<td>3.9% of total population (about 17% of those aged 61+)</td>
<td>2.19% of total population (9.6% of those aged 65+)</td>
<td>A minimum estimate of 20% of the elderly (1990)</td>
<td>12.07% among women age 60+, men age 65+</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cost in local currency</td>
<td>$1.7 billion</td>
<td>$15.5 billion</td>
<td>$13 billion</td>
<td>$370 million</td>
<td>$39 billion</td>
</tr>
<tr>
<td>2. Estimated cost in US$</td>
<td>0.9%</td>
<td>0.9%</td>
<td>3.6%</td>
<td>0.36%</td>
<td>0.9%</td>
</tr>
<tr>
<td>3. Estimated percentage of the Gross National Product</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

26 Estimated by utilization rates by age group, based on Enge, 1999.
27 Estimated by utilization rates of the elderly by type of services, based on Coolen, 1995.
28 Some 2.7 million older persons, 12.4% of the elderly, are estimated to be eligible for benefits in 2000; however, it is assumed that only about a third of those living in the community will apply the first year (Campbell and Ikegami, 2000). The cost estimates are based on these assumptions. There is evidence that these estimates may be exceeded.
29 Expenditures for the Federal LTC Allowance Act are about AT$ 18 billion, and for the Provincial LTC Allowance Act about AT$ 3 billion on average.
30 Expenditures are for the broad package of services available to the entire population.
31 Expenditures are only for community services for the elderly.
B. DESCRIPTION OF THE PROGRAMMES

This section describes the structure and components of the long-term care laws of the five countries. We analyse the alternatives available and the choices these countries ultimately made. We then compare their choices based on a conceptual framework that helps us identify the major structural features of each law. We also present data on rates of utilization and costs.

1. Framework

In all of the countries, long-term care is covered by a special law based on personal entitlement. Most of the countries have enacted one federal law for the entire population in need of long-term care. Two countries, Israel and Austria, have enacted more than one law. Austria has enacted two such laws – a federal law covering 90% of the population and provincial law that covers the remaining 10% of the population. Israel has enacted three laws covering long-term care – the Community Long-term Care Insurance Law, covering women age 60 and men age 65 and over; the Attendance Allowance Law, covering people age 18-64; and the Disabled Child Law, covering minors age 0-17. It is the Community Long-term Care Insurance Law (for the aged) to which we will refer.

The Netherlands was first to provide long-term care in a legal framework, mandating coverage of care in nursing homes as early as 1968. Later it expanded coverage to care provided in the community, such as home nursing and home help (1989), and care in old age homes (1997). On 1 April 1988, Israel mandated the provision of services in the community under the Community Long-term Care Insurance Law. During the past decade, Austria, Germany and Japan have passed similar laws. Austria enacted its federal long-term care law on 1 January 1994, while Germany enacted its law in two stages: Coverage of community care began on 1 April 1995, and coverage of institutional care began on 1 July 1996. Japan began implementation of its long-term care law, which covers both home and institutional care, on 1 April 2000.

2. The Nature of the Insuring Agency and the Degree of Integration with other Components of the Service System

Long-term care may be provided as part of other community health and welfare services or as a discrete programme. The countries under discussion all chose to formulate special discrete programmes for the provision of long-term care. These programmes are based on the principle of personal entitlement and are not constrained by budgetary limitations. In most of the countries, the agency responsible for providing care under the law is part of the health and/or welfare system: In Austria, the Ministry of Labour, Health and Social Affairs is the insuring agency; in Germany, special care funds were established under the auspices of existing sickness funds; in Japan, the municipalities – which are responsible for social services and for health insurance for retirees and others who are not employed – share responsibility with the Ministry of Health and Welfare. In Israel, the National Insurance Institute – that is, the system of social security, which is independent of the health care system – is responsible for the provision of long-term care insurance. In the Netherlands the Ministry of Health, Welfare and Sport is the insuring agency, under the auspices of existing health insurers.

One problem in the care of the disabled and chronically ill is fragmentation; the responsibility for funding and service delivery is divided among several organizations. Fragmentation of the system of services and lack of coordination of care impede the efficient provision of appropriate services and create confusion and discomfort for the disabled and their families. Therefore, a major issue in developing programmes to address the needs of
the disabled is creation of a continuum of care between the acute and long-term care systems, and between the health and social service systems.

One way to establish a continuum of care is by integrating different components of care and subsuming them under one agency. Proponents of the integration of acute and long-term care believe that combining them gives health insurers and providers an incentive to find less expensive alternatives to institutionalization, such as rehabilitation and prevention; to carefully plan and coordinate short-term acute services with rehabilitative and long-term care services; to coordinate community and institutional health services; and to expand community-based medical and nursing long-term care services.

However, concerns have been raised about this approach. One concern is that long-term care services will be neglected when they are integrated into the more general health system, and acute health care needs will be given greater priority. Another concern is whether adequate financial mechanisms will be developed to compensate insurers of health for the risks of long-term care. This is necessary to avoid disincentives to serving people with greater long-term care needs. This concern is particularly important in systems where there is competition among health insurers, with incentives to avoid complex, difficult, and costly cases. When services are financed through a budget rather than through pre-paid personal entitlements, and there is no competition among health care providers, the integration of acute and long-term care is more feasible. Finally, there is some reluctance to implement the same financing principles for long-term care as for acute medical care, since it is difficult to include cost-containment mechanisms in long-term care provision, beyond those implemented in medical care.

As noted above, all of the countries have subsumed the provision of long-term care under agencies that have responsibility for other health services, albeit by establishing separate programmes rather than organizationally and financially integrating the services into an existing health insurance programme. In Germany, for example, the government initially proposed combining health and long-term care. Nevertheless, the Social Dependency Insurance programme was ultimately made the separate responsibility of “care funds.” This decision was made to facilitate cost containment in the long-term care scheme and distinguish it from acute care. It also apparently freed the federal government from direct liability for programme deficits. The question of what would happen if deficits arose was left open (Scheil-Adlung, 1995; Schneider, 1999; Cuellar and Wiener, 2000; see Germany in section D). The Netherlands is quite unique. There is an entitlement that can even be claimed in the courts, but there is also the possibility of rationing - through waiting lists. Thus, the Dutch are able to impose limits to total expenditures nationally and by region. We surmise that some rationing may also be done by stricter needs assessment when funds are scarce, although there is no discussion of this in the literature.

3. **Eligibility Criteria**

The perspective of the authors of long-term care insurance laws is reflected in the criteria they set for determining eligibility for benefits and assessing the level of benefits. Several major issues must be addressed in determining eligibility:

a. **Should a long-term care programme cover people of all ages, or should it be age-limited?**

There are three possibilities: a) include people of all ages in the same programme; b) define specific long-term care laws for different age groups (this may involve establishing separate eligibility criteria and/or benefits); c) limit long-term care benefits to one specific age group.
b. Should benefits be limited to very severely disabled people, or include the moderately disabled, who are at less risk of institutionalization?

Within a given cost framework, there is a trade-off between limiting benefits to the severely disabled, providing more benefits to fewer people, and offering benefits to people with varying levels of disability thus providing smaller benefits to a greater number of people. Another question is whether to include all disabilities, without regard for the cause of disability (i.e. physical, mental).

c. Should an individual’s income level be included in the assessment of eligibility?

Programmes that provide coverage regardless of income level embody the principle of universal insurance, thereby preventing the stigma usually associated with receipt of income-tested benefits. However, programmes that cover only lower income populations make it possible to provide more benefits to those who are eligible, or to reduce costs.

d. Should the amount of family (informal) assistance available be included in the assessment of eligibility?

Considering available family support makes it possible to target those most in need of assistance. On the other hand, providing supportive families with extra assistance may strengthen them, enabling them to continue caring for longer periods of time; it also reflects society’s recognition of their effort. In insurance frameworks it is difficult to include such criteria because they are subject to the discretion of the person making the assessment. There is also a sense that if you have paid, you are entitled to benefits.

The sections below discuss the resolution of these issues in each of the five countries. We assess whether age and income level are considered eligibility criteria, what level of disability entitles an individual to benefits, and whether other criteria, such as family assistance, are considered when assessing eligibility.

Age:

Coverage is extended to all age groups in Germany, the Netherlands and Austria (from age three). In Japan, the law covers those age 40-64 who suffer from age-related problems (e.g. CVA, senile dementia) and all those age 65 and over. In Israel, the Community Long-term Care Insurance Law covers women age 60 and over and men age 65 and over, while the needs of other populations are addressed by other long-term care insurance programmes, as noted above.

Health and functional status:

Eligibility in Austria, Germany, The Netherlands and Israel is based on disability, independent of the reason for the disability – whether mental, physical or sensory. In Japan, this is true for the elderly population, but for those age 40-64, as mentioned above, the law covers only those who suffer from age-related problems. Difficulty in performing activities of daily living (ADL), such as washing, dressing, eating, and mobility, is the primary test of eligibility in all of the countries. Additional criteria include difficulty in performing instrumental activities of daily living (IADL, cleaning, cooking, doing laundry, doing errands), impaired cognitive functioning, and the need for constant supervision. In Austria, people with vision or hearing impairment or difficulty in mobility are automatically eligible for benefits.

In a number of the countries functional status is translated into the extent of need for assistance, expressed as the number of hours of assistance an individual needs per day or month. In Austria, benefits are provided to people who need personal care for at least 50 hours per month. In Israel and Germany, the need for personal care is measured on a daily basis: in Germany eligibility is granted to people who need personal care for at least 1.5
hours per day, while in Israel eligibility is granted to people who need 2.5 hours of personal care per day (2 hours for those living alone). In other words, the baseline of eligibility in Israel is higher than that in Germany, and resources are allocated to people with greater needs, who are more severely disabled. If we translate this baseline into need on a monthly basis, the level in Israel is also higher than in Austria, where the threshold is similar to that in Germany. In Japan the threshold for support is quite low, and the lowest category, called "assistance required," includes people who are able to sustain an independent daily life. At this level services are aimed at preventing deterioration and include counseling; the other five levels are called "care required" (Campbell and Ikegami, 2000; Okamoto, 2000). There has been debate in Germany about the baseline for eligibility. Some claim that providing at least limited assistance (e.g. housekeeping chores only) to the less disabled will help maintain their functional status and defer their institutionalization. Those who support the current baseline of eligibility claim that lowering it may cause informal care to be replaced by formal care (Goerke, 1996).

Because the laws cover long-term care, most of the countries also base eligibility on a minimum forecasted need for care over at least six months. Thus, individuals who need services for a short period only (e.g. following an acute event) usually are not eligible for coverage. Israel has recently reformed its law so as to provide limited (two-month) coverage to people who have been discharged from an acute hospital; if care is needed for a longer time, the recipient must reapply for coverage. This reform developed in part from concern that some of those eligible for care under the law were receiving it long after their situation had improved, because reassessment was problematic. It is hoped the reform will contain costs.

**Availability of informal care:**

Except for the Netherlands, none of the five countries include the availability and extent of family assistance in the eligibility test. However, in Israel an applicant's living situation (whether he lives alone or with others) is factored into the assessment of eligibility. Although the amount of assistance received from relatives is not assessed, living alone adds points toward eligibility.

**Income test:**

An individual's income level, as determined by a means test, is not a criterion for receiving benefits in most of the countries, reflecting the universal approach of most of the laws. Only Israel requires a means test, and it is set at a high level relative to the income status of the elderly, such that at present it affects few people: To be eligible for full benefits, a single person must have an income that is not higher than the average wage. Those whose income is up to 1.5 times the average wage are eligible for 50% of the benefits, and those whose income is even higher are not eligible for any benefits. Couples and families with children have higher cutoff points.

In Germany, some have been critical of the fact that benefit level is not linked to income, and benefits are provided to the same extent to people with low, moderate and high incomes (Schneider, 1999).

**Additional eligibility criteria:**

The Netherlands is unique in its holistic approach to assessment of an individual's need for long-term care. Its assessment process reviews psychosocial functioning, the state of the home and environs, and the type and level of formal care received from other sources. Indeed, the criteria in the Netherlands resemble those utilized in many other developed countries providing long-term care services without legal entitlement.
4. Eligibility Assessment

Beyond establishing criteria, it is necessary to establish a procedure for evaluating or assessing eligibility.

The evaluation of applicants for long-term care benefits differs among the countries reviewed here. This section examines these differences, as reflected in whether or not a structured assessment tool is used nationwide, who conducts the assessment (a medical or nursing board or some other agency), and whether assessment of eligibility is identical for benefits provided in the home and in an institution.

Assessment tools:

In most of the countries, a structured, uniform assessment instrument is used nationwide. The use of a uniform assessment tool helps standardize the assessment process. The Netherlands, unlike the other countries, allows the person performing the assessment to exercise his or her discretion in suiting benefits to the individual applicant. At present, there is no national set of assessment tools, although one is being developed (Huijbers and Martin, 1998).

Levels of need defining eligibility:

Each country has delineated a number of levels of eligibility, and in most countries, the level is determined by the number of hours of care an applicant is expected to require per day or month. Israel has set two levels of eligibility (2.5 and 6.5 hours or more of personal care required per day), Germany has set three levels (from 1.5 up to 5 hours or more of care per day), Japan has set six levels using a point system (ranging from 25 minutes to 110 minutes a day), and Austria has set seven levels of eligibility (from 50 up to 180 hours or more of personal care per month - which may be translated into between 1.6 and 6 hours or more of care per day). The greater the number of levels into which eligibility is divided, the greater the extent to which resources may be allocated according to functional level. In Israel, after 11 years of experience, levels of care have been re-examined and a change in the law has been proposed-- to include three levels of disability instead of two.

Responsibility for assessment:

Responsibility for assessing eligibility may fall upon the insuring agent or an external agency. The use of an external agency is designed to assure objective, autonomous, and uniform assessment. In some countries the system is semi-independent. In Germany, medical boards are directly responsible for assessment; however, care funds conduct the assessment for eligibility through the sickness funds' medical service and reimburse the sickness funds for the use of the service. In Israel, the National Insurance Institute is directly responsible for assessment but uses independent public health nurses. In Japan, the municipalities are responsible for assessment, but they use care managers, who may be employees of organizations that provide services. It has been argued that because of the overlap between their roles as care managers and providers, there may be a conflict of interest, and the process of eligibility determination may have a built-in bias towards severity, to favour providers. The plan is that final decisions about eligibility will be made by an expert committee (Campbell and Ikekami, 2000). In the Netherlands, since 1998, external agencies (RIOs – Regional Assessment Organizations) have been established locally; they comprise representatives of applicants, consumer groups, service providers, physicians, and staff of the local authority. RIOs employ professionals from various fields for the assessment. In Austria the insuring agent is also the assessing agency.
Professionals making the assessment:

In each country, eligibility assessment is performed either by professionals from a single field – e.g., physicians, nurses – or by a multi-professional team. In part this depends on the nature of the criteria: The narrower the criteria, the less the need for a multi-professional approach. There is a tradeoff between the costs of eligibility assessment and the biases of a specific professional approach, even with the use of a structured tool. Assessment of eligibility by a multi-professional team facilitates a multi-dimensional perspective on an applicant’s needs, which may help those involved later (after eligibility is determined) in planning an appropriate programme of care. In Austria, physicians alone perform the assessment of eligibility, and in Israel nurses are solely responsible. In Germany, assessments may be performed by physicians or nurses. In Japan the decision has been made to provide some training to professionals from various fields to carry out the specific function of assessment of eligibility (so-called care managers) 32. In the Netherlands, consistent with the comprehensive criteria used in that country, a multi-professional team performs the assessment. Since regulations do not explicitly state the profession required, professionals from various fields may be involved in the assessment (such as physicians, nurses, social workers, geriatric psychologists, social gerontologists).

Assessment should be uniform and consistent, whether determining eligibility for care in the home or eligibility for institutionalization. In Austria, Germany, the Netherlands and Japan, one agency is responsible for determining eligibility for both community services and institutionalization, such that the assessment process has continuity. In Israel, where the law provides for benefits in the community only, not for institutional care, the assessments are separate.

5. Benefits

This section discusses the benefits provided under long-term care laws in the five countries under review. It examines the way in which services are provided – whether as in-kind (services) or as an unrestricted cash allowance, or as a cash allowance restricted to the purchase of services, or a combination of these alternatives; the main services covered (institutional care and/or home care and/or other services); and the level of benefits.

How services are provided:

There are three basic forms of provision: services in kind; cash allowances without restrictions, which enable a beneficiary to use the funds as he sees fit; and cash allowances with a restriction – that is, to purchase services – in which case the beneficiary must submit receipts for services or have checks co-signed by providers. If the restricted cash benefit may not be used to pay family members, it is closer to the provision of in-kind services. If, on the other hand, the restricted cash benefit may be used to pay family members, it is closer to the provision of unrestricted cash allowances.

Most of the countries provide in-kind services; however, in recent years there has been a trend toward providing cash allowances as part of the package of services. In Austria, people needing long-term care are given cash allowances. In Germany, people receiving benefits at home may choose among a cash allowance, in-kind services, or a combination of the two, while people eligible for benefits in an institution are given in-kind services only. In

32Who these professionals may be has been defined very broadly; they include nursing home aides and care workers with experience who have received in-service training only.
Japan, after debate, the decision was made to provide in-kind services and not allow cash allowances for family care.\footnote{However, a decision has been made in the last few months to award 100,000 yen (about $900) to beneficiaries who meet all of the following criteria: a) apply for LTCI benefit and be determined as most disabled (level 4 or 5); b) have little or no income (near poverty line); c) receive no services from LTCI system for one year. This is not an insurance benefit of the LTCI. Instead, it is a grant paid out of general revenues.}

The recipient of a cash allowance in Austria or Germany is not obligated to use it to purchase services but, rather, may incorporate it into his household budget or use it to compensate family members.

In the Netherlands only in-kind services are provided. Cash benefits are provided under an experimental programme of “personal budgets” to a limited group of applicants who are eligible for care in the home, but they must use the cash to purchase services, including services from family members. In Israel, only in-kind services are provided, unless these are unavailable, in which case a cash allowance is provided (very few clients have received cash benefits).

The amount of the cash allowance is lower than the monetary value of in-kind services. For example, in Germany it is between 45% and 53% of the level of in-kind services, depending on the recipient’s functional level.

**Unrestricted cash benefits versus in-kind services**

Unrestricted cash benefits are controversial because of uncertainty about their effects. Those who favour cash allowances claim that they empower recipients by increasing their autonomy and freedom of choice of services and service providers, facilitate flexible care planning and enable recipients to schedule personal assistance as they please and to choose and directly contract with service providers (including non-organized caregivers). Proponents of this approach claim that the flexibility enhances the elderly person’s quality of life (Freedman and Kemper, 1996). Furthermore, cash allowances may give families a stronger incentive to continue caring for an elderly or disabled relative, since they offer disabled people an opportunity to express their appreciation for the efforts of unpaid helpers, or acknowledges lost employment income of the caregivers. It is assumed that the provision of cash allowances will generate competition among service providers and thereby improve services. The justification for the lower benefits provided when they are in cash is the assumption that clients purchase services from non-organized providers or family members, and therefore obtain services at a lower rate.

Those who oppose the provision of cash benefits argue that costs will be high due to high participation rates, and quality of care will be poor because of the lack of adequate supervision over service provision. Some question whether the elderly will really receive the care they need: Clients may have difficulty choosing providers on their own, and families may abuse the funds or neglect the elderly person’s needs; use of funds is difficult to regulate. It is also not clear whether the funds actually promote the availability of services and provide options to consumers. Critics claim that cash allowances alone are not sufficient to spur the development of community services, and that efforts to this end must be made at both national and local levels. Finally, it is argued that considerable choice and flexibility can be built into in-kind services as well.

The issue of whether or not to provide cash allowances for family care was a major focus of the debate in Japan. Despite public support, it was decided not to allow cash
benefits. Professionals claimed that rapid expansion of formal services should be the top priority and this would not be stimulated by cash benefits. Feminists argued that cash allowance would merely become part of the household budget while female family caregivers continued to provide the bulk of care. Concern was also raised that if cash allowances were offered, there would be a rush of applications for benefits though the government was counting on a relatively low level of applications initially, in order to phase in the programme gradually (Campbell and Ikegami, 2000).

To assess the advantages of each of these alternative forms of benefits, we need more empirical data. The major questions are these: Which benefits are preferred by clients and why? How do those choosing cash allowances spend them? What would help recipients of cash allowances and their families use them efficiently? Does the provision of cash allowances improve the level and accessibility of services (has the recipient’s freedom of choice of providers increased)? What are the implications of provision of cash allowances for the quality of services? What are the implications of provision of cash allowances for public expenditures? How does the provision of a cash allowance affect family care, if at all?

As mentioned above, in the Netherlands, cash allowances are offered as part of an experimental programme but they are restricted to purchasing services. Cash allowances were granted to 3%-5% of beneficiaries, or about 5,500 people, in 1997 (Coolen, 1998; Huijbert and Martin, 1998). An evaluation of the programme showed that recipients reported an improvement in services and more control over service provision and choice of providers. For example, clients could more easily dismiss an employee or provider if they were dissatisfied (Weekers and Pijl, 1998). Another study found that satisfaction was high: People receiving cash allowances (“personal budgets”) reported being more satisfied than did people in a control group, who received services in kind (Miltenburg, 1995).

In Germany, unrestricted cash allowances for community care are offered as an option. In 1996, among the community-based population, most (79%) of those eligible for benefits chose cash allowances, while 11% chose a combination of cash allowances and in-kind services and 9% chose services only. The proportion of those choosing cash allowances declined with increasing disability, however. That is, a higher percentage of those with substantial disability than those with severe, or very severe disability chose cash benefits (84%, 77% and 67%, respectively) (Deutscher Bundestag, 1997; Schneider, 1999). In 1998, there was something of a decline in the choice of cash benefits: About 74% of the community-based population chose cash benefits, 11% chose in-kind services and 14% chose a combination of the two. Sixty percent of the most disabled group in the community chose cash only, compared with 80% of the least disabled group (Cuellar and Wiener, 2000).

Another major finding of the studies in Germany was that cash allowances were used primarily to supplement the family budget or reward family members, rather than to purchase the services of formal caregivers (Evers, 1997). In a survey conducted in Hamburg, the great majority of respondents (85%) cited the advantage of being able to use the funds without restriction (Runde et al., 1996). Examination of the effect of cash allowances on the extent of care provided by relatives in Germany revealed that family care remained unchanged. Families reported caring for their relative as they always had (Cuellar and Wiener, 2000). They perceived the cash allowance as a token of gratitude more than as a significant financial contribution. As noted earlier, cash allowances in Germany are lower than the monetary value of services in kind.

Some have criticized how cash allowances are provided. They claim that the disabled or their families are not able, and in many instances do not know how, to negotiate directly with service providers (Evers, 1997; Schneider, 1999). Moreover, a large proportion of beneficiaries have cognitive impairments and nevertheless receive cash benefits. In response to these concerns, a system has been instituted whereby beneficiaries electing cash are subject to periodic visits every four to six months, depending on disability level, to ensure
that adequate care is being provided. Schneider (1999) and Cuerall and Wiener (2000) argue that there is also a need to develop more counseling and care management services. At present, counseling services are not widely available and most beneficiaries and their families make their decisions on their own, or with the assistance of a direct service provider. Given the complexity of choosing appropriate services and negotiating and contracting with service providers, counseling may be needed to help consumers make more effective decisions.

The high proportion of beneficiaries choosing the cash option in Germany has been explained in part by lack of an adequate supply of services, but this needs further examination (as will be discussed below). In Austria, as well, it is argued that there is a lack of service supply; and the forecast is that Japan will face similar problems of lack of service supply in some areas, especially in the first stages of implementation.

In Austria, where only unrestricted cash benefits are provided, an evaluation study of beneficiaries residing in the community (who are 93% of all beneficiaries) revealed that 56% of those surveyed used one or more social or nursing services: 47% received services in their own home and 22% received services outside their home (Badelt et al., 1997). Among those receiving services at home, about 10% received home nursing, 17% home help and 14% meals-on-wheels. Service utilization varied greatly by region (ranging from 34% in Carinthia to 84% in Vorarlberg). These differences may be explained in part by gaps in the availability of services in some regions. Badelt et al. (1997) also found that of the 77% of primary caregivers who responded to a question about being reimbursed, 14% did not receive payment for performing caregiving duties, 27% (most of them spouses of the disabled person) reported that payment was incorporated into the household budget, 20% stated that they did not receive regular payments, and 40% received a regular monthly payment. About 88% of primary caregivers were family members, and most of them lacked professional knowledge and information. Seventy-two percent reported feeling strained, at least occasionally. To ease this situation and to ensure quality care, the Austrian Federal Ministry of Labour, Health and Social Affairs has been offering counseling for primary caregivers since 1 January 1998.

In Israel also there was initially a great deal of concern about the adequacy of the supply of services. The concern, however, has proven unjustified because after the implementation of the Community Long-term Care Law, there was tremendous growth in community services, particularly in for-profit organizations.

After 11 years of implementation of the Community Long-term Care Law, debate has again arisen over cash allowances. One of the factors behind the renewed debate is the increase in the number of elderly who employ 24-hour caregivers (usually foreign workers), at a cost well exceeding the value of in-kind services provided under the law. At present, such caregivers must register with an agency that is licensed to provide services under the law. The agency receives a payment for the caregiver from the social security administration and pays the caregiver half of what it receives from social security (taking part as profit and part to cover its expenses). The family makes up the difference in the caregiver’s salary. If families received a cash allowance directly from social security, they could purchase the service from non-organized workers at a lower cost. Therefore, some have proposed providing restricted cash allowances, to families that can prove they employ a caregiver around the clock, to be used only for the purpose of paying this caregiver. The proposal is being discussed at the Knesset, (Israeli Parliament).

The main services covered:

There are several options for the services to be provided under a long-term care law:
a. The package may include community services only, institutional services only, or a combination of the two. The advantage of including both types of services in the same programme is the flexibility this affords in providing the most appropriate care.

b. If covered, “community services” may include a limited number of services, such as personal care, or they may include a variety of services, such as skilled visiting nurses, home adaptations, or vacation days to families. The broader the package of services, the greater an individual’s choice and hence ability to address needs appropriately.

Countries differ in the range of benefits they offer under the law. Austria, Germany, the Netherlands and Japan cover both institutional and home care as part of their insurance schemes. Only Israel has chosen not to cover institutional care. This decision reflected in part a desire to place greater emphasis on community care (since institutional care was already covered by budgeted programmes and there was a shortage of community services), and in part a desire to contain costs.

Most of the countries offer a variety of community services, including personal care, housekeeping, and day care. In the Netherlands, Germany and Japan, the package of services includes respite care, assistive devices, care at night, and assistance with home adaptations. In Austria, the cash allowance enables people to purchase any services they see fit.

Several additional services are provided in each country:

In Germany, pension and accident insurance is awarded to persons providing high levels of unpaid services (at least 14 hours per week), and depending on the number of weekly hours of care they provide and their relative's level of eligibility, they are eligible for up to four weeks of vacation per year, during which time the law pays for a temporary institutional or other care arrangement (up to set rates); they are also eligible for training courses on informal care of the disabled.

In the Netherlands the package of benefits is very broad and includes services that are not long-term care in nature. Beneficiaries may receive care for mental disability (psychiatric consultation, hostels, day care centres, and institutions), dietary consultation, acute hospital care after 365 days, rehabilitation, care for blindness and deafness (tests, treatment, counseling and institutions), tests for metabolic disorders, vaccinations for children, and maternal counseling; under certain conditions transplantation of organs may also be covered (for a full description of benefits see: Ministry of Health, Welfare and Sport, 1998).

Israel's law also provides absorbent undergarments, emergency alarm systems, and laundry services.

The law in Japan includes skilled visiting nurses, rehabilitation, and medical supervision.

**Level of benefits:**

With the exception of the Netherlands, the countries set both minimum and maximum limits on benefits. The countries differ in the breadth of the range of benefits, however. In Austria, the highest benefit is ten times that of the lowest benefit, in Japan it is about six times, in Germany it is four times, and in Israel, the highest benefit for community services is 50% more than that of the lowest benefit. In the Netherlands, there is no formal benefit limit, but there are limits on some specific services, such as home nursing (Huijbers and Martin, 1998).

There is also a great deal of variation in these countries in the amount of care that can be purchased with the benefits. Though it is not possible to document the actual amounts for
all countries, the maximum level of benefits appears to be higher in the Netherlands and Japan than in Germany and Israel. In the Netherlands, the maximum number of hours of home nursing allowed is 3 hours per day; however, in special cases (such as terminally ill patients, or patients who are discharged early from the hospital), the amount can be extended to 8 hours for the duration of 3 months. Israel and Germany provide a maximum of about 2 hours per day for home help.

It is clear that in most of these countries the benefits cover only part of the needs. In Germany, for example, it is estimated that in 1995 a beneficiary at the substantial care dependency level would have needed a minimum of DM 2030 to cover full needs (that is a minimum of 90 minutes of assistance per day), while SDI home care benefits for this category were MD 750; thus the programme covered about 37% of needs. A beneficiary at the severe care dependency level would have needed a minimum of DM 4,100 in 1995 to cover full needs (a minimum of 3 hours of assistance per day), while the SDI was DM 1800, that is about 44 percent of needs. Finally, a beneficiary at the very severe level would have needed a minimum of MD 6,667 (a minimum of 5 hours of assistance per day), while SDI was DM 2800, that is, about 42 percent of needs. With regard to institutional care, in 1995 the benefits in Germany covered between 44% and 64% of the charges, depending on the location of the facility and the degree of dependency (Schneider, 1999).

In Israel, the first level of benefits provides 10 hours of care a week, but according to eligibility criteria, a person at this level needs 17.5 hours of care per week; thus the benefit covers about 57% of need. For the most severe cases, who need at least 45.5 hours of care per week, the benefit includes 16 hours of care per week and thus covers a maximum of 35% of the needs. In Austria, it is estimated that benefits cover about 4 hours of nursing care or 8 hours of home help for those at level one (who need a minimum of 50 hours of care per month). In other words, the benefit covers at most 16% of the needs of people in this category. For people at level seven (who need more than 180 hours of care per month), the benefits cover about 40 hours of nursing care or 80 hours of home help – that is, 44% of needs, at most. The Austrian benefit covers about 50% of the cost of institutional care. In Japan, the level of benefits is higher and is assumed to cover needs more broadly; for example it will cover nearly the full cost of institutional placement (Campbell and Ikegami, 2000). In the summary table we indicate the benefit levels in dollar equivalents.

As noted above, cash allowances are lower than the monetary value of in-kind services. For example, in Germany the cash allowance is between 45% and 53% of the value of in-kind services, depending on level of functioning. In Israel, where cash allowances are provided only when no services are available, the cash allowance is 80% of the value of in-kind services.

**Informal support:**

It is clear that the laws do not attempt to meet the full long-term care needs of the disabled but, rather, view the individual and the family as partly responsible for financing and directly providing care. The passage of a long-term care law implies a country’s commitment to reducing the burden of care on families, but not to replacing the family’s role. The question thus arises as to the effect of the laws on informal (family) care, and the extent to which formal services tend to replace family care.

Policy makers are often concerned that an increase in formal services will cause families to relinquish their caring responsibilities; however, the evidence, although limited, suggests that service provision does not reduce family care (Hanley, Wiener and Harris, 1991; Muscovice, Davidson and McCaffrey, 1998).

The experience of these countries also does not substantiate this concern. In Israel, no evidence has been found of a decrease in the amount of informal services as a result of the
provision of formal services. It appears that community services supplement rather than replace informal care. Yet caregivers' sense of burden is significantly reduced (Morginstin and Baich-Moray, 1992; Brodsky and Naon, 1993), because the availability of formal services gives family members a broader choice about what type of care they will provide. In addition, knowing that formal care is guaranteed by statute and therefore reliably available gives families a sense of security that enables them to continue caring (Brodsky and Naon, 1993). However, despite the improvements brought about by the expansion of formal services, many caregivers still feel a considerable burden because of the limits on benefit levels, and what they perceive as insufficient choice in the services to which they are entitled (Morginstin and Baich Moray, 1992; Brodsky and Naon, 1993; Brodsky and Morginstin, 1999).

Similarly, the findings of an evaluation in Germany show that families continue to care for their relatives as they did prior to receiving the cash allowance, which is perceived as a token of gratitude (Cuellar and Wiener, 2000).

6. Programme Operation

Auspices of service providers and availability of services:

One of the principles underlying all of the laws is a preference for community and home services over institutional care. In order to maintain low rates of institutionalization, it is necessary to ensure a supply of services.

To encourage service provision, the laws in all the five countries have eliminated barriers to the entry of the private sector into the long-term care market, thereby increasing competition among providers. Indeed, in all these countries the laws enable for-profit agencies to provide services alongside government agencies and NGOs. The agencies providing services are expected to maintain high professional standards (in the spirit of the public sector) and provide services in an efficient, cost-effective manner (in the spirit of the private sector). Of course, regulation is required to ensure quality.

In Israel, for example, there was a tremendous development of community services following implementation of the law, particularly by for-profit organizations. As a result, while personal care services were provided in the past by large, national, non-profit organizations, at present, 11 years after implementation of the law, about 60% of eligible elderly receive care from new for-profit service agencies.

It is worth noting that the CLTCI Law also established a fund (with a total budget of 10% of annual contributions) for the development of services by the Ministries of Health, and Labour and Social Affairs. These funds were initially viewed as temporary and were meant to ease the transition to the new law, but they have been continuously extended.

Nonetheless, service development has been perceived as a major issue in most of the countries reviewed. There have been reports of insufficient services and community infrastructure in Austria; although the government provides a cash allowance, it does not provide an adequate supply of services (Keigher, 1997). However, under a long-term care agreement between the federal government and the provinces, the provinces have undertaken to guarantee nationwide availability of social services by 2010. They will accomplish this in three stages, and they have already submitted their respective plans for closing existing gaps by that time (Federal Ministry of Labour, Health and Social Affairs, 1999).

Some have criticized the German law for its failure to reduce the shortage of services and increase investments in service development. It has been suggested that this is one of the reasons for the high utilization of cash benefits. Neither the government nor the private sector has succeeded in developing services in all geographic areas since implementation of
the law. While the for-profit market has developed in the wake of this measure, it has not kept pace with need (Schneider, 1999). Moreover, the assumption that provision of cash allowances will in itself generate competition among service providers is not always borne out. For example, in rural areas and small local authorities in Germany, one company may have a monopoly, precluding choice among service providers.

At the same time, however, the overall supply of services in Germany has increased and there is even an oversupply of personal care providers in some areas, in part due to the unanticipated number of people choosing cash benefits rather than services (Cuellar and Wiener, 2000). Though in the past most care providers were NGOs, at present 46% are for-profit agencies, 49% are NGOs and 5% government agencies. It has also been claimed that, to promote competition and keep prices down, any provider guaranteeing adequate care at a reasonable price is approved, regardless of actual need and demand (Scheil-Adlung, 1995).

In Japan, there is also concern about whether the quality and quantity of home and institutional services will meet demand. Many of Japan’s municipalities have not yet established sufficient facilities or administrative systems to cope with developments following implementation of the law (Gross, 1997, Seike, 1998).

**Responsibility for care planning:**

Care planning may be the responsibility of the individual and his family, or the responsibility of a third party. In Austria, the individual and family are responsible for planning care. In the Netherlands, the assessment team (RIO) reports its eligibility decision to the applicant, who then initiates self-referral to a service provider, who designs a programme of care in accordance with the guidelines of the assessment. Regional AWBZ offices have been taking increasing responsibility for ensuring that the programme of care is met. In Japan the responsibility for planning care may reside with the individual and his family, or with a care manager. However, for practical reasons, much of this responsibility resides with the care manager, since this prevents clients from having to pay for services out of their own pocket and wait for reimbursement. As noted above, care managers may be employees of organizations that provide services; therefore, it has been argued that the care planning process may have a tendency to favour certain providers. In Israel, a professional team (regional committee) is responsible for care planning. In Germany, the care funds that make the assessment are also responsible for care planning for those receiving in-kind services; however, the assistance provided in care planning is minimal and the provider organization itself actually makes a care plan (Schneider, 1999, Cuerrall and Wiener, 2000).

Clearly, in most countries the entity that assesses eligibility does not design the programme of care. This separation arose partly from a desire to ensure that assessment is objective.

**Quality assurance:**

There are a number of components of quality assurance: training and supervision of formal and informal caregivers, licensing of service providers according to defined criteria, establishment and regulation of quality standards, assistance with care planning, and the development of information systems to monitor processes and outcomes.

Some elements of the laws require new quality assurance strategies. In the case of cash allowances that may be used to purchase services from non-organized providers, or to pay family members, the only way to supervise quality is to monitor the extent to which the client’s needs are met. When services are purchased from organized providers, various demands related to quality can be made on the agency. The question of what quality assurance means when cash assistance is provided has not been adequately addressed. In
addition, since most countries encourage the role of the for-profit sector in service provision, effective quality assurance is essential.

Quality of care is the "weak link" in all of the countries, most of which have emphasized the need to develop clearer criteria for quality assurance and to increase regulation.

In Germany, the following criteria are used to determine an agency's eligibility to provide services: the agency must employ at least one registered nurse with at least two years practical experience, and the experience must have been obtained within the past five years.

According to 1994 legislation, providers in Germany undergo external regulation of quality by the care funds and sickness funds. In addition, providers must establish an internal system of quality assurance, which includes establishing 'quality circles', enabling institutional residents to provide feedback on the quality of their care (through specially designed questionnaires), and setting standards. Providers are also encouraged to take voluntary measures, such as holding quality assurance conferences or implementing voluntary certification programmes. In May 1996, care funds, central municipal associations, public authorities providing welfare benefits, and service providers jointly issued the first binding statement on quality principles and guidelines. These take into account the quality of the structure, process and outcomes of care.

Applicants who choose the cash allowance for personal care are obligated by law to undergo three inspection visits, the costs of which are partially paid by the client. The purpose of these visits is to ensure the quality of informal care, to update the client's knowledge of available services, and to advise informal caregivers. The visits are made by formal service providers, which raises the question of a conflict of interest, since providers may see inspection as an opportunity to advertise their services. A more rigorous definition of inspection has been proposed by Jansen and Kardorff (1996), based on case management principles (Boscher, 1999). Further, it has been suggested that the nurses responsible for inspection need special training (Gro, 1998 in Boscher, 1999). The law also obligates care funds to offer free training classes to informal caregivers.

In the Netherlands, a number of systems of quality assurance are used. There is periodic formal inspection of service providers by a representative of the health care system, and providers themselves use internal quality control mechanisms to assess services; it is in their interest to present themselves as providing high quality services, given the competition among providers. The law mandates that every service agency have a consumer council. Currently efforts are under way to enhance these systems. Tools for inspection and regulation are being developed (Huijbers, 1999), and the federal government is planning to increase regulation by setting price and quality standards (Coolen and Weekers, 1998).

Israel employs several mechanisms of quality assurance: licensing of service providers, structured training of home care workers, the development of standards of quality, and the establishment of quality assurance mechanisms. For example, Israel's social security administration has invested considerable effort in the development of structured training courses for personal care workers in the home. The first such courses provided 106 hours of training. An effort was then made to reduce the cost and enhance the efficiency of these courses. At present, a 50-hour course emphasizing basic caregiving and communication skills is offered. Personal care workers may also attend supplementary courses that increase their skills and train them to care for specific populations, such as the severely disabled elderly or the mentally frail (Korazim and Kahan-Strawczynski, 1997). It should be noted that participation in these courses is not mandatory.

Israel's law stipulates that care be provided only by agencies licensed by the Ministry of Labour and Social Affairs. These agencies are required to submit the qualifications of their
personal care workers for inspection by social workers, nurses, or senior personal care workers. The agencies also provide in-service training to every new personal care worker. While there are no uniform standards regarding the extent of training and there is a great deal of variance in the training provided by different agencies, training is widespread. Moreover, standards of quality have been developed for personal care workers, and these have been disseminated in three languages (Hebrew, Arabic and Russian). All of the agencies providing personal care use them as a training tool. Nevertheless, there is still no regulatory mechanism based on these standards.

The National Insurance Institute monitors long-term care in two ways: through random interviews with the elderly in their homes to examine whether beneficiaries are receiving the appropriate quantity and type of services, and to determine their satisfaction; and through an organizational review of service providers. The review includes the payments to personal care workers and is designed to ensure that all the social benefits covered by wage agreements are paid. These reviews are conducted annually on about one-third of the service providers, so that each provider is reviewed at least once every three years. Those providers who are found deficient are reviewed again the following year.

Interestingly, Israel’s social security administration has implemented a programme in which volunteers monitor beneficiaries under the law. These volunteers call the beneficiaries and ask them whether they are satisfied with services and whether there are any problems with service providers; if there are, they are reported to the social security administration. The programme has been quite successful in identifying problems.

Day care centres providing services under Israel’s Community Long-term Care Insurance Law must also be licensed to provide services. The Ministry of Labour and Social Affairs is responsible for licensing, as well as for inspection based on standards of quality developed in recent years (Korazim and Kahan-Strawczynski, 1997).

7. Finance

The entitlements provided by the LTC laws may be financed in a number of ways: a special payment or premium, general taxation, a co-payment for the use of services, or some combination of these. All of the countries except Austria have established special payments to a fund that is separate from the financing of other health and welfare services. This fund is generally supplemented by general taxation and co-payments.

Special premium (employee/employer contributions):

In all of the countries except Austria, employees and employers contribute to financing the law, and the contribution is a percentage of taxable income.\(^{34}\)

In the Netherlands, the employer pays the lion’s share of the premium (9.6%) for incomes of NFL 8,600 - NFL 47,000. Those who have a higher income pay a flat rate.

In Germany, a 1.7% premium is divided equally between employer and employee. However, employers are compensated for their share in the payroll tax by designation of a holiday as a working day. There is a ceiling of DM 6,375 in the former West Germany and DM 5,400 in the former East Germany.

In Israel, employees pay more than employers (the premium rate is 0.16%). However, the Israeli programme is in deficit: its actual costs are much greater, and are financed by surpluses in other branches of social security.

\(^{34}\) Premium contributions for the self-employed may be different, and the premiums for those who are not employed may be covered by other funds.
In Japan, persons age 40-64 pay a premium of 0.9% of their monthly income, shared with their employer, up to a ceiling, and persons age 65 or over have the premium deducted from their public pension, using a special sliding scale.

The countries differ in regard to contributions from elderly people who are not employed (that is, who have retired). In Germany, retirees pay half of the premium, while in Japan retirees participate in the premium (although some changes have been made in the past few months, including a short term freeze on premiums to be made up by extra budget money [Campbell and Ikegami, 2000]). In Israel, retirees are not required to pay.

**General taxation:**

In all of the countries except Germany, the federal government participates in financing the system through general taxation, though the role of general taxation differs from one country to another. In Austria, for example, the system is financed entirely by general taxation\(^{35}\); in Japan, 50% of the cost is funded by general taxation (half of general taxation is national, 25% is prefectural and 25% municipal); and in Israel, about 20% of the cost is financed by general taxation (to cover those who have not accumulated a minimum residency period, such as new immigrants).

**Co-payments:**

Services are financed in part through co-payments. Some countries require co-payments for all services (the Netherlands, Japan), while others (Austria, Germany) require co-payments only for institutional services. Israel does not require co-payments for the community services provided under the law. In addition to their contribution to financing, co-payments can serve as a means of cost containment, by restraining utilization. On the other hand, they may deter some people from using the services they need.

**8. Coverage**

The summary table provides data on the number of beneficiaries (the most current data available are presented for each country).

In Austria, there were a reported 324,000 benefit recipients in 1998, or 3.9% of the total population. The majority (83%) of recipients were age 61 or over, representing about 17% of all of those age 61 and over. In Germany, there were a reported 1.8 million benefit recipients in 1999, or 2.19% of the total population. The majority (78%) of recipients were age 65 or over, representing 9.6% of all those age 65 and over (Deutscher Bundestag, 1997). The German rate appears low given the fact that the eligibility threshold is similar to Austria and the figures include both community and institutional care. In Israel, 1999 reports cited 88,000 benefit recipients, or 12.0% of the elderly (women age 60+ and men age 65+). The Israeli rate is high given that it does not include recipients of institutional care. In Japan, where the law has only recently been implemented, it was estimated that 2.7 million elderly people, comprising 12.4% of the elderly population, would be eligible for benefits in 2000. This estimate would seem low, however, in light of the broad benefit package and the low eligibility threshold. It was assumed that, of those living in the community, only one-third would apply for benefits. Therefore, it was estimated that there would be 1.35 million beneficiaries during the first year of the law’s implementation - 6.2% of the elderly population (Campbell and Ikegami, 2000). No estimations were available for those aged 40 to 64. As of March 31, 2000, 2.5 million elderly had applied, of whom 1.8 million (about 8% of the elderly) already had a care plan (6% of the elderly are in institutions). It is thought that

\(^{35}\) However, the sickness insurance contributions of employers and employees were raised in 1993, so as to finance the extra costs incurred through the long-term care allowance.
most of those eligible for benefits have already applied. Moreover, the government has not altered its spending forecasts, since it believes that not all of the benefits will be accessed because of the 10% co-payment demanded of beneficiaries (Ikegami, 2000).36

In the Netherlands, no data were available on total recipients. From data on utilization rates by type of service, it may be estimated that a minimum of 20% of the elderly received institutional or community care.

Although these data give some indication of differences in coverage, we do not have a basis for comparisons with the percentage potentially in need in each country.

9. Cost

The cost of the various laws is compared in the table as a percentage of Gross National Product (GNP). Germany and Austria devote about 0.9% of their GNP to the long-term care system. Israel spends the smallest portion of its GNP - about 0.36%, since the law covers only community care for the elderly. The Netherlands spends the most on its law, with up to 3.6% of its GNP devoted to expenditures related to this programme. The much higher cost of benefits in the Netherlands reflects the much broader benefit package, which includes a number of medical and related health services and therefore cannot be compared to packages in the other countries. In Japan, where the law has just been implemented, it was estimated that the cost for the year 2000 would be about 1.3% of GNP.

As noted earlier, the Israeli programme is in deficit, as its actual costs are much greater than contributions. The deficit is financed with surpluses from other branches of social security. Efforts are being made to identify the reasons for the deficit and address this problem. The reliability and validity of the assessment of eligibility for benefits are being re-examined. And efforts are being made to strengthen the periodic reassessment of functional status, so as to ensure that only those who are eligible for benefits continue to receive them. To date, however, reassessment has been problematic for bureaucratic reasons. Furthermore, some have questioned the cost-effectiveness of reassessment and the balance between the frequency of reassessment, its cost, and the savings from the expected reduction in the number of beneficiaries (Zipkin and Morginstin, 1998). A very recent amendment to the law places a two-month limit on benefits to people whose profile indicates that their need for care may be short - such as those discharged from an acute hospital. After two months, a client may reapply if he still needs benefits.

Germany’s Social Dependency Insurance has not been running a deficit. In fact, it has produced surpluses, partly because cash payments are lower than the monetary value of in-kind services, and a higher than expected share of cash transfers has helped keep the budget within its prescribed limits.

In the Netherlands, expenditures under the Exceptional Medical Expenditures Act (AWBZ) have increased during the past several years. It has been suggested that this is a result of the transfer of numerous services to the AWBZ budget, and the concomitant reduction in expenditures elsewhere in the health care system (Huijbers and Martin, 1998).

Although Japan is just beginning to implement its law, concerns have been raised that costs and spending will turn out to be higher than has been officially estimated (Campbell and Ikegami, 2000). Many Japanese fear that in the event of a deficit, benefits will be reduced and/or premiums will increase (Ikegami, 1997; Gross, 1997, Campbell and Ikegami, 2000).

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36 This assumption is based on the fact that, prior to implementation of the law, 70% of recipients of home care services paid nothing, because their income was very low. It is anticipated that many of these people will find it difficult to meet the 10% co-payment (Ikegami, 2000).
In most countries, the law has in part replaced existing alternative sources of support. For example, in Germany the municipal budgets for social assistance for long-term care have declined since the implementation of the SDI (Schneider, 1999; Cuellar and Wiener, 2000). In The Netherlands, as mentioned above, the high expenditures are a result of the transfer of medical and health related services to the AWZB basket of services, with a reduction in expenditures elsewhere in the health system (Huijbers and Martin, 1998). In Japan, a high percentage of the elderly in need of institutional long-term care have been financed by health insurance; these services will now be covered by the long-term care law. Indeed, cost replacement is expected to cover much of the cost of the new law and introduce more control over cost increases. In Israel, before the implementation of the law, the sick funds and the Ministry of Health provided home care for the disabled elderly.

**Substitution of community for institutional care, and of long-term care for acute hospitalization:**

As noted earlier, all of the countries discussed in this paper have been challenged to meet the long-term care needs of the disabled while containing costs. One of the hopes of those planning the programmes was that the broader availability of services would reduce the utilization of acute care hospitals and long-term care residential facilities. Below, we briefly examine these issues in the various countries based on the limited available evidence.

Since the cost of an acute hospital stay is a very significant component of total health expenditures, policymakers have tried to reduce hospitalizations of the elderly. One problem is the difficulty in discharging from an acute care hospital a disabled elderly patient who needs long-term care, but for whom there is no appropriate institutional or community solution. Authors of the long-term care laws in the different countries expected that these laws would help to reduce hospitalizations.

In Japan, for example, one problem with the system of care for the elderly was the overuse of hospitals by people needing long-term care. This circumstance arose due to a lack of financial barriers to hospital-based long-term care, along with the absence of a negative stereotype associated with hospital care and the absence of a role for general practitioners as ‘gatekeepers’ (Ikegami and Campbell, 1995). Many elderly who needed care avoided using the welfare system, turning instead to the more expensive services offered through the health insurance system (Ihara, 2000). The Japanese concept of hospitalization has traditionally differed from the Western one: Patients with chronic illnesses who in the West would be placed in nursing homes have in Japan always been treated as in-patients in hospitals. In fact, three-quarters of Japan’s population age 65 and over who need institutional care are in hospitals (Ikegami, 1997). Furthermore, the average length of hospital stay is quite long (Nakahara, 1997): one-third (32%) of the elderly in Japan’s hospitals remain there for more than a year. Long-term care has thus come to be provided through health insurance, and the fiscal situation of insurers has deteriorated due to the long-term hospitalizations of elderly patients. Further, alternative institutional solutions have not developed. The perception that the system of care was not functioning efficiently, and that long-term care needs were therefore not being adequately addressed was a major impetus for the reform of Japan’s system of long-term care.

In Austria, a strict distinction is made between the need for acute care and the need for long-term care. Nevertheless, people often remain in the hospital if no nursing home beds are available. This is estimated to account for between 5% and 10% of hospital bed days. A major purpose of the long-term care allowance and the expansion of social services (community, semi-institutional, and institutional care) is to ensure that such people are discharged from the hospital and can be looked after at home or in a nursing home (Rubisch et al., 1998).
In addition, there has been a move to increase the provision of community long-term care and reduce the need for more costly institutional care. "Aging in place" is perceived as preferred by the elderly and, in the majority of cases, as a less expensive alternative to institutional care. In Israel, one of the stated aims of the Community Long-term Care Insurance Law is to reduce the need for institutional care. In Austria and Germany, a co-payment is levied on people entering a long-term care institution. In Germany, beneficiaries are required to pay at least 25% of the cost of institutional care, so as to keep institutional care from becoming financially preferable to personal home care (Schneider, 1999). The majority of beneficiaries in Germany have opted to stay in the community. As of July 1997, about 1.6 million people were receiving benefits under the SDI Act. Approximately 1.2 million people (74%) were receiving benefits for care at home and approximately 430,000 people were receiving benefits for care in an institution.

The extent to which the long-term care laws have influenced patterns of referral to institutions has depended in part on the extent and type of care provided in the community. When the extent of services is limited, these services are less likely to offer an alternative to institutionalization, particularly for the more severely disabled elderly. In addition, a problem in several countries is the lack of an adequate supply of community services, without which it is not possible to offer community care as an alternative. Over and above the availability of community services, other factors may affect an elderly client's ability to choose between community and institutional services, including the supply of beds and the amount of co-payments for institutional care.

In Israel, two studies have looked at whether the law affected the demand for institutional services. The first was conducted one year after implementation of the Community Long-term Care Insurance Law, and the second four years after implementation of that law. The findings of the first study indicated that, contrary to expectations, there was a significant increase in the number of applicants for institutional placement immediately following implementation of the law. This may have been a result of better access to the service system, since the law led to a great number of applications for assistance, increased contact with professional caregivers (through assessment of eligibility), and greater awareness of existing services - particularly institutions. Thus the decline in the need for institutional placement resulting from the law was probably offset by the increased demand for assistance resulting from the discovery of new cases among the very disabled. This implies that the law helped identify and refer severely disabled elderly clients - who had hitherto gone unrecognized by caregiving authorities - to institutional care (Naon, Factor and Primak, 1993).

The second study was conducted in 1992, four years after the law's implementation. Its findings showed a significant change in the patterns of institutionalization of moderately disabled, or frail elderly. The total number of frail elderly residing in institutions and waiting for placement was 25% less in 1992 than in 1987 (prior to the law's implementation). The findings also showed that following the law's implementation, those frail elderly who applied for institutional placement suffered from more severe physical and cognitive problems, were older, and included a higher proportion of widows and widowers than did frail elderly applicants prior to the law's implementation. However, there were no significant changes in the characteristics of the more severely disabled who were institutionalized, probably because their condition was extremely serious even prior to the law's implementation. There were also no further significant changes in the proportions of severely disabled who were institutionalized. Thus, the findings of this study showed that among the frail elderly, significant changes in the patterns of institutionalization indeed occurred following implementation of the Community Long-term Care Insurance Law in Israel. The use of services under the law enabled the less severely disabled to remain in their homes and avoid institutionalization (Naon and Strosberg, 1995). There is also evidence of a continuing decline in applications for institutionalization by elderly people with moderate
disability. The lack of impact on the severely disabled has been attributed to the relatively low level of the benefit.

In the Netherlands, an explicit goal of AWBZ was to prevent institutionalization. And indeed, institutionalization rates have dropped from 10% in the 1970s to less than 7% in 1995, in part due to the creation of national standards for the supply of long-term care beds (de Klerk, Huijsman and Rutten, 1995). However, constant changes in the law have made it difficult to evaluate its effects, and because there has been no systematic evaluation of the law, we do not know what part it played in the reduction of institutionalization rates. Nevertheless, the Netherlands has actively implemented and evaluated experimental programmes aimed at reducing institutionalization (Peterson and White, 1989; Alter and Hage, 1993; Baldock and Evers, 1991). For example, the Dutch government has supported the development of experimental programmes that allocate personal budgets, expand services (e.g. sheltered housing, intensive personal care, and short-term institutionalization), and increase cooperation among service providers. Experiments conducted in Groningen, Rotterdam, Nieuwegein, and Venlo show that some substitution of community for institutional care is possible (Evers and Leichsenring, 1994; Coolen, 1995; de Klerk et al., 1995).
C. SUMMARY AND EMERGING ISSUES

The countries presented herein were chosen because they provide long-term care services through programmes based on entitlements. This approach is in contrast to most developed countries, which provide long-term care services through programmes that are characterized by means tests and well defined budget constraints.

Many issues of design arise in implementing an entitlement approach; consequently, there is considerable variation in the way in which these programmes have been implemented. The similarities and differences are briefly summarized below.

Similarities

The programmes are similar for the most part (in at least 4 countries), in that they

1. Create separate programmes, rather than integrate them into existing health insurance programmes.

2. Designate premiums shared by employees and employers to finance the programme, complemented by general taxation.

3. Place general responsibility for the new long-term care programme under agencies that were already responsible for health services.

4. Confine eligibility criteria to functional and health status, rather than considering the degree of family support.

5. Do not attempt to cover all of the disabled and their needs. Rather, they cover only those above a defined minimum level of disability (those who need help with IADLs and ADLs, but not with IADLs only) and therefore do not include all those who need long-term care. They attempt to exclude those who have only a short-term need for long-term care. They also do not attempt to cover all long-term care needs but, rather, prefer covering a portion of these needs, either by limiting the package of services and/or by limiting the total benefits per recipient. They all view the individual as responsible for financing part of his long-term care costs, and the family as responsible for providing some direct care.

6. Include disabled people of all ages in one programme.

7. Base eligibility on disability, independent of the reason for the disability – whether mental, physical or sensory.

8. Provide services according to universal principles, and therefore avoid using means tests.

9. Standardize the assessment of eligibility and the package of services, and develop structured assessment tools, establish distinct eligibility levels, and provide special training to the professionals making the assessment. These actions diminish discretion and promote objectivity. In some countries, the desire to promote objectivity is reflected in the assignment of assessment to an external body, rather than to the insuring agency.

10. Assign the implementation of assessments to health professionals (nurses, physicians).

11. Use individual professionals rather than teams of professionals to perform the eligibility assessment.

12. Provide a broad package of services, including both institutional and community care, in one programme. The majority of recipients remain in the community.
13. Promote the development of service providers from the NGO and for-profit sectors, rather than relying on public provision.

**Differences**

1. The number of levels of disability, which define the scope of entitlement, range from two levels in Israel to seven levels in Austria. The number of levels of care determine the sensitivity of the level of benefits to needs; i.e. fewer resources are provided to those who are less disabled and more resources go to those who are more severely disabled, within the same budget.

2. Provision of professional assistance in developing a care plan differs considerably.

3. Co-payments exist either for all services, or only for institutional services.

4. The value of the limits to benefits, as reflected in the amount of services that can be purchased, also varies.

5. The approach to cash allowances varies, but there is an increasing tendency to make them available, at least as an option. The cash option itself is either unrestricted, or restricted to the purchase of services from formal or informal providers.

6. The division of responsibility for financing, between employers and employees and between payroll contributions and general tax revenue, differs considerably.

7. The countries differ in the extent to which they provide additional complementary long-term care services to those who are eligible but have low income and little family support. They also differ in the extent to which these complementary systems are integrated conceptually into the programme.

**Major lessons**

From the experience of these countries there emerge a number of general lessons. We highlight some of the most important of these.

A basic design issue that emerges from the variation among the laws is the extent to which needs should be addressed, as reflected in the level of benefits. This determination depends on the view of the appropriate and expected roles of the disabled person and his/her family.

Beyond introducing an entitlement, these countries have made major commitments to significant change in long-term care policies. They have thus made a significant commitment to:

1. Allocate greater resources to long-term care.

2. Develop systems of long-term care that integrate home and institutional care, social and health services and the care of the disabled across the life span.

3. Shift the balance between community and institutional care by making considerably greater resources available for community services.

4. Allocate central funding for long-term care, so that access to services is less determined by local resources and priorities.

5. Empower consumers by providing greater choice among types of services and service providers.

6. Encourage families to continue caring for disabled and elderly relatives by sharing with them the responsibility and the burden of care.
The countries have employed several broad strategies that are worthy of consideration.

- A concern with the availability of services is common in all the countries. A common strategy to expand service availability has been to encourage for-profit agencies to enter the long-term care market. The availability of services is a key prerequisite for both the successful provision of services in kind and the effective use of cash benefits.

- While increasing the range of service providers, competition is restricted to quality and not price (which is mostly fixed). This reflects an effort to avoid the emergence of separate services for the rich and the poor, and to control costs.

- The countries use a range of methods to limit costs. They include setting minimum disability levels for eligibility, setting maximum benefit levels and requiring co-payments. In addition, Israel uses a means test (albeit a liberal one) and the Netherlands takes into account family support. This illustrates that in entitlement programmes that do not have budget limits, there are a range of alternative mechanisms to contain costs.

- The basic strategy adopted by most of the countries has been to provide coverage of a greater number of people rather than providing more intensive services to a smaller group. This clearly implies that there is not a commitment to meet the full needs even when no other source of care is available. The case of the Netherlands is different: it does not set limits to the total benefits of the recipient, but limits the maximum amount of specific services (home nursing). It also considers the availability of family support when determining the amount of services to be provided. The Netherlands is an interesting example of combining an entitlement with a discretionary process of assessment of eligibility.

There are also important components of these systems that require much further development and attention:

- Significant efforts have been made to standardize and ensure objectivity in eligibility assessment. However, given the importance of the assessment tools, we were surprised to find little reference to efforts to evaluate their reliability. One of the key features is the number of eligibility levels and these vary significantly across the countries; this too requires more analysis and evaluation.

- The extent and nature of the efforts to ensure quality and prevent abuse vary significantly across the countries and there is a general feeling that much greater efforts are required to more effectively and efficiently ensure quality. The question of what quality assurance means when cash assistance is provided has not been adequately addressed.

- The countries are experimenting with a range of approaches to the choice between in-kind and cash benefits including combinations of the two. Our analysis points to the importance of carefully defining each of these options. For example, in-kind services can be provided with more or less allowance of consumer choice and autonomy. In addition, some countries use the term cash benefits even when use of the cash is restricted to purchase of services. The services purchased may or may not include services by relatives. Thus countries’ experiences pose a variety of options to consider. However, the outcomes of their experiences are subject to different interpretations, and many questions remain unanswered. This is clearly a design issue that requires much further study.

- Countries are experimenting with different forms of contracting and subcontracting service provision. This is another area needing much further study.

- Providing financial support, whether in cash or in kind, is not sufficient to assure that disabled persons will obtain the most appropriate services. The need to find better ways
to coordinate access to fragmented service delivery systems, and the need to provide
information and counseling are major challenges in all the countries.

- The entitlement programmes that we have analysed do not always represent the only
available source of public assistance for long term care. The countries offer services that
can provide supplementary assistance for those eligible under the law, as well as services
to those who are not eligible. However, the countries do not always provide an
integrated view of how the entitlement programme fits with other, non-entitlement
sources of help. It is important to address the long-term care system in a more
comprehensive way.

- One of the basic concerns of those who question or oppose the entitlement approach is
concern that the cost will be much beyond projected levels and will be subject to a
dynamic of constant increase. In Germany this has not materialized as a problem, while
in Israel it has become a major issue. Unfortunately, the data available on the various
systems is not sufficient to fully address this issue.

It is clear that the countries reviewed in this report have placed long-term care at the
forefront of their national political agendas. In delineating the nature and specific
components of their long-term care programmes, the countries have had to choose from
among alternatives that have different implications for meeting the needs of the disabled
and for costs. The options include the target population and eligibility criteria; the type of
benefit (cash allowances, services in kind, or both) and services offered (community care,
institutional care, or both), as well as the range of services and level of benefits; and the
organizational structure and responsible insuring agency (i.e. whether long-term and acute
care are organizationally and financially linked or discrete). We have described how each
country has made its choices, and have highlighted their potential ramifications. We have
also alluded to major aspects of implementation that need further attention, such as quality
assurance mechanisms, counseling for clients and family caregivers on the availability and
choice of services, and the need to develop satisfactory coordination mechanisms among the
various components of the health and social systems and between acute and long-term care.
In some of the countries, there is also a need to invest more in developing appropriate
service infrastructure and trained manpower.

Unfortunately, the ability to learn from the experience of these countries is limited by
the lack of adequate systems for monitoring outcomes and evaluating implementation. As
these programmes continue to develop, more attention will hopefully be given to systematic
efforts to evaluate their experience and share it with other countries.
D. A REVIEW OF LONG-TERM CARE IN FIVE COUNTRIES

1. Austria

Background

As of 1999, Austria had a population of 8.11 million, 1.2 million of whom (15.4%) were age 65 or over and nearly 560,000 of whom (7%) were age 75 or over (International Data Base, 2000). It is estimated that the proportion of elderly people in the population will reach 16.5% by 2010, and 21.5% by 2025 (United Nations, 1998).

The elderly support ratio in relation to the working-age population (that is, the number of persons 65 and over per 100 persons age 20 to 64) stands at 25, and it is expected to reach 37 by 2025. Life expectancy at birth is 80.99 years for women and 74.52 for men (International Data Base, 2000), and life expectancy at the age of 65 is 18.8 years for women and 15.2 for men (World Health Statistics Annual, 1996). Disability-adjusted life expectancy at birth is 74.4 years for women, and 68.8 years for men; expectation of disability at birth is 6 years for women and 5.6 years for men (World Health Report, 2000).

One consequence of this increase in the number of elderly is an expected increase in the number of people needing long-term care. It is estimated that in 1995, about 284,000 people aged 60 and over needed some long-term care. Significant differences in the aging of the population and the concomitant need for long-term care services are forecast for the federal provinces. For example, the number of residents of Vienna requiring long-term care is expected to decline by more than 10% by 2020, but the number of residents of Salzburg and Tyrol needing long-term care is expected to increase by about 70% by that time, and the number of residents of Vorarlberg needing long-term care is expected to increase by 100% (Rubisch et al., 1998).

At the same time that the population of elderly is increasing, the ability of the family to care for elderly relatives is decreasing, due to the increased labour force participation of women, the growing divorce rate, increased mobility, and the growing proportion of people living alone (Rubisch et al., 1998). The parent support ratio – that is, the number of those age 80 and over per 100 persons age 50-64 – stands at 19, and will reach 28 by 2025. This provides a rough indication of the expected burden of care. The parent support ratio by females (the ratio of those age 80 and over to women age 50-64) stands at 38, and this will reach 56 by 2025 (International Data Base, 2000). In other words, fewer women will be available to care for the increasing population of elderly.

Until January 1994, statutory sickness insurance provided benefits only in the event of acute illness; long-term care was not covered. This led people needing long-term care to use acute hospital care. It is estimated that they accounted for 5%-10% of acute hospital bed-days. One reason for changing the Austrian system of care and expanding social services was to curtail this use of acute hospital services (Rubisch et al., 1998).

In addition, long-term care services were provided by social welfare agencies at the discretion of the federal provinces and they were limited in scope. The level of services provided and the criteria for receiving them differed among the provinces due to their uneven tax bases and independent sovereignty, and the provincial governments could not be equalized without federal assistance.

Advocacy organizations for the disabled lobbied to improve long-term care services and standardize eligibility criteria across Austria. At the same time, public criticism arose in provinces that had difficulty meeting the costs of long-term care, especially among the elderly and their families, who found it difficult to pay for care (Evers et al., 1994). These
factors led the federal government to an attempt to find ways to standardize and fund the equitable provision of long-term care (Keigher, 1997; Rubisch et al., 1998).

**The Long-term Care Allowance Act**

Austria has enacted two laws: The Federal Long-term Care Law, which covers people who are entitled to social security pensions (90% of the population), and the Provincial Long-Term Care Law, which covers the remaining 10% of the population. In January 1993, the Austrian parliament ratified the Long-term Care Allowance Act. An agreement between the federal and provincial authorities was signed in May 1993, and the Federal and Provincial Act went into effect on January 1, 1994. Thus the uniformity of long-term care allowances is guaranteed throughout Austria.

The Long-term Care Allowance Act introduced a cash allowance to which there is statutory entitlement. Under the Act, those eligible for long-term care are given a cash benefit, which may be used to purchase formal services or pay informal caregivers, or used for any other purpose, at the client’s discretion. The goals of the law are to help people remain at home for as long as possible by enabling them to receive appropriate services, and to help them make the transition to an institutional framework when necessary. The benefit is designed to increase the recipient’s sense of autonomy and self-determination, and relieve the financial and emotional burden of informal caregivers, most of whom are women. In addition, the cash benefit was intended to create demand that would spur the development of local services and improve the standard of services (Evers & Leichsenring, 1994; Keigher, 1997).

**Insurer:** The Federal Ministry of Labour, Health and Social Affairs grants the long-term care allowances.

The provincial authorities make arrangements for decentralized development and expansion of community and institutional services so as to extend full geographic coverage while maintaining minimum standards. To ensure that enough staff are available for home care services, the federal and provincial authorities have agreed to improve staff training and working conditions.

**Eligibility:** Eligibility is based on disability, independent of the reason for the disability – whether mental, physical or sensory; eligibility is not based on financial status or the availability of family assistance.

Eligibility is granted to people who have a need for personal care for at least six months and need more than 50 hours of care per month. Eligibility is granted to those age three or older; however, in cases of extreme hardship, the benefit may be granted at a younger age.

The law distinguishes seven levels of disability based on the assistance required with activities of daily living (ADLs) and instrumental activities of daily living (IADLs – e.g. housekeeping and shopping), translated into the extent of need for care per month (see Table 1). People with Level I disability need between 50 and 74 hours of assistance, while people with Level IV disability need more than 180 hours of assistance per month.

In addition, certain types of disability automatically classify an individual at particular level. For example, people who need a wheelchair are classified as having at least Level III disability, people who are blind are automatically classified as having Level IV disability, and people who are both blind and deaf are automatically classified as having Level V disability.
Table 1: Disability Levels

<table>
<thead>
<tr>
<th>Level of disability</th>
<th>Hours of care needed per month</th>
</tr>
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<tbody>
<tr>
<td>I</td>
<td>50-74</td>
</tr>
<tr>
<td>II</td>
<td>75-119</td>
</tr>
<tr>
<td>III</td>
<td>120-179, including persons with severe sight impairment</td>
</tr>
<tr>
<td>IV</td>
<td>180 or more, including blind persons</td>
</tr>
<tr>
<td>V</td>
<td>180 or more, needing an unusually high level of care, including deaf and blind persons</td>
</tr>
<tr>
<td>VI</td>
<td>180 or more, needing permanent supervision or comparable level of care</td>
</tr>
<tr>
<td>VII</td>
<td>180 or more, practical immobility or comparable condition</td>
</tr>
</tbody>
</table>

*Eligibility Assessment:* At present, eligibility is assessed and level of disability determined by private physicians; in the future, nurses and other professionals will be involved in this process. Screening of applicants is carried out by the same authorities that dealt with granting helpless persons' allowances and related benefits before implementation of the new long-term care programme.

A study by Badelt (1997) showed that about 68% of beneficiaries were satisfied with the category in which they were classified.

*Benefits:* As noted earlier, people needing long-term care are given an unrestricted cash allowance. The benefits, by level, range from about $160 to $1,686 (see Table 2). Benefit payments are made 12 times a year and are tax exempt.

Table 2: Disability Levels and Benefits Awarded

<table>
<thead>
<tr>
<th>Level of Disability</th>
<th>Payment per Month (in US$)</th>
<th>Payment per Month (in ATS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>160</td>
<td>2,000</td>
</tr>
<tr>
<td>II</td>
<td>295</td>
<td>3,688</td>
</tr>
<tr>
<td>III</td>
<td>455</td>
<td>5,690</td>
</tr>
<tr>
<td>IV</td>
<td>683</td>
<td>8,535</td>
</tr>
<tr>
<td>V</td>
<td>927</td>
<td>11,591</td>
</tr>
<tr>
<td>VI</td>
<td>1,264</td>
<td>15,806</td>
</tr>
<tr>
<td>VII</td>
<td>1,686</td>
<td>21,074</td>
</tr>
</tbody>
</table>

*Calculated by the authors (according to 1988 exchange rates, ATS 12.5=$1.00)*


Recipients continue to receive the benefit even after entering a nursing home. Recipients in the home can keep some pocket money from their public pension, as well as 20% of the long-term care benefit. The long-term care benefit is terminated, however, if the recipient is hospitalized in an acute hospital for 4 weeks or more.

The cash allowance is intended to enhance consumer independence. It may be spent in any way the beneficiary believes will meet his or her health and/or personal needs. Generally the money is used to pay an informal caregiver, or to purchase formal personal care assistance or housekeeping and escort services (Badelt, 1998).

A beneficiary deemed “not capable of running his/her affairs” may have a legal representative appointed to manage the money on his/her behalf (Evers et al., 1994).

About 7% of beneficiaries are in an institution, and their benefits are transferred directly to the provider, as noted above. An evaluation of beneficiaries residing in the community revealed that 56% of those surveyed use one or several social or nursing services...
(47% received services in their own home and 22% receive services outside their home). Among those who receive services at home, about 10% receive home nursing services, 17% receive home help services, and 14% receive meals-on-wheels. Service utilization varies by region, ranging from 34% in Carinthia to 84% in Vorarlberg. These differences may be explained in part by gaps in the availability of services among regions (Badelt et al., 1997).

It is important to note that benefits are not meant to cover all needs but, rather, are designed to cover part of the actual cost of care. For example, it is estimated that benefits cover about four hours of nursing care or eight hours of home help for those with a Level I disability (who need a minimum of 50 hours of care per month). In other words, the benefit covers at most 16% of the needs of people in this category. For people at Level VII (who need more than 180 hours of care per month), the benefit covers about 40 hours of nursing care or 80 hours of home help - 44% of need, at most. The Austrian benefit covers about 50% of the cost of institutional care.

**Providers:** Services are provided by NGOs, non-organized workers, and family members. NGOs provide about 90% of community services. As noted above, the provincial authorities are responsible for service development and supply. Based on an agreement between the federal government and the provinces, the latter have agreed to provide community and institutional services that meet a minimum standard. To ensure implementation, the provinces have also agreed to perform needs assessments and draw up a plan for reducing the gaps between need and supply by the year 2010.

The Federal Ministry of Labour, Health and Social Affairs oversees the programme. Beneficiaries are required to file reports on the care they purchase with the allowance (Keigher, 1997). Local authorities have the power to reduce or terminate a recipient's funding, or to provide care directly if an individual is reported to be badly neglected. However, according to Furstl-Grasser et al. (1999), such cases are very rare.

**Finance:** A unique feature of the long-term care programme in Austria is that it is financed from general tax revenues, rather than from a special contribution, as are other social insurance programmes. Despite the use of general taxation, there is a personal entitlement and the programme has no budget restrictions. It is important to note that employee and employer sickness insurance contributions were increased in 1993, to offset the extra costs incurred by the introduction of long-term care allowances.

**Coverage:** As of 1998, 324,000 people were receiving long-term care benefits under the law: 86% under the Federal Long-term Care Allowance Act, and 14% under the Provincial Long-term Care Allowance Act (Enge, 1999). They represented about 3.9% of the total population and some 17% of those aged 61 and over.

As can be seen in Table 3, of those eligible for the benefit in September 1997, most (80%) were classified as having one of the three lowest levels of disability: 12.4% were classified as having Level I disability, 47.3% were classified as having Level II disability, and 21% were classified as having Level III disability; only 2.6% were classified as having the highest two levels of disability (Rubisch et al., 1998).
Table 3: Recipients of the Federal Long-term Care Benefit, by Level of Disability, September 1997

<table>
<thead>
<tr>
<th>Level of Disability</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>33,388</td>
<td>12.4</td>
</tr>
<tr>
<td>II</td>
<td>127,373</td>
<td>47.3</td>
</tr>
<tr>
<td>III</td>
<td>56,427</td>
<td>21.0</td>
</tr>
<tr>
<td>IV</td>
<td>25,190</td>
<td>9.4</td>
</tr>
<tr>
<td>V</td>
<td>19,625</td>
<td>7.3</td>
</tr>
<tr>
<td>VI</td>
<td>4,268</td>
<td>1.6</td>
</tr>
<tr>
<td>VII</td>
<td>2,822</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>269,093</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Rubisch et al., 1998

An examination of the characteristics of benefit recipients conducted in 1995 by Badelt (1998) revealed the following: About two-thirds of the recipients were women, and about 46% of the recipients were widows; about two-thirds of the recipients had a relatively limited education; about half had low incomes; and the proportion of recipients with high incomes was less than 1%. According to the Austrian Ministry of Labour, Health and Social Affairs (1999), the income structure of beneficiaries shows that there would be no point in introducing a means test for the long-term care benefit, since very low income ceilings would have to be imposed to achieve any worthwhile budgetary savings. This in turn would make a large portion of those affected more heavily dependent on social assistance.

The great majority (83%) of recipients are 61 years or over (36% age 61-80, and 47% age 81 or over); 9% of the recipients are age 41-60; 5% are age 21-40; and 3% are age 0-20 (Enge, 1999).

Cost: The cost of the Federal Long-term Care Allowance Act is approximately ATS 18 billion (about $1.4 billion) annually (Rubisch et al., 1998). The cost of the Provincial Long-term Care Allowance Act is approximately ATS 3 billion annually. Thus the total cost of long-term care programmes is ATS 21 billion ($1.7 billion) (Enge, 1999). Austria devotes about 0.9% of the GNP to these programmes.

Issues in the Implementation of the Long-Term Care Allowance Act

A major concern voiced at the outset of the programme (Evers 1994) was whether the supply of services would increase enough to allow for genuine choice and real opportunities to reduce the burden on family caregivers. According to Keigher (1997), Badelt (1997), and Furstl-Grasser et al. (1999), a key objective of reforming the provision of long-term care was to give more support to family caregivers by developing and expanding community services. However, this objective has been achieved only partially, with considerable differences among regions. As noted above, under the long-term care agreement between the federal government and the provinces, the latter have undertaken to guarantee nationwide provision of social services by 2010. They will accomplish this in three stages, and they have submitted their respective plans for closing existing gaps by that time (Federal Ministry of Labour, Health and Social Affairs, 1999).

Another issue of importance is the assessment of eligibility. At present, since this assessment is made by physicians, the success of an application may depend on the applicant’s relationship with the physician. For example, critics have claimed that blue collar workers may be less likely to have their applications approved.

Little systematic evaluation of the programme has been carried out. As noted earlier, Badelt et al. (1997) conducted a major study in 1995 and 1996, using a questionnaire mailed to a representative sample of recipients (N = 1,489) and their primary caregivers (N = 1,396). More detailed interviews were conducted with 100 respondents and their primary
caregivers. This study showed that about 88% of primary caregivers were family members and most of them lacked professional knowledge and information. Seventy-two percent of them reported feeling strained, at least occasionally. To ease their situation, as well as to ensure quality, the Federal Ministry of Labour, Health and Social Affairs has been offering counseling for primary caregivers since 1 January 1998.

The programme appears to have enabled more people to use formal services, thereby reducing the burden on family caregivers. As noted above, 56% of the beneficiaries have reported purchasing at least one formal service since implementation of the law. Furthermore, one-third of disabled respondents have reported receiving more formal services since implementation of the law. However, one-quarter of them also reported needing more help (Badelt et al., 1997).

As noted above, recipients may use the cash benefit to pay their family caregiver. Badelt et al. (1997) found that, of the 77% of primary caregivers who responded to a question about reimbursement, 14% said that they did not receive payment, 27% (usually the spouse of the disabled person) reported that payment was incorporated into the household budget, 20% received no regular payments, and 40% received a regular monthly payment.

Those favouring the cash benefit in Austria claim that it allows for greater freedom of choice and flexibility in the provision of care. A frequent argument is that cash benefits have stimulated the development of service suppliers, and the law’s creation of a demand for services has increased the supply of services.

It has also been claimed that most dependent people will still be unable to afford sufficient help at market prices and may therefore prefer to purchase care from unorganized individuals in the “grey market” – that is, illegal foreign workers, workers who evade income tax, or workers who earn wages below legal limits (Evers & Leichsenring, 1994; Keigher, 1997).

In addition, concern has been raised about the employment rights of family members who provide personal care (Keigher, 1997). Given the lack of options for purchasing services, relatives often provide care out of necessity, rather than choice. Studies indicate that about one-quarter of the caregivers under retirement age find that their employment is impeded or limited by caring for a relative. This is regarded as a social problem, since people who are not employed do not receive social insurance. Some argue that even family caregivers who are paid should be covered by social insurance, although this will raise the cost. About 30% of the caregivers interviewed indicated that they do not themselves have a pension, but are insured through their spouse’s pension (Badelt, 1998).

In order to improve the situation of family caregivers, since 1 January 1998, people who care for a close relative who has been classified with a Level V, VI, or VII disability and who have had to forfeit employment in order to care for their disabled relative, have been given the option of continuing to pay into their pension insurance at a lower rate. Under this scheme, the federal government pays the insurance contribution that would have been paid by the caregiver’s employer.

The Austrian programme is unique in adopting a full cash strategy and not assuming direct responsibility for in-kind service provision. Therefore, it is important to evaluate in depth the implications of the law for meeting needs and for costs.

2. Germany

Background

As of 1999, Germany had a population of 82.6 million, 13.2 million of whom (15.9%) were age 65 or over and nearly 5.6 million of whom (6.8%) were age 75 or over (International
Data Base, 2000). It is estimated that the proportion of elderly people in the population will reach 19.8% by 2010, and 23.4% by 2025 (United Nations, 1998).

The elderly support ratio in relation to the working-age population (that is, the number of persons 65 and over per 100 persons age 20 to 64) stands at 25, and is expected to reach 40 by 2025. Life expectancy at birth is 80.50 years for women and 74.01 for men (International Data Base, 2000), and life expectancy at the age of 65 is 18.6 years for women and 14.7 for men (World Health Statistics Annual, 1996). Disability-adjusted life expectancy at birth is 73.5 years for women, and 67.4 years for men; expectation of disability at birth is 6.6 years for women and 6.3 years for men (World Health Report, 2000).

A 1992 representative survey of people living in private households in Germany estimated that about 1.2 million persons (or 1.5% of the total population) were disabled in ADLs. About 71% of them were age 65 or older (6.9% of the 71% were over age 65 and 16.8% of them were age 80 and over), and 29% of them were under age 65 (Schneekloth, 1996). Conservative estimates foresee an increase in the number of those needing long-term care services from 1.5 million in 1993 to 2 million by 2020 and 2.3 million by 2040 (Blondeau & Dubois, 1997; WHO, 1998).

At the same time, there is concern about the ability of families to care for their elderly relatives. The parent support ratio - that is, the ratio of those age 80 and over per 100 persons age 50-64 - stands at 18, and it will reach 32 by 2025. This provides a rough indication of the expected burden of care. The parent support ratio by females (the ratio of those age 80 and over to women age 50-64) stands at 36, and this will reach 63 by 2025 (International Data Base, 2000). In other words, fewer women will be available to care for the increasing population of elderly. Moreover, the assistance of women is expected to decrease further in the coming century due to the increased number of women in the work force, and to changes in family structure (Schneider, 1999; Alber, 1996).

In Germany, health care is provided under a national health insurance law that covers people whose income is below a set ceiling; they are allowed to choose their provider (sick fund). People whose income is above this ceiling may voluntarily join a health insurance plan. In 1999, the monthly gross wage cut-off for voluntary membership in a sick fund was as follows: DM 6,375 in the former West, and DM 5,400 in the former East. The health insurance scheme covers acute medical care. Policy concerning long-term care has been slow to evolve, and minimal. In contrast to acute care, care for the frail and disabled non-working population was for many years the responsibility of the local Länder, which received no direct federal contribution; care was provided through means-tested welfare programmes. Thus, long-term care was a growing financial burden on local governments (Cuellar & Wiener, 2000; Schneider, 1999). People needing formal care had to pay out of pocket; if they could not meet constantly rising costs, they had to turn to welfare assistance. People needing institutional care, whose costs easily exceeded even above-average pension allotments, almost always had to call upon the welfare system. Yet in order to be eligible for welfare benefits, one had to have depleted his personal assets and exhausted the possibility of family support and direct care. The need for long-term care thus also placed financial strain on the dependent's closest relatives.

According to Schneider (1999), it was not until two issues came to the fore that long-term care was placed on the public agenda. First, the high prevalence of poverty among the elderly was straining municipal budgets since 80% of those needing institutional care were dependent upon welfare benefits. Second, the quantity and variety of formal care were insufficient. Private for-profit providers were all but barred from the market by the preferential treatment toward and subsidization of NGOs. Studies conducted in the 1970s, 1980s, and early 1990s revealed both quantitative and qualitative under-provision of care to the elderly. The provision of formal care by NGOs could not keep pace with the increasing extent and variety of demand (Schneider, 1999; Alber, 1990).
This situation created a need for the development of national policy that would improve the accessibility and availability of long-term care services and ease the fiscal crisis of local authorities. Public policy makers felt they had three alternatives: market-led strategies, tax-based transfers or an expansion of social insurance coverage (Schneider, 1999). Below is a discussion of these alternatives and the rationale for choosing expanded social insurance coverage.

**Market-driven versus public provision of long-term care insurance**

Prior to the introduction of a comprehensive, federal approach to insurance for long-term care, the market was minimally effective in developing attractive and affordable insurance schemes. Private insurance expanded significantly but was still limited to a minority of the population (Schneider, 1999).

From the insurers’ perspective, the uncertainty of risk factors for long-term care hindered the development of a private long-term care insurance market. From the clients’ perspective, a number of factors may have been deterrents to the purchase of insurance against old-age dependency: a lack of risk awareness; a preference for present over future consumption; a preference for family care over formal care; the limited coverage offered by private long-term care insurance policies; insufficient means to meet insurance premiums; and the availability of welfare benefits to those needing care. Young and low-income households were especially likely to avoid private insurance schemes (Schneider, 1999).

In addition, there was concern about consumer protection and equity in a purely market-based system of insurance provision. Even with expert knowledge of potential care requirements, an individual client might find himself in too weak a position vis-à-vis insurance companies to negotiate a policy that would meet his needs. Insurers could either reject high-risk clients or charge high premiums, thereby limiting access to coverage to wealthy households.

While some of these pitfalls could be addressed by government regulation - e.g. making long-term care insurance mandatory, regulating insurers, or introducing tax deductions or transfers that would make premiums affordable, market strategies were perceived as leaving much uncertainty. Furthermore, market strategies would not address the needs of family caregivers, who risked foregoing job-linked pension benefits, health insurance and accident insurance if they remained at home to care for an elderly relative.

**Tax-based transfers versus a social insurance approach to long-term care**

Traditionally in Germany, financial support for frail and dependent elderly people came from taxes. Specifically, it was provided as Hilfe zur Pflege (“help with care”), a means-tested welfare benefit. An obvious alternative seemed to be to increase access to this benefit through the existing transfer system, or to design another transfer system that would offer benefits to care recipients and caregivers.

Some advocates of the tax-based solution considered relaxing the entitlement criteria for the welfare benefit to make it available to clients whose incomes were well above the poverty line. Others proposed that close relatives of care recipients be released from their obligation to pay maintenance. One shortcoming of this solution was that many elderly people did not apply for the welfare benefit because they considered it demeaning to have to receive welfare. Furthermore, this approach would have increased the financial strain on municipalities.

**The Social Dependency Insurance Act (SDI)**

After many years of discussion about the most effective way to improve the system, the Social Dependency Insurance (SDI) Act was enacted in 1994, introducing universal long-
term care insurance. The new act adopted some basic features of existing German social insurance schemes, but also introduced components that represented a new approach to financing and cost-containment.

The Social Dependency Insurance Act was implemented in two stages: in April 1995, it was implemented for home care, and in July 1996, institutional care was added.

**Insurer:** Special "care funds" were established under the auspices of existing sickness funds. All residents of Germany are legally obligated to participate in the statutory long-term care insurance scheme. However, persons with higher incomes, who are not subject to statutory health insurance, may be released from this obligation if they can prove they own a private long-term care insurance policy that offers benefits comparable to those provided by the statutory long-term care insurance scheme (Scheil-Adlung, 1995).

Long-term care insurance could have been established under the auspices of Germany's social insurance system in any of three ways: by making it a new responsibility of the sick funds, by making it an additional responsibility of the pension funds, or by making it an independent appendage to the existing system. While the government initially sought to combine acute health and long-term care, Social Dependency Insurance (SDI) was ultimately organized as a separate responsibility of the so-called "care funds." This decision was motivated by several factors.

First, according to analysts of the German law (Scheil-Adlung, 1995; Schneider, 1999; Cuellar & Wiener, 2000), the decision facilitated the introduction of cost-containment mechanisms into the system of long-term care, beyond those available in acute care. The long-term care programme has several cost-containment mechanisms that distinguish it from acute care. Since monthly costs are capped, programme outlays do not depend on the amount of services provided per person or on provider payment levels, but rather on the numbers of eligible persons. Further, the long-term care law has freed the federal government from direct liability for programme deficits, although it did not answer the question of what would happen if deficits were to arise. In addition, no automatic mechanisms have been built into the law, and benefit increases require new legislation - they do not automatically increase with inflation.

Another factor was the desire to avoid controversy over employment contributions to the long-term care programme. Employers opposed higher contributions to social insurance funds because they would increase labour costs. The decision to establish a separate programme made it possible to establish a different principle for sharing contributions between employers and employees. In this programme employers are compensated for their premium payments through the workers' concession of a holiday (Scheil-Adlung, 1995; Schneider, 1999).

Finally, the decision to organize Social Dependency Insurance as a separate entity under the care funds was based on concern that long-term care services might be neglected if they were integrated into the general health system, since acute health care would receive greater priority (Schneider, 1999).

Despite these advantages, the separate social dependency insurance scheme has been criticized for perpetuating fragmentation between acute and long-term care, which impedes continuity of care and is considered unsound from a health care perspective (Schneider, 1999). Moreover, because the line between acute and long-term care is difficult to draw, charges of cost shifting between the two programmes are common. One of the goals of the long-term care legislation was to enhance rehabilitation services; however, the law does not provide adequate financial support in this area. At the same time, sick funds are reluctant to invest in rehabilitation given that the potential payoff for such treatment would be appropriated by the care funds (Schneider, 1999; Cuellar & Wiener, 2000).
Although the special care funds are legally independent corporate bodies, they are closely linked to the sick funds and take advantage of their structure: sick fund staff handle both health insurance and SDI claimant records. Care funds screen applicants with the help of sick fund medical staff and reimburse the sick funds for this service.

**Eligibility** is granted regardless of age or financial status, or reason for dependency, and includes dependency resulting from physical or mental disability. Eligibility is granted to people who need assistance in two or more activities of daily living (ADLs) for at least 6 months. The need for assistance in instrumental activities of daily living (IADLs) is considered only if a person has met the ADL requirements. The law distinguishes three levels of disability – substantial, severe, and very severe – based on the frequency with which assistance is needed in personal care and housekeeping (see Table 1). People with substantial disability need assistance at least once a day for about 1.5 hours; people with severe disability need assistance three times a day for 3 hours; and people with very severe disability need assistance day and night, for at least 5 hours.

**Table 1: Levels of Disability Defined by Social Dependency Insurance**

<table>
<thead>
<tr>
<th>Level of Disability</th>
<th>Disabilities in ADLs and IADLs</th>
<th>Frequency of Assistance in ADLs/IADLs</th>
<th>Amount of Assistance Needed in ADLs/IADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial</td>
<td>Two or more ADLs; need for assistance with IADLs</td>
<td>ADLs at least once a day; IADLs several times a week</td>
<td>Min. 90 minutes for ADLs and IADLs, with at least 45 minutes for ADLs</td>
</tr>
<tr>
<td>Severe</td>
<td>Two or more ADLs; need for assistance with IADLs</td>
<td>ADLs at least three times a day; IADLs several times a week</td>
<td>Min. 3 hours for ADLs and IADLs, with at least 2 hours for ADLs</td>
</tr>
<tr>
<td>Very severe</td>
<td>Two or more ADLs; need for assistance with IADLs</td>
<td>ADLs day and night; IADLs several times a week</td>
<td>Min. 5 hours for ADLs and IADLs, with at least 4 hours for ADLs</td>
</tr>
</tbody>
</table>

Source: Schneider, 1999.

Eligibility criteria do not include income or the availability of family assistance. Germany chose a universal programme in which disability, rather than a subjective evaluation of potential informal support or unmet needs, is the basis for eligibility.

Expanding eligibility for the cognitively impaired has recently been debated. Critics contend that existing criteria do not adequately address the needs of persons with cognitive impairment (e.g. Alzheimer’s disease) because they need time-consuming general supervision, which is not factored into eligibility assessments. Concern has been expressed, however, that counting supervision hours in the assessment process would place all cognitively impaired persons in the most costly category. Although changes may be expected in this area, it is likely that proposals to accommodate more persons with dementia will involve tightening eligibility for others, to ensure budget neutrality (Cuellar & Wiener, 2000).

Evers (1998) argues that the eligibility process is not sufficiently flexible in matching benefits to needs. Prior to enactment of the law, the patterns of payment were based on the amount and duration of care required. By setting three discrete eligibility levels, the law made it more difficult to match the amount of services to the level of need.

**Eligibility Assessment:** Screening for social dependency insurance is performed by medical staff of the sick funds (primarily physicians, who are reimbursed by the care funds). Care funds then issue authorizations to service providers.
Benefits: The level of benefits is determined by the level of disability. Benefits may be provided as in-kind services, cash allowances or a combination of the two. Recipients of a cash allowance are not obligated to use it to purchase services, but may incorporate it into their household budget. The amount of the cash allowance is 45%-53% lower than the monetary value of in-kind services. Beneficiaries may receive the benefits for which they are eligible in the community or in an institution.

Coverage of community care includes personal care, housekeeping, assistive devices, home adaptations, day care, night care, and respite care.

Coverage of institutional care involves the provision of in-kind services only, which are graduated according to the level of disability. The costs of board and lodging are not reimbursed by the care funds, and clients are required to share at least 25% of the total cost. This is meant to be an incentive to choose community care, which is perceived as preferable to institutionalization (Schneider, 1999).

Table 2 details the benefits provided per month. At the end of 1997, benefits for the substantially disabled living at home ranged from DM 400 for cash benefits to DM 750 for services in-kind, and about DM 2,000 for those in institutions. For the most severely disabled living at home, benefits ranged from DM 1,300 for cash benefits to DM 2,800 for services in kind; for those in institutions it was about DM 2,800 (DM 3,300 in exceptional cases).

Table 2: Monthly Benefits Provided under the Social Dependency Insurance Act, in Deutsche marks (DM) and United States Dollars ($)∗

<table>
<thead>
<tr>
<th>Level of Disability</th>
<th>Care at Home</th>
<th>Care at a Day Care Centre</th>
<th>Care in an Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial</td>
<td>DM 400-750</td>
<td>DM 750</td>
<td>DM 2,000</td>
</tr>
<tr>
<td></td>
<td>$200 - $375</td>
<td>$375</td>
<td>$1,000</td>
</tr>
<tr>
<td>Severe</td>
<td>DM 800-1,800</td>
<td>DM 1,500</td>
<td>DM 2,500</td>
</tr>
<tr>
<td></td>
<td>$400 - $1,400</td>
<td>$750</td>
<td>$1,250</td>
</tr>
<tr>
<td>Very severe</td>
<td>DM 1,300-2,800</td>
<td>DM 2,100</td>
<td>DM 2,800</td>
</tr>
<tr>
<td></td>
<td>$650 - $1,400</td>
<td>$1,050</td>
<td>$1,400</td>
</tr>
<tr>
<td>Exceptional hardship</td>
<td>Up to DM 3,750</td>
<td></td>
<td>DM 3,300</td>
</tr>
<tr>
<td></td>
<td>$1,875</td>
<td></td>
<td>$1,650</td>
</tr>
</tbody>
</table>

Source: Schneider, 1999.

∗Sums in DM are accurate for the end of 1997, and sums in US$ were calculated by the authors at exchange rates DM2= $1.

It is important to note that benefits are not meant to cover all needs but are designed to cover only part of the actual cost of care. It is estimated that in 1995 a beneficiary at the substantial care dependency level would have needed a minimum of DM 2030 to cover full needs (that is, a minimum of 90 minutes of assistance per day), while SDI home care benefits for this category were MD 750. Thus the benefit covered about 37% of needs. For the severe care dependency level, a beneficiary in 1995 would have needed a minimum of DM 4,100 to cover full needs (a minimum of 3 hours of assistance per day), while the SDI was DM 1800, that is, about 44% of needs. For the very severe level, a beneficiary would have needed a minimum of MD 6,667 (a minimum of 5 hours of assistance per day), while SDI was DM 2800, that is, about 42% of needs. For institutional care, the benefits in Germany covered between 44% and 64% of the charges in 1995, depending on the location of the facility and the degree of dependency (Schneider, 1999).
People who have additional needs are eligible for additional benefits from the welfare system, on an income-tested basis (Alber, 1996; Scheil-Adlung, 1995; Schneider, 1999; Schulte, 1996).

The law attempts to provide special support for family caregivers by including day or night care, day care centres, training courses organized by care funds, and various forms of respite care, such as an alternate provider for up to 4 weeks a year and short-term residence in an institution. In addition, contributions to old-age pension and accident insurance are made for informal caregivers who provide care for more than 14 hours a week and who are not gainfully employed for more than 30 hours a week. At present, about half a million family caregivers - 90% of whom are women - receive such pension coverage (Deutscher Bundestag, 1997).

Providers and Quality Assurance: Services may be provided either by NGOs or the for-profit private sector. As noted earlier, prior to implementation of the law, the quantity and variety of formal care were insufficient, there was a lack of facilities for the elderly, the care in old age homes was below standard, and there was a shortage of personnel (Brautigam & Schmid, 1996; Evers & Olk, 1991; Backer, 1991).

As a possible solution to these problems, legislators laid a foundation for the development of the for-profit sector by eliminating barriers to the entry of private providers into the long-term care system (Klie, 1996, in Schneider, 1999). In addition, any provider offering guarantees of adequate care at reasonable prices is approved, regardless of actual demand. These measures are intended to promote competition and keep prices down (Scheil-Adlung, 1995).

Under the law, the private market has indeed developed: The number of agencies providing long-term care has nearly tripled - from 4,000 in 1992 to 11,700 in 1997 (Deutscher Bundestag, 1997). Nevertheless, the increase has not kept pace with need, and there is still a lack of providers and professional services (Schneider, 1999).

Various measures to address quality assurance have been introduced. Agencies are required to employ at least one registered nurse with at least 2 years' practical experience, obtained within the past 5 years, to be eligible as a service provider.

According to the 1994 legislation, providers in Germany are obliged to undergo external regulation of quality by the care funds and sickness funds. In addition, providers must establish an internal system of quality assurance, which includes establishing quality circles, enabling institutional residents to provide feedback on the quality of their care (through specially designed questionnaires), and setting standards. They are also encouraged to take voluntary measures, such as holding quality assurance conferences or implementing voluntary certification programmes. In May 1996, care funds, central municipal associations, public authorities providing welfare benefits and services providers jointly issued the first binding statement of quality principles and guidelines. These take into account the quality of the structure, process and outcomes of care.

Applicants who choose the cash allowance for personal care are obligated by law to undergo three inspection visits, the costs of which are partially paid by the client. The purpose of these visits is to ensure the quality of informal care, to update the client's knowledge of available services, and to advise informal caregivers. The visits are made by formal service providers, but this has raised the question of conflict of interest, since providers see inspection visits as an opportunity to advertise their services. Further, compensation for these visits is not high and hence does not encourage extended consultation. Moreover, since the visits are not fully financed, they are not well accepted by clients. Dissatisfaction has been expressed mainly by the young disabled, who were used to managing their own care needs before the new legislation (Deutscher Bundestag, 1997; Neumann, 1996; Schneider, 1999).
The law obligates care funds to offer free training classes to informal caregivers. There also seems to be a need for training of the nurses responsible for inspection (Gro, 1998, in Bscher, 1999). Jansen and Kardoff (1996) have proposed more conceptual development of inspection based on case management principles (Bscher, 1999).

For recipients of in-kind benefits, care funds negotiate agreements that specify services and fees with authorized providers. The reimbursement system is complicated. Providers of services at home must specify the elements of service, each of which is worth a certain number of points; care funds set standard payments for each point, but these may differ by region or federal state.

The law assigns the task of quality assurance and monitoring to care funds and to third-party agents. A clause of the law stipulates that care funds, federal states, local authorities and service providers (both NGOs and for-profit organizations) must agree upon uniform principles of quality assurance for care provided both at home and in institutions. Providers must cooperate with quality assurance inspections performed by the care and sick funds.

Schneider (1999) argues that adequate mechanisms for quality assurance and public accountability have not been institutionalized; that legislator missed the opportunity to set federal standards for professional training and licensing; that the training provided to home care workers is not uniform; and that the profession remains unattractive.

Schneider (1999) and Cuerral and Wiener (2000) also argue that there is a need to develop more counseling and care management services, given the complexity of the process of choosing appropriate services, and negotiating and contracting with a service provider. At present, there are no broad-scale counseling services. For the most part, beneficiaries and their families make decisions on their own, or with the assistance of a provider. Discussions are underway about how to assist consumers more effectively.

**Finance:** A payroll tax (premium) of 1.7% of gross wages is levied to finance the system. The contribution is shared equally by employees and employers, although, as mentioned above, employers are compensated for their premium payments through designation of a holiday as a working day. Retirees share premium payments equally with their pension fund. Coverage is extended to spouses and children of members of the SDI scheme, without the need for an additional premium payment.

The payroll tax is levied on gross wages, with a ceiling of DM 6,375 in former West Germany and DM 5,400 in former East Germany. This limit is adjusted annually, and equals 75% of the contribution assessment ceiling for old-age insurance.

In addition, there is a co-payment for institutional services; beneficiaries entering a long-term care institution are required to pay at least 25% of the cost of institutional care.

**Coverage:** In 1998, the number of people receiving benefits was about 1.8 million. This approximated the number of people estimated to be eligible, based on a household survey in 1992 (Schneider, 1999). More detailed data is available for 1997. As of July 1997, about 1.6 million people were receiving benefits under the SDI Act, and another 100,000 clients were covered by payments from private insurers. Of the recipients of care, 41.8% were substantially disabled, 42% were severely disabled, and 16.2% were very severely disabled. Approximately 1.2 million people (74% of beneficiaries) were receiving benefits for care at home, and approximately 430,000 people were receiving benefits for care in an institution. Of those who were receiving care at home, 46% were substantially disabled, 42% were severely disabled, and 12% were very severely disabled. Of those who were receiving care in an institution, 31% were substantially disabled, 42% were severely disabled, and 25% were very severely disabled. It should be noted that applications for benefits at a day care centre or in a short-term care facility were low (between 0.2% and 2%); Schneider (1999) notes that this may reflect their lack of availability.
More than two-thirds of beneficiaries were women, and about two-thirds were age 74 or over (see Table 3).

**Table 3: Recipients of SDI Benefits, by Age, Gender, and Type of Care, as of 30 June 1997 (in %)**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total (N = 1,595,597; 100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>%</td>
</tr>
<tr>
<td>0-14</td>
<td>4</td>
</tr>
<tr>
<td>15-24</td>
<td>2</td>
</tr>
<tr>
<td>25-64</td>
<td>16</td>
</tr>
<tr>
<td>65-74</td>
<td>14</td>
</tr>
<tr>
<td>75 and over</td>
<td>64</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>69</td>
</tr>
<tr>
<td>Men</td>
<td>31</td>
</tr>
<tr>
<td><strong>Type of Care</strong></td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td>73</td>
</tr>
<tr>
<td>In an institution</td>
<td>27</td>
</tr>
</tbody>
</table>

Source: Schneider, 1999, based on the Federal Ministry of Labour and Social Affairs (Deutscher Bundestag, 1997)

As expected, the utilization of institutional care rose with the level of disability: Of those beneficiaries who were substantially disabled, 80% were receiving care at home and 20% were receiving care in an institution, while of those who were severely disabled, 56% were receiving care at home and 44% were receiving care in an institution (see Table 4). The literature does not provide comparative data on the extent of institutionalization prior to and following implementation of the law.

**Table 4: Recipients of SDI Benefits, by Type of Care and Level of Disability, June 1997 (in %) as of 30**

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Level of Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Substantial</td>
</tr>
<tr>
<td>At home</td>
<td>80</td>
</tr>
<tr>
<td>In an institution</td>
<td>20</td>
</tr>
<tr>
<td>Day care centre</td>
<td>0.2</td>
</tr>
<tr>
<td>Short-term care</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Source: Schneider, 1999, based on the Federal Ministry of Labour and Social Affairs (Deutscher Bundestag, 1997)
According to 1996 data, 28.5% of the applications to receive benefits at home were rejected after an assessment by a medical board; 23.8% of the applications to receive benefits in an institution were rejected. No more recent statistics are available (Deutscher Bundestag, 1997; Schneider, 1999).

In 1996, among the community-based population, most (79%) of those eligible for benefits chose cash allowances, while about 11% chose a combination of cash allowances and in-kind services and 9% chose services only (see Table 5). As would be expected, the proportion choosing cash allowances declined with the level of disability. A higher percentage of those with substantial disability than those with severe, or very severe disability chose cash benefits (84%, 77% and 67%, respectively) (Deutscher Bundestag, 1997; Schneider, 1999). In 1998, there was something of a decline in the choice of cash benefits: About 74% of the community-based population chose cash benefits, 11% chose in-kind services and 14% chose a combination of the two. Sixty percent of the most disabled group in the community chose cash only, compared with 80% of the least disabled (Cuellar & Wiener, 2000).

Table 5: Preferred Benefit for Care at Home, by Level of Disability, 1996 (in %) as of July-December

<table>
<thead>
<tr>
<th>Preferred Benefit</th>
<th>Level of Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Substantial</td>
</tr>
<tr>
<td>In-kind services</td>
<td>8.8</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>83.7</td>
</tr>
<tr>
<td>Combination</td>
<td>6.6</td>
</tr>
</tbody>
</table>

Source: Schneider, 1999, based on the Federal Ministry of Labour and Social Affairs, (Deutscher Bundestag, 1997)

When the law was passed, policy makers believed that cash benefits would empower consumers of long-term care, increase their autonomy and freedom of choice of services and service providers, and generate competition among service providers, thereby improving services. Furthermore, cash allowances were viewed as giving families a stronger incentive to continue caring for an elderly or disabled relative and offering disabled people an opportunity to express their appreciation for the efforts of helpers.

A major finding of studies of the law in Germany is that cash allowances are used primarily to supplement the family budget, rather than to purchase services of a formal caregiver (Evers, 1997). For example, a study conducted at the University of Hamburg37 (Runde et al., 1996) found that the majority of cash recipients (85%) cited the advantage of being able to use the funds without restriction.

Problems with the availability of services have been cited as one factor affecting the decision to choose cash benefits (Cuellar & Wiener, 2000). According to Evers (1995), the

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37 The study was conducted in the spring of 1996, before the introduction of the benefits for institutional care. Respondents (n=3,359) were age 30 or over. Runde, et al. 1996: “Germany’s Social Long-Term Care Insurance: Design, Implementation and Evaluation”. *International Social Security Review* 52:31-74.
preference for cash benefits may be also a response to problems in the way services are provided (e.g. inflexible hours).

Some have criticized how cash allowances are provided in Germany. They claim that the disabled and their families are not able, and in many instances do not know how, to negotiate directly with service providers (Schneider, 1999; Evers, 1997). Moreover, a large proportion of beneficiaries have cognitive impairments and yet receive cash benefits. In response to these concerns, beneficiaries electing cash are subject to periodic visits every 4-6 months, depending on their disability level, to ensure that adequate care is being provided. Moreover, as mentioned above, the need to develop more counseling and care management services has been noted.

**Cost:** The annual expenditure for SDI in 1999 was estimated to be DM 31 billion (about $15.5 billion). As mentioned above, about a quarter of clients receive benefits for institutional care; however, because institutional care is more expensive, it accounts for a higher share of expenditures. Institutional care takes about 42% of expenditures, home care cash allowances 29%, home care services 12%, pension contributions for carers 8%, and other benefits such as short-term care the remaining 9% (Report by The Royal Commission on Long-Term Care, 1999). Germany devotes about 0.9% of the GNP to the programme.

The programme is not running a deficit, and revenues exceed outlays. This may be due in part to consumers’ preference for cash benefits (whose financial value is lower than that of in-kind services) (Schneider, 1999). Given the surplus, suggestions have been made to either reduce SDI contribution rates or expand coverage. However, this is unlikely to occur now since the Ministry fee the surplus is of too recent accrual to be evidence of over-estimation of long-term care costs, and prefer to keep the current contribution level (Report by The Royal Commission on Long-Term Care, 1999).

**Issues in the Implementation of the Social Dependency Insurance Programme**

Because of the lack of systematic evaluation, it is difficult to draw conclusions about the impact of the SDI Act. Below we describe some of the key issues that have arisen during public debates following implementation of the law.

**The benefit ceiling and eligibility criteria**

The law has been criticized for not covering needs more fully. As noted earlier, benefits are not intended to cover the full cost of long-term care. Both in-kind and cash benefits (the entitlements for cash allowances are even less generous than those for in-kind services), and entitlements for institutional long-term care are designed to be lower than estimated costs. One way of providing more intensive services without increasing costs would be to change eligibility criteria, for example by taking into consideration income. Some have criticized the fact that the benefit level is not linked to income and benefits are equally provided to people with low, moderate and high incomes (Schneider, 1999).

To fully cover the need for formal home care services, beneficiaries may need to seek supplementary coverage, or pay out-of-pocket. If the beneficiary does not have supplementary private insurance, he will probably need to apply for social assistance benefits (Scheil-Adlung, 1995). It is estimated that 40% of the people receiving long-term care will apply for social assistance benefits, mainly for institutional care. This is viewed by some as inconsistent with the SDI’s goal of significantly reducing the need to apply for social assistance benefits (Schneider, 1999). Nevertheless, as a result of SDI, the municipal budgets for social assistance for long-term care have declined (Cuellar & Wiener, 2000).

There has also been discussion of the minimum disability level required for eligibility. As noted above, one must need at least 1.5 hours of assistance daily to receive
benefits. In 1995, it was estimated that 450,000 people who needed less personal care were not receiving benefits under the law (Schneider, 1999), and another two million people who needed assistance with housekeeping only were not receiving benefits under the law (Evers, 1998). The decision to link eligibility with the need for frequent assistance has drawn much criticism as being short sighted. It is argued that providing assistance to people who need it less might help them maintain their functional status and defer premature institutionalization (Schneider, 1999).

Advocates of present entitlement levels predict that more generous provision of benefits would lead to the replacement of informal care by formal care, and hence an escalation of costs (Goerke, 1996; Greiner & Schulenburg, 1996). However, this question needs further study (Schneider, 1999).

The Hamburg study cited above (Runde et al., 1996) found that most (80%) beneficiaries were satisfied with their current situation. More than half stated that their situation had improved owing to the new long-term care entitlement, 43% reported that the quality of their care had improved, and 35% noted that they now employed a professional service provider. In addition, 35% of the respondents agreed that “the government has done enough for home care.” The issue of whether the law reduces informal care or encourages it (as the legislators intended) requires further study. However, 60% of the respondents in the Hamburg study believed that the law had positively influenced willingness to take responsibility for the care of a family member, and 67% stated that it provides recognition of informal caregivers.

The issues raised about the implementation of the law in Germany are now being actively discussed. As Schneider (1999) states, “A variety of scenarios for programme improvement are conceivable. Choice should be informed by ongoing research into long-term care and the broader impacts of long-term care policy.”

3. The Netherlands

Background

As of 1999, the Netherlands had a population of 15.8 million, 2.1 million of whom (13.6%) were age 65 or over and nearly 950,000 of whom (6%) were age 75 or over (International Data Base, 2000). It is estimated that the proportion of elderly people in the population will reach 15.8% by 2010, and 23% by 2025 (United Nations, 1998).

The elderly support ratio in relation to the working-age population (persons age 65 and over per 100 persons age 20 to 64) stands at 22, and it will reach 38 by 2025. Life expectancy at birth is 81.17 years for women and 75.28 for men. Life expectancy at the age of 65 is 19.1 years for women and 14.7 for men (International Data Base, 2000). Disability-adjusted life expectancy at birth is 74.4 years for women, and 69.6 years for men; expectation of disability at birth is 6.7 years for women and 5.4 years for men (World Health Report, 2000).

The parent support ratio – that is, the ratio of those age 80 and over per 100 persons age 50-64 – stands at 18, and it will reach 25 by 2025. This provides a rough indication of the expected burden of care. The parent support ratio by females (the ratio of those age 80 and over to women age 50-64) stands at 37, and this will reach 51 by 2025 (International Data Base, 2000). In other words, fewer women will be available to care for the growing population of elderly.

Health care in the Netherlands is largely funded through a system of public and private insurance schemes. The insurance system is divided into three categories in accordance with the current method of classifying health care. The first category is insurance
for acute medical care, covered by public or private insurance schemes, the most important of which is governed by the Health Insurance Act (implemented in 1966). Persons whose annual salary is below a statutory ceiling, and all recipients of social security benefits are insured by this act, covering about 64% of the Dutch population. Another 5% are covered by the health insurance scheme for public servants, and about 31% are privately insured. The second category includes the exceptional medical expenses associated with long-term care or high cost treatment, where the risk is perceived as such that it cannot be born by individuals or adequately covered by private insurance. This care is covered by the Exceptional Medical Expenses Act. The third category includes supplementary components of care, perceived as being less necessary and covered by private health insurance schemes. The insurers themselves determine the content and scope of the benefit and the conditions.

The Dutch parliament first entertained the possibility of providing the country’s citizens with insurance for long-term care and medical risk in 1962; in 1967, the parliament passed a law to this effect (Exceptional Medical Expenses Act [AWBZ]), and implementation began on 1 January 1968. Though the benefits covered by the law initially served mainly as a means of funding long-term or high-cost care in various types of institutions, these benefits have been changed or extended over the years to cover more elements of health care, many of which are not long-term care in nature (Ministry of Health, Welfare and Sport, 1998). For example, in the 1980s psychiatric care, aids and appliances once covered by public or private health insurance were transferred to AWBZ. At the beginning of the 1990s, the benefits under AWBZ were extended to include genetic testing, rehabilitation, audiology treatments and medications (these were transferred back to health insurance programmes in 1996). This process was motivated by the government’s desire to create a more comprehensive health insurance system by integrating the different insurance programmes. However, to date the government has not succeeded in fully implementing this plan.

In the 1980s, as a result of an increase in expenditures for long-term care, the Dutch government reexamined its policy, which had favoured the institutionalization of elderly and disabled people. In fact, in 1980, the rate of institutionalization was over 10% – quite high compared to other European countries. In 1980 home nursing services were introduced into the AWBZ, and in 1989 the programme was expanded to include home help services.

These developments reflected a policy of cost containment based on a new philosophical approach – “the caring society” – which encouraged people to take greater responsibility for themselves, rather than relying on institutional frameworks. This approach later evolved into the “substitution policy.”

The “substitution” policy was designed to promote the replacement of institutional services by less expensive community services. This policy reflected a belief that many elderly were receiving more care than they required: For example, some elderly people opted to remain in the hospital even after their treatment was finished, while others preferred to enter an institution despite being able to live independently (Pijl, 1991; Evers & Leichsenring, 1994; Pijl et al., 1994).

The substitution policy led to the development of a variety of experimental programmes, each of which was accompanied by an evaluation (Coolen, 1995):

• expanded home-care services (e.g. 24-hour, 7-day assistance for people with multiple needs);
• increased home care for people recovering from surgery or suffering from a terminal illness;
• day-care facilities in old age homes, geared for people who find it difficult to maintain an independent lifestyle but who are not institutionalized (day-care frameworks in long-term care institutions had existed previously);
short-term care in old age homes for people who suffer from significant but temporary deterioration in functioning (this service was meant to help reduce the burden on informal caregivers); and

sheltered housing for people capable of living independently in a supportive environment that offers technical adaptations, access to community services, and assistance from a nearby service centre or old age home.

More recently, three additional types of experimental programmes have been developed: programmes to increase flexibility and coordination among service providers (based on a philosophy of designing “tailor-made solutions”); programmes that give elderly people choices, through a “personal budget”; and programmes that extend the services of sheltered housing.

The Exceptional Medical Expenses Act (AWBZ)

As mentioned above, the Exceptional Medical Expenses Act was implemented in January 1968. The law initially included coverage for high-cost long-term institutional care but it has been expanded over the years to include other services. The most significant changes were the introduction of home nursing in 1980, home help in 1989, and residential care in 1997 (Ministry of Health, Welfare and Sport, 1998; Huijbers & Martin, 1998).

**Insurer:** The insurer is the Ministry of Health, Welfare and Sport, which designates health insurance companies to implement the AWBZ (health insurance funds, private health insurance companies approved by the government, and the insurance schemes for public servants). These insurance companies are regulated by the Ministry’s Health Insurance Council.

**Eligibility criteria:** Eligibility is granted to all residents of the Netherlands without regard to nationality, and to foreign workers. Entitlement is universal and includes all ages. The Netherlands has adopted a holistic approach to assessment of an individual’s need for long-term care. Its assessment process reviews the applicant’s general health, physical disability resulting from illness, psychological and social functioning, home and environment, as well as the formal and informal care available to him and the possibility of continuing this care. The Dutch government allows for considerable professional discretion in assessment of the type and level of assistance needed, and includes the availability of informal care as a criterion. An individual’s income level is not a criterion for receiving benefits, reflecting the universal approach of the law.

**Eligibility assessment:** Since 1998, assessments have been made on a regional basis, through Regional Assessment Organizations (Regionaal Indicatief Organisatie, or RIO). Each RIO comprises representatives of policyholders, consumer organizations, service providers, physicians, insurers, and the local authority or municipality. These representatives appoint professional assessment teams - whose members vary with the type of application for benefits and may include nurses, social workers, psycho-geriatricians and social geriatricians. A further review by a team of experts is necessary for admission to an institution. At present, there is no national, uniform set of assessment tools, although one is being developed (Huijbers & Martin, 1998).

Assessments are valid for a finite period, except for applications for long-term institutional care. In the case of disability caused by an unusual but not permanently damaging event, the assessment is valid for 1 month. Based on the team’s assessment, the RIO will determine whether institutional or community care is required, as well as the urgency of its provision. In the Netherlands, long-term care insurance does not set a clear limit on the total benefits per beneficiary, although it limits the amount of specific services (such as home nursing).
The assessment team reports its decision to the applicant, who then initiates self-referral to service providers. The applicant himself chooses the provider from which he will receive care; however, his freedom of choice is limited by the limited nature of the service provision market (private providers are active in large cities only; elsewhere, one large organization usually offers services), the waiting lists for admission to old age homes, and the concentration of long-term care institutions in large cities. The urgency of a case affects how soon care is received.

Once an individual has approached a service provider and received its agreement to provide services, a programme of care is designed in accordance with the guidelines of the assessment. To a large extent, the individual is responsible for obtaining services. However, regional AWBZ offices have been taking increasing responsibility for ensuring that the programme of care is carried out.

**Benefits and service providers:** Services are provided in kind to people who are eligible for benefits in the home or in an institution. The package of services offered includes a variety of community services, such as home nursing, personal care, homemaking, day care, respite care, assistive devices, and night care. Under an experimental programme of “personal budgets,” restricted cash benefits are provided for people who are eligible for care in the home; they must use the cash benefits to purchase services from formal and informal providers. In this way, the family may be compensated for providing informal assistance. The services provided and the frameworks in which they are provided are briefly described below.

**Home care**

The two types of home care — home nursing and home help — are provided mainly by non-profit organizations, which operate in defined areas; there is no competition among them. A few for-profit agencies also provide home care, primarily in the large cities. Providers of home care must meet three criteria: They must provide a range of services, including nursing care, personal care (assistance with ADLs), homemaking, and the loan of assistive devices; they must comply with a set of uniform standards of quality (measured primarily by personnel qualifications); and they must uphold collective labour agreements with professional home help aides and nurses (Boot & Knappen, 1996).

**Home nursing**

Home nursing includes nursing care and the loan of assistive devices (e.g., wheelchairs, walkers, etc.). The services are provided by qualified nurses with a background in public health. The services may be provided for a long or a short period of time. There is no specification of the minimum length of time the service is to be provided. This is adapted to the needs of the elderly person; however, there is a limit on services of 3 hours a day (in exceptional cases, such as the terminally ill, this service may be extended to a maximum of 8 hours per day).

**Home help**

Home help is defined as assistance with housekeeping and personal care, and emotional support. The hours of care provided are determined by the individual’s needs. Home help staff are divided by the type of population served (e.g., those who care for the elderly, those who care for disabled young people), and they receive special training. Sometimes the same worker provides both personal care and housekeeping services.

An additional programme called “Alpha Care” provides home help dispensed by housewives who are paid directly by clients, rather than through a professional service agency. This service is less expensive, and it is limited to 16 hours per week.
Institutional care

Nursing homes

Nursing homes provide diagnosis and assessment, nursing care, rehabilitation and terminal care in a positive social environment.

Residential homes for the elderly

Admission to residential homes for the elderly is limited to those 65 or over. These homes provide an appropriate environment for people who cannot live alone and provide assistance with ADLs, activity therapy, and medications. Sometimes they provide services to the community such as hot meals, alarm systems and emergency assistance, help with bathing and showering, recreational day care programmes and respite care (Monk & Cox, 1991). Adjacent to many residential homes for the elderly are sheltered housing projects for people who are capable of living independently if they have a supportive and adapted environment. AWBZ covers most services in these accommodations.

The distinction between nursing homes and residential homes for the elderly has become blurred over the years. Both types of facilities are now expected to help organize programmes for the community. Most of them have “day hospital” or day care programmes that serve elderly people residing in the community who need supervision for part of the day. AWBZ covers expenditures for both day hospitals and day care, including transportation, consultation, and personal programmes of care.

Other services

The package of services offered by AWBZ is very broad and covers assistive devices, rehabilitation (under special conditions), in- and out-patient psychiatric care, psychotherapy, care of the blind and the deaf (tests, treatment, counseling and institutions), tests for metabolic disorders, vaccinations for children, care for the mentally disabled (e.g. special day care, hostels, institutions), tests for Hepatitis B during pregnancy, and nutritional counseling. Acute hospitals are covered under special circumstances: AWBZ will cover the cost of care, including treatments and room and board, after 1 year; the first year of hospitalization is paid for by an individual’s regular public or private health insurance. If an individual is discharged but re-admitted to the hospital within 26 weeks, AWBZ will cover all his hospital expenses. If the re-admission occurs after 26 weeks have passed, the expenses are covered by regular health insurance. Under certain conditions transplantation of organs may also be covered (Ministry of Health, Welfare and Sport, 1988).

Personal budget

As noted above, the “personal budget” is granted on an experimental basis to people eligible for home care. It enables them to choose and directly pay service providers (whether non-profit or for profit), or pay informal caregivers. In 1995, the Health Insurance Fund Council decided to set guidelines for receiving a personal budget, in order to prevent money from being spent on personal consumption items or employment of aides from the (illegal) “grey” market who are not meant to be covered by AWBZ. These guidelines were voted into law in 1996.

To receive a personal budget, an individual must need care for more than 3 months and must continue to live in his home. Eligibility for a personal budget is determined based on an assessment of need, including whether immediate family members can provide support. The personal budget is calculated by multiplying the number of hours of care that the older person is estimated to need by the authorized cost per hour of the indicated type of care. Need is reassessed every 6 months.
Apart from a small, fixed sum of NFL 2,400 per year, which may be spent on care entirely at the older person’s discretion, an older person does not directly control his personal budget. The Association of Personal Budget-Holders is the intermediary between budget-holders and providers. This arrangement was negotiated by the Ministries of Social Affairs and Finance to assuage anxiety about the possible purchase of services on the grey market and the consequent evasion of social security and income tax payments. While the budget-holder may choose service providers, he delegates financial administration of his personal budget to the Association, which pays the providers.

Service providers and quality assurance: Services may be provided by governmental agencies, NGOs and for-profit agencies. There have been efforts to increase the role of the for-profit sector, but the majority of the services are provided by NGOs.

Quality assurance is the responsibility of the national government, and a number of systems of quality assurance are used. There is periodic formal inspection of service providers by a representative of the health care system. Providers are also expected to have internal quality control mechanisms that assess services. It is in their interest to present themselves as providing a high level of services, given the competition among providers. Finally, the law mandates that every agency supplying care have a consumer council. Efforts are now underway to strengthen quality assurance. Structured instruments for inspection and regulation are being developed (Huijbers, 1999), and the federal government is planning to increase regulation by setting price and quality standards (Coolen & Weekers, 1998).

Finance: AWBZ is funded through a compulsory premium, a co-payment, and general taxation.

The compulsory premium is integrated into the income tax structure. In 1997, the premium was 8.85% of income; it rose to 9.6% in 1998 for people earning between NFL 8,600 and NFL 47,000 a month. The employer pays the lion’s share of the premium. Those who earn above NFL 47,000 pay a flat payment. Children (under the age of 15) and persons over 15 with no taxable income are not required to pay a premium (Ministry of Health Welfare and Sport, 1998).

Co-payments are determined by the type of care and the recipient’s level of income. For home nursing, there is a payment of NFL 55 annually to register with a home nursing agency, which then makes the co-payment on its members’ behalf. If an individual needing home nursing does not belong to such an agency, the required membership fee for the first year is NFL 137. The co-payment for home help and for Alpha Care is NFL 10 per hour. Those with lower incomes pay NFL 5 per week, regardless of the number of hours of care they receive. The maximum co-payment for all forms of home care is NFL 250 per week. Co-payments for home care (and Alpha Care) are transferred to the Central Administration Office (CAK) of AWBZ, which pays the service providers. Even those receiving the “personal budget” may be charged a user’s fee similar to that charged for services in kind, depending on their income.

The co-payment for institutional care is determined according to an individual’s income (but not assets – as was the case prior to 1997). The co-payment is set yearly by the Ministry of Health. In 1998, the monthly co-payment was NFL 2,200. However, individuals earning less than NFL 4,734 per month (and couples earning less than NFL 7,893) are exempted from the co-payment. The co-payment for long-term care institutions is determined in the same way as that for old age homes. People under age 65 have a co-payment of NFL 1,350 per month (Huijbers & Martin, 1998).

Coverage: At the time of this writing, no data was available on the total number of beneficiaries of the AWBZ law. To provide some indication of utilization of services, Table 1 shows the rate of utilization among those 65+ by kind of service, and Table 2 shows the
utilization rate of people aged 75+ by level of disability, based on a 1990 study by Coolen (1995).

In 1990, 9.5% of the elderly were in an institution, less than 1% were admitted for short-term stays in an institutional setting, 20% received home nursing on an occasional basis, 4.5% received home nursing on a regular basis, and 9% received home help.

### Table 1: Percentage of the Elderly Population (Age 65 and Over) Using Services (1990)

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage of Elderly Using Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing homes</td>
<td>2.5</td>
</tr>
<tr>
<td>Residential homes for the elderly</td>
<td>7.0</td>
</tr>
<tr>
<td>Short-term admission in residential homes</td>
<td>0.7</td>
</tr>
<tr>
<td>Day care in nursing homes</td>
<td>0.3</td>
</tr>
<tr>
<td>Day care in residential homes</td>
<td>0.8</td>
</tr>
<tr>
<td>Home nursing on regular basis</td>
<td>4.5</td>
</tr>
<tr>
<td>Home nursing – occasional</td>
<td>20.0</td>
</tr>
<tr>
<td>Home help</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Source: Coolen, 1995

A later analysis of service utilization by Coolen and Weekers (1998), among a random sample of 1,226 elderly people age 75 and over, illustrates the variation in utilization with functional status: the utilization rate among the moderately disabled (disabled in IADLs) was 44% as compared to 88% among the very severely disabled (disabled in ADLs and IADLs) (see Table 2). The table also shows that 16% of the moderately disabled were in an institutional setting, while the percentage among the severely disabled reached 69%.

### Table 2: Use of Long-term Care among People Age 75 and Over, by Level of Disability* (in %)

<table>
<thead>
<tr>
<th>Level of Disability</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home help or home nursing</td>
<td>10</td>
<td>27</td>
<td>24</td>
<td>11</td>
</tr>
<tr>
<td>Home help and home nursing</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Residential homes for the elderly</td>
<td>6</td>
<td>16</td>
<td>35</td>
<td>51</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>44</td>
<td>76</td>
<td>88</td>
</tr>
</tbody>
</table>

*Moderate disability = inability to perform homemaking tasks; severe and very severe disability = inability to perform ADLs and homemaking tasks.

Source: Coolen and Weekers, 1998

The data suggest that compared to other countries, there is a high level of utilization of institutional care, and a high level of utilization of occasional home nursing that in other countries is often financed through health insurance. Moreover, the pattern of service utilization reflects the absence of a minimum disability level.
No data were found in the literature on the number of applications for AWBZ services that were rejected. Data began to be collected on the number of applicants and rejections in 1998, when RIO activities began.

**Cost:** By 1997, the expenditures for the services covered under AWBZ amounted to NFL 26,267 million (about $13 billion). The proportion of expenditures on services for the elderly was about 52%: 21% for long-term care institutions, 20% for old age homes, 7% for home help and 4% for home nursing. Forty-eight percent of the budget was spent on other services (see Table 3).

### Table 3: Expenditures for AWBZ Services in 1997 (%)

<table>
<thead>
<tr>
<th>Service</th>
<th>Total Expenditure (NFL 26,267 million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing homes</td>
<td>21</td>
</tr>
<tr>
<td>Homes for the elderly</td>
<td>20</td>
</tr>
<tr>
<td>Home help</td>
<td>7</td>
</tr>
<tr>
<td>Home nursing</td>
<td>4</td>
</tr>
<tr>
<td>Other services</td>
<td>48</td>
</tr>
</tbody>
</table>


The breakdown of financing in 1997 (provided by Huijbers & Martin, 1998), was as follows:

1. Premiums - NFL 23,844 million (87%).
2. Co-payments - NFL 3,421 million (12.5%). Co-payments for residential homes were 32% of expenditures, co-payments for nursing homes were 12% of expenditures, co-payments for home nursing were 16% of expenditures, and co-payments for home help were 12% of expenditures.
3. General revenues through the Ministry of Health - NFL 107 million (0.4%).

Expenditures increased from NFL 24,841 million in 1993 to NFL 28,265 in 1998. However, the increase was the result of the transfer of some services to the AWBZ basket of services, and hence a reduction in expenditures elsewhere in the health system (Huijbers & Martin, 1998). It is estimated that the Netherlands devoted about 3.6% of the GNP to the AWZB law.

### Issues in the Implementation of the Exceptional Medical Expenses Act

There has been no systematic evaluation of the long-term care insurance law in the Netherlands. In fact, constant changes in the law have made it difficult to evaluate the law’s implications for addressing needs and costs. For example, one goal of the law was to preclude institutionalization. Indeed, institutionalization rates have dropped over time - from 10% in the 1970s, to less than 7% in 1995. However, because there has been no systematic evaluation of the law, we do not know what part it played in the reduction of institutionalization rates. We do know that the reduction was due in part to the creation of national standards for the supply of long-term care beds (de Klerk, Huijsman, & Rutten, 1995). At the same time, the Netherlands has been active in the implementation and evaluation of experimental programmes aimed at resolving problems that have persisted in the system such as lack of coordination and continuing efforts have been made to reduce the rate of institutionalization and enhance flexibility in meeting individual needs (Peterson & White, 1989; Alter & Hage, 1993; Ballock & Evers, 1991). As noted earlier, the Dutch
government has supported the development of experimental programmes that allocate personal budgets, expand services (e.g. sheltered housing and short-term institutionalization), and increase cooperation among service providers.

There is a particular need for systematic evaluation of the personal budget programme. As noted above, this is intended for people who are eligible for home care, and it provides a sum of money that may be used to purchase services or pay informal caregivers, at the recipient’s discretion. Since most of the expenditures for long-term care for the elderly take the form of in-kind services, only 3%-5% of total expenditures are allocated for the personal budget programme. In 1997, about 3,500 beneficiaries received a personal budget. Service utilization patterns and satisfaction among the beneficiaries in this programme have been monitored (Miltenburg & Ramakers, 1996; Ramakers & Miltenburg, 1997 in Coolen & Weekers, 1998). It was found that most of them (54%) use the personal budget for housekeeping services, 10% for personal care, 4% for home nursing, and 32% for a combination of various types of care. The studies reported that recipients of personal budgets were satisfied with the control of care these gave them. Of those who used their personal budget to purchase housekeeping services only, one-third (37%) hired informal caregivers or unorganized workers, while two-thirds (63%) contracted with a professional agency. Some beneficiaries think of the personal budget primarily as a way of rewarding informal caregivers. An indirect positive consequence of personal budgeting has been increased pressure on established providers to become more competitive in quality and price. According to Weekers and Pijl (1998), the most striking findings from evaluation studies are the reported improvement in the quality of services and increases in elderly budget-holders’ feelings of autonomy. Beneficiaries have reported that service providers related to them better, and they experienced fewer turnovers of workers than before.

Despite their satisfaction, personal budget recipients have complained that the process of receiving a personal budget is lengthy, and information about eligibility is insufficient. Professionals have criticized the lack of sufficient alternative suppliers of services to enable real choices of services, the lack of flexibility in service provision, and problems of coordinating service provision (services may be provided by a number of personnel working in the same organization). At present, the choice of service providers is limited, since most service providers operate as monopolies (Coolen & Weekers, 1998).

Associations of disabled and elderly people have pushed for greater access to personal budgets, emphasizing that this would increase their freedom to choose the type and amount of services they receive. However, opposition has arisen among service providers, which fear for their market shares, and among labour unions, which want to protect their members’ rights. Policy makers also cite problems of cost containment.

Some model projects have introduced innovative methods of service provision, with improved coordination and flexibility. Experiments conducted in Groningen, Rotterdam, Nieuwegein, and Venlo, for example, show that some substitution of community care for institutional care is possible (Evers & Leichsenring, 1994; Coolen, 1995; de Klerk et al., 1995). A number of these experimental programmes have created case management mechanisms or umbrella organizations that pool their funds to provide services; allocate personnel, resources and services; organize service provision; evaluate needs; and intervene in the community to reduce admission to institutions. However, their impact on the overall cost of long-term care has been modest.

As Coolen and Weekers (1998) note, some success has been achieved in preventing the blocking of hospital beds and reducing lengths of hospital stay. Programmes of continuing care at home – that is, medical care for chronically ill elderly patients provided by qualified nurses and physicians – have reduced bed blocking to less than 5% of total hospital days. As Coolen and Weekers (1998) also point out. However, some of the experimental programmes have generated additional demand for formal care from “new clients” – people
who had previously relied on themselves or informal support. For example, programmes like intensive home care, day care, short-term institutionalization, and sheltered housing have proved attractive to people who are not at risk. As a result of this kind of expansion, even if institutional rates are reduced, the overall cost of LTC is not lower.

The Dutch system has unique features that clearly distinguish it from the other long-term care systems. Most striking are the broad commitment to meeting needs, the flexibility of the system, and the efforts to tailor services to individual and family needs. The end result is a holistic approach to assessment of needs and eligibility, which includes family care.

4. Israel

Background

In 1999, Israel had a population of 5.7 million, 567,164 of whom (9.9%) were age 65 or over, and of those nearly 250,000 (4.4%) were age 75 or over (International Data Base, 2000). It is estimated that the proportion of elderly people in the population will remain stable up to 2010, but will reach 14% of the total population by 2025 (United Nations, 1998).

The elderly support ratio in relation to the working-age population (that is, the number of persons 65 and over per 100 persons age 20 to 64) stands at 19, and it is expected to reach 24 by 2025. Life expectancy at birth is 80.61 years for women and 76.71 for men (International Data Base, 2000), and life expectancy at the age of 65 is 17.8 years for women and 15.8 for men (World Health Statistics Annual, 1996). Disability-adjusted life expectancy at birth is 71.6 years for women, and 69.2 years for men; expectation of disability at birth is 8.3 years for women and 7.1 years for men (World Health Report, 2000).

While Israel's population is still significantly younger than that of other developed countries, it has aged very rapidly. In less than 50 years, the proportion of the elderly has doubled. Immigration plays a unique role in Israel. In the past, the immigrant population tended to be relatively young, thereby having the effect of slowing the rate of aging of the overall population (Brodskey & Bergman, 1993; Habib & Tamir, 1995). This has changed with the recent recurrence of large-scale immigration, primarily from the former Soviet Union, which began in 1990. The number of elderly immigrants from the former Soviet Union had reached 109,000 by the end of 1998 – 18% of all of the elderly in Israel. The population of immigrants from the former Soviet Union (16% of whom are age 65 or older) is older than the general Israeli population. Therefore, it has and will continue to contribute significantly to growth in the population of elderly (Mashav, 1999).

Most relevant to the planning of long-term care services is the growth in the population of disabled elderly. In recent years there has been a proportionally greater increase in the number of elderly who are disabled. The changes that have taken place in the age, gender and ethnic origin of Israel's elderly population have contributed to the increase in the number and proportion of disabled elderly. During the past two decades, the number of disabled elderly has grown 2.5 times, and in 1997, about 14% of the elderly (including those living in institutions) were disabled in at least one of the activities of daily living (ADLs).

The percentage of elderly people who live alone increased from 12% in 1961 to 28% in 1995. However, this does not necessarily indicate a lessening of family willingness to provide help and support. Family structure has remained fairly traditional in Israel. Most of Israel's elderly have an informal support system, and the majority are cared for at home: only 4.5% reside in long-term care institutions. Even among the disabled elderly, 76% live at home. It is clear that this would be impossible without a great degree of family support (Brodskey & Habib, 1997, Brodskey & Naon, 1991; Noam & Habib, 1992).
The parent support ratio, that is, the number of those age 80 and over per 100 persons age 50-64, stands at 20, and will remain stable to 2025. The parent support ratio for females (the number of those age 80 and over per 100 women age 50-64) stands at 39 and will reach 42 by 2025 (International Data Base, 2000); that is, fewer women will be available to care for the increasing population of elderly. Reliance on informal caregivers is based on the assumption that women are available to fill caregiving responsibilities. The increasing number of women joining the labour force makes it crucial to understand the implications of labour force participation for caregiving, and the ways in which the burden of care affects the primary caregiver’s work responsibilities. It is also important to examine the balance of familial and state responsibility for the elderly (Brody & Morginstin, 1999).

The System of Care

In response to the aging of Israel’s population over the past two decades, the system of services for the elderly has undergone rapid development and change. Social services in general have grown dramatically in Israel, and services for the elderly have increased in tandem.

Acute Health Services

In January 1995, a new National Health Insurance Law went into effect. This law mandates universal health coverage and defines a basic basket of services to which all citizens are entitled. Within the framework of this law, all of Israel’s residents are insured by one of four service providers, or sick funds (similar to American health maintenance organizations). Even before implementation of the law, 95% of the population was voluntarily enrolled in one of the four sick funds.

In addition to assuring universal coverage and the right of mobility among sick funds, this law introduced a capitation formula for allocating health insurance premiums, collected by the National Insurance Institute (Israel’s social security administration). The capitation formula is weighted according to age, thus providing an incentive for sick funds to develop and improve services for the elderly. However, there is ongoing debate about the adequacy of this incentive. As in all countries, the elderly use health services more than any other segment of society. Visits to physicians by the elderly are double those of the general population, and the elderly’s rate of hospitalization is three times higher than that of the general population, accounting for approximately 40% of hospitalization days (Mashav, 1999).

Health services covered by the law include primary care (ambulatory care), acute hospitalization, medications, laboratory tests, medical rehabilitation, and professional home care (provided by doctors and nurses). Institutional long-term care services for the severely disabled were intended to be included; however, this component of the law has not been implemented, and it is not clear if and when it will be implemented.

The health insurance programme is funded mainly through individual income-based premiums paid directly by employees to the social security administration and by several revenue sources which are then distributed using the capitation formula. The majority of primary care is provided at neighbourhood clinics that integrate medical, nursing and paramedical staff. Acute inpatient care is provided by hospitals, which are owned by the government, the largest sick fund, or a public organization. An important aspect of the evolution of inpatient care for the elderly has been the development of geriatric wards, which provide follow-up or intensive rehabilitation to patients who have been discharged from other hospital wards. Another model of geriatric care is the multi-level geriatric complex, which ensures continuity between acute care, rehabilitation, and long-term institutional care.
The System of Care for the Disabled Elderly

Responsibility for financing services for the aged is shared by a number of agencies; they include the National Insurance Institute, the Ministry of Labour and Social Affairs, the Ministry of Health, and the four sick funds. These agencies operate within a clearly defined but complex system in which responsibility is determined by type of service and by level of disability, classified along a continuum from dependency in instrumental activities of daily living (IADLs) (the semi-independent), to moderate dependency in ADLs (the frail), to severe dependency or cognitive impairment (the severely disabled and mentally frail and those requiring complex or medically skilled nursing care). The National Insurance Institute, or social security administration, provides community services for chronically disabled and mentally frail elderly under the Community Long-term Care Insurance Law, which is described below. The Ministry of Labour and Social Affairs is responsible for financing institutionalization and community care (personal care, housekeeping services) for the semi-independent and frail elderly, and for operating day care and sheltered housing frameworks. It does so through a network of local social bureaus, which provide these services on a discretionary basis and within budgetary constraints. Eligibility criteria for public assistance are based on an assessment of the family situation and a means test. The Ministry of Health is responsible for institutional care for the severely disabled, and the sick funds are responsible for elderly people who require complex nursing (medically skilled nursing) in institutions.

The rate of institutionalization is relatively low: About 4.5% of the elderly are in institutions: 2% are in homes for the aged (the responsibility of the Ministry of Labour and Social Affairs), and 2.5% are in nursing homes (the responsibility of the Ministry of Health). For the most part, the government is not involved in the direct delivery of long-term care services. Government authorities refer patients to institutions, some of which are private (for-profit) and some of which are NGOs. About half of the individuals in institutional settings are referred to them by the Ministry of Health or the Ministry of Labour and Social Affairs, and the government participates in the financing of their care. The other half self-refer to institutions and they pay for care themselves, without government assistance.

Thus, the two major sources of funding of institutional long-term care are the elderly and their families, and the government - that is, the Ministry of Health and the Ministry of Labour and Social Affairs. Government assistance is based on an income test. Interestingly enough, according to the Alimones Law, which provides for filial responsibility, children in Israel are required to contribute to the cost of institutional care, depending on their economic situation and that of their elderly parent. In 1999, for example, individuals who were referred by the Ministry of Health to institutions and received public assistance contributed about 17% of the cost of their care. In addition, about 30% referred themselves to nursing or mentally frail beds privately, without public assistance. In 1999, total public expenditures for institutional nursing care covered about 55% of the costs; the remaining 45% was paid out of pocket by patients or their families (Bin-Nun, 1999).

As noted above, when the National Health Insurance Law was enacted, it mandated that after 3 years of implementation (that is, in 1998), responsibility for institutional long-term care of the severely disabled elderly (the mentally frail and those requiring complex nursing care) would be transferred from the government (Ministry of Health) to the sick funds. This approach was based on the view that the sick funds should take responsibility for the medical and nursing care of the elderly, along a continuum from acute to chronic care. However, questions have arisen about the feasibility and desirability of making this transfer. First, some policy makers and service providers have expressed concern that long-term care services may be neglected when they are integrated into the more general health system and acute health care needs may receive greater priority. It has also been pointed out
that if the financing of acute and long-term care is integrated, it will be necessary to revise the capitation formula. However, developing adequate financial mechanisms to compensate the sick funds for the risks of long-term care is problematic. These mechanisms are required to avoid disincentives to serve persons with greater long-term care needs. But in the Israeli health system, there are already competitive providers of health services with an incentive to avoid the more complex, difficult and costly cases. A special national committee was established in October 1999 to re-examine the feasibility and desirability of integrating the organization and financing of the acute and long-term care systems. In April 2000 the committee recommended that, because of the concerns noted above, the systems should not be integrated. However, it recommended that efforts should be made to improve coordination between the two systems and to develop mechanisms to ensure continuity of care.

The Community Long-Term Care Insurance Law

As noted above, the National Insurance Institute provides community services to the chronically disabled and mentally frail elderly under the Community Long-term Care Insurance (CLTCI) Law. This law is responsible for major changes that have occurred in the provision of community care for the elderly in recent years. In the 1980s, forecasts of a significant growth in the number of disabled elderly raised fears that the cost of institutionalization would skyrocket if alternatives were not found. At the same time, uneven distribution of funding for community and institutional services led to the desire for a more appropriate funding balance. Policymakers realized that they had not sufficiently considered community resources as an alternative way to meet the needs of the elderly. Moreover, there was consensus regarding the desirability of enabling the elderly to remain in the community for as long as possible and making institutionalization a last resort. All of these factors led to a range of efforts to develop community services (Habib & Factor, 1993).

Despite the consensus about the need to expand home-care services, a major debate arose as to the best way to develop these services. This debate focused on whether the right to home-care services should be an entitlement under social security or subject to budgetary constraints. Israel chose to adopt the social insurance approach. In 1980, a 0.2% employee contribution to national insurance was levied to create a reserve fund for implementing the law. In 1986, the Israeli Parliament completed the enactment of the Community Long-term Care Insurance (CLTCI) Law, and full implementation began in April 1988.

This legislation has produced dramatic change in the system of long-term care – in the quantity of resources available for home care and in the organization of service provision, and it made a transition from discretionary, budgeted programmes to universal entitlement to benefits. The CLTCI Law formally defined the government’s legal obligation to provide a minimum level of long-term care services to the disabled elderly, based on personal entitlement and clearly defined eligibility criteria. The law thus reflected a commitment to statutory allocation of resources for functionally dependent elderly.

**Insurer:** The National Insurance Institute is responsible for implementation of the CLTCI Law; it has become the major source of funding for personal care services for the disabled elderly.

**Eligibility criteria:** Eligibility is extended to men over age 65 and women over age 60 who are functionally disabled in activities of daily living (ADLs), or who require constant supervision as a result of cognitive disabilities (this need is defined as the risk that an individual, if left unsupervised, will harm either himself or others).

Elderly people residing in nursing homes are not eligible for benefits under the law. Nevertheless, 15% of annual contributions are transferred to the Ministry of Health and the Ministry of Labour and Social Affairs for financing institutional placement.
It should be noted that, since 1979, social security has provided benefits to disabled people under the Attendance Allowance Law and the Disabled Child Law. The attendance allowance is provided to disabled people who, in addition to having lost their earning capacity (which entitles them to a disability pension), are limited in their daily functioning and require the assistance of others. An unrestricted cash benefit is provided to persons who are dependent on the help of others to perform everyday functions as a result of a physical or mental impairment. Earlier questions were raised about the need for similar legislation for the elderly, who were not eligible for an attendance allowance if they applied after reaching retirement age. With implementation of the CLTCI Law, an impaired person receiving an attendance allowance benefit who has reached the age of 60 (for women) or 65 (for men) can choose to continue receiving a cash benefit under the Attendance Allowance Law, or to transfer his entitlement and receive benefits under the CLTCI Law.

As noted above, difficulty in performing activities of daily living (ADLs) and the need for constant supervision are the primary criteria for eligibility under the CLTCI law. Eligibility for benefits is based on the level of need for assistance, as indicated by the number of hours of assistance required per day; benefits are granted to elderly people who need at least 2.5 hours of personal care per day. Eligibility for benefits is not affected by the informal assistance an elderly person receives or may receive from family members. Thus, Israel has chosen a universal programme in which disability, rather than a subjective evaluation of potential informal support and unmet need, is the basis for eligibility. However, an applicant's living situation (whether he lives alone or with others) is factored into the assessment of eligibility: an elderly person living alone receives extra points in the assessment of eligibility; this is described below. The less disabled elderly, who are not eligible for services under the CLTCI Law, may receive home care services from the social welfare system under a budget-restricted, income-tested programme, which provides fewer hours of care.

There is a means test for receiving benefits under the CLTCI law, but it is set at a high level relative to the income status of the elderly. To be eligible for full benefits, a single person must have an income that is not higher than the average wage, and a couple must have an income that is not higher than 1.5 times the average wage. An additional amount equivalent to half the average wage is added for each child. Half of the benefit is provided when income exceeds the means test but is not higher than 1.5 times the average wage for a single person, or 2.25 times the average wage for a couple; in these cases, an additional sum of 0.75% of the average wage is added for each child. Those with higher incomes are not eligible for benefits.

*Eligibility assessment:* The assessment of disability is performed by public health nurses from the Ministry of Health, under contract with the National Insurance Institute. This assessment has legal standing as the basis for eligibility determination and is subject to judicial review on appeal. It is carried out at the home of the applicant, using a structured protocol. The first part of the assessment covers five ADLs: mobility, dressing, bathing, feeding and incontinence. Scores ranging from total independence to total dependence are given in each area. Intermediate scores in each area reflect either the ability to perform an activity only when assisted, and/or the need for prompting to perform the activity. The second part of the assessment involves determination of the need for the constant presence of another individual in the home to prevent the applicant from harming himself or another. This assessment takes into account the applicant's awareness of his surroundings, and his judgment, memory and history of accidents (Zipkin & Morgenistin, 1998).

ADL scores may range from 0 to a maximum of 8 points; in addition, the need for constant supervision gives 6.5 points, and living alone gives 2 points (therefore, the maximum a person may receive is 16.5 points). Israel has set two levels of eligibility: for the
lower benefit level, a minimum of 2.5 points (or 2.0 for those living alone) is required, while for the higher benefit level, a minimum score of 6.5 points is required.

The greater the number of levels into which eligibility is divided, the greater the extent to which resources may be allocated according to functional level. Therefore, in Israel, after 11 years of experience, the levels of care have been re-examined, and a change in the law has been proposed to include three levels of disability instead of two.

Eligibility may be reassessed on the initiative of the National Insurance Institute, or on the initiative of an applicant who wants to increase his or her eligibility level. A high percentage of reassessments are performed on the applicant’s initiative.

**Benefits:** Basic eligibility is for in-kind services. Cash benefits are provided only to eligible people for whom services are unavailable, and only then if the beneficiary does not live alone (because it is assumed that a disabled elderly person living alone would not be able to use the cash benefit effectively. A negligible number of elderly have received cash benefits due to the unavailability of a service provider.

The “basket of services” provided under the law includes a defined list of community services: personal care, housekeeping, day care, laundry services, undergarments for the incontinent, and emergency alarm systems in the home.

Services are provided at two benefit levels, as noted above: at the lowest benefit level, services are paid for at 25% of the average wage, while the highest benefit level pays for services at 37.5% of the average wage (in 1999, payments at the basic benefit level were equivalent to about $360, which can purchase about 10 hours of personal care per week, and at the higher benefit level they were equivalent to $540 or 15 hours of personal care per week).

An elderly person may choose to use the benefits for a combination of services: for example, two visits a week to a day care centre and the remainder in personal care services. In the rare cases when services are unavailable, the cash benefit is provided at a rate of 80% of the relevant benefit level; the difference is attributable to administrative costs for providing benefits in-kind.

As noted earlier, upon submission of an application, a public health nurse assesses dependency at the home of the applicant. This generally takes no longer than 2 weeks, including receipt of the assessment by the local office of the National Insurance Institute, where eligibility and level of eligibility are officially determined. Once eligibility has been established, responsibility for administering the benefits is delegated to a local professional committee, comprising representatives of the local branch of the National Insurance Institute, the social welfare department of the local authority, and a nurse from the largest sick fund. In consultation with the beneficiary, these local committees devise a care plan and identify the agency that will provide personal care services. Under the law, services must be provided to a beneficiary within 60 days of the first of the month subsequent to submission of the application (in reality, services are provided much sooner).

**Providers and quality assurance:** Home care (personal care and housekeeping services) is provided by semi-professional staff working in certified, licensed agencies. These agencies may be NGOs or for-profit agencies. The choice of service provider is made by the local committees responsible for care planning, in consultation with the client and his family. During initial implementation of the law, there was a great deal of concern about the adequacy of the supply of services. Therefore a decision was made to encourage service development, expand the network of community services and allow the entrance of for-profit agencies. The concern about supply proved to be unjustified since there was a tremendous growth in community services following implementation of the law and enhanced competition among providers. At present, about 114 organizations (243 agencies, including branches) employ about 40,000 home-care workers, many of whom work part-
time. There has been a particularly dramatic increase in for-profit organizations, but the number of non-profit agencies has increased as well. In the past, publicly funded personal care services were provided either by large, national, non-profit organizations or by non-organized workers. At present, 11 years after implementation of the law, 73% of the service provider organizations are for-profit, and about 60% of eligible elderly receive care from these new for-profit service agencies.

This proliferation of service providers has created a dilemma. On the one hand, competition, in principle, improves the quality of care and enhances choice. On the other hand, when there are a large number of service providers in the market, inspection of quality becomes complicated. Furthermore, uncontrolled competition can lead to bankruptcy, particularly of smaller for-profit providers; and this is detrimental to the continuity of care for the elderly. To prevent such a scenario, the National Insurance Institute has intervened in order to limit the number of providers (for example, by setting a minimum number of clients per provider) (Katan & Loewenstein, 1999). This was challenged in the courts by the agencies, but the agencies lost the case, enabling the National Insurance Institute to set criteria by which providers may be selected by tenders. This plan is currently in operation.

In an additional effort to encourage service supply, the CLTCI Law established a fund (set at 10% of annual contributions) for the development of both community and institutional services. Although the fund was initially temporary and was meant simply to ease the transition to the new law, it has been continuously extended. A significant proportion of this allocation has been used to develop day care centres and train home-care workers. Allocations to long-term care institutions have been used to expand the supply of beds and upgrade services.

Israel employs several mechanisms of quality assurance: licensing of service providers, structured training of home care workers, the development of standards of quality, and the creation of quality assurance mechanisms.

Israel's law stipulates that care can be provided only by agencies licensed by the Ministry of Labour and Social Affairs. These agencies are required to submit to inspection of their personal care workers, by social workers, nurses, or senior personal care workers.

The National Insurance Institute has invested considerable effort in the development of structured training courses for personal care workers in the home. The first such courses provided 106 hours of training. Efforts were then made to reduce the cost and enhance the efficiency of these courses. At present, a 50-hour course emphasizing basic caregiving and communication skills is offered. Personal care workers may also attend supplementary courses that increase their skills and train them to care for specific populations, such as the severely disabled elderly or the mentally frail (Korazim & Kahan-Strawczynski, 1997). It should be noted that participation in these courses is not mandatory.

The agencies also provide in-service training to every new personal care worker. There are still no uniform standards for the extent of training, and there is a great deal of variation in the training provided by different agencies, but nevertheless, training is very widespread. Moreover, standards of quality have been developed for personal care workers, and these have been disseminated in three languages (Hebrew, Arabic and Russian) (Korazim & Kahan-Strawczynski, 1999). The agencies providing personal care use these standards as a training tool. A study of home care workers currently underway is examining their background, work experience, work performance, satisfaction with job and training needs. The study results will provide a basis for future quality and manpower development (Korazim & Goren, forthcoming).

The National Insurance Institute monitors long-term care in two ways: 1) through sample interviews with the elderly in their homes to examine whether the beneficiary is receiving the appropriate quantity and type of services, and determine how satisfied the
beneficiaries is with the services; and 2) through an organizational review of agencies, which includes the appropriateness of payments to personal care workers, to ensure that all the social benefits covered by wage agreements are paid. These reviews are conducted annually on about one-third of the service providers, such that each provider is reviewed at least once every 3 years. Those providers who are found deficient are again reviewed the following year.

Interestingly, the volunteer unit of Israel’s social security administration has implemented a programme in which volunteers monitor beneficiaries under the law. These volunteers call the beneficiaries and ask them whether they are satisfied with services and whether there are any problems with service providers; if there are, they are reported to the social security administration. The programme has been quite successful in identifying problems.

Day care centres providing services under Israel’s Community Long-term Care Insurance Law must also be licensed. The Ministry of Labour and Social Affairs is responsible for licensing, as well as inspections based on new standards of quality developed in recent years (Korazim & Kahan-Strawczynski, 1997).

**Finance:** There are two sources of financing of the CLTCI Law: a special payment to the National Insurance Institute, and general taxation. Contributions began to be collected in 1980 and were set at 0.2% of employee wages. They were divided equally between employers and employees (0.1% each). As a result of subsequent government policy, the rate for employers has been reduced to 0.06%; the government pays the 0.04% difference. In addition, government support covers elderly immigrants who would have been ineligible under earlier residency requirements (12 months’ residence), and housewives who are uninsured under the social security law. This coverage has constituted an increasingly large share of total benefits (now about 20%) (Zipkin & Morgentin, 1998).

**Coverage:** In 1999, 88,185 elderly were entitled to benefits under the CLTCI Law (23,928 men age 65 and over, and 64,257 women age 60 and over), representing about 12% of the elderly population. A 1997 analysis of benefit recipients revealed that more than half were age 80 or over. Table 1 shows the rate of coverage by age and sex.

| Table 1: Eligibility Rates (%) for Benefits, by Age and Sex, 1997 |
|-----------------------------|------------------|
| **Total**                   | 11.1             |
| **Age**                     |                  |
| 60-64                       | 1.5              |
| 65-69                       | 3.5              |
| 70-74                       | 7.5              |
| 75-79                       | 14.0             |
| 80-84                       | 23.3             |
| 85 and over                 | 41.7             |
| **Gender**                  |                  |
| Men (65 and over)           | 8.4              |
| Women (60 and over)         | 12.6             |

Source: National Insurance Institute, 1999
In 1997, about 11% of the elderly target population were eligible for benefits. Rates among elderly women were substantially higher than for men; they stood at 12.6%, compared to 8.4% among men. As would be expected, the rate of eligibility rose sharply with age. In 1997, the rate for men and women age 65-69 was 3.5%, while the rate for men and women age 85 and over was 41.7%.

Table 2 shows that in 1997, 78% of all beneficiaries were eligible for the lower benefit, while 22% were eligible for the higher benefit. The overwhelming majority of beneficiaries received personal care services in their homes. Emergency alarm systems have become increasingly popular, and in 1997, 13% of beneficiaries received them. Also, a significant proportion of beneficiaries attended day care centres and received disposable undergarments (about 7% each).

<table>
<thead>
<tr>
<th>Level of Benefit</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower benefit</td>
<td>78.0</td>
</tr>
<tr>
<td>Higher benefit</td>
<td>22.0</td>
</tr>
</tbody>
</table>

**Type of Service**

- Personal care at home: 88.8
- Day care: 7.1
- Disposable undergarments: 6.9
- Emergency alarm systems: 12.6
- Laundry and other: 0.8

*A person may receive more than one service at a time.

Source: National Insurance Institute 1999

The annual percentage of applications has remained stable for the past several years (about 8% of the elderly population), as has the rate of approval (about 50% of the applications). However, the rate of re-applications has shown a steady rise, and these accounted for an estimated 45% of all applications in 1997 (Zipkin & Morginstin, 1998).

**Cost:** In 1999, total expenditures for the CLTCI programme were almost NIS 1.5 billion (about $370 million). These expenditures included direct benefits to eligible elderly, 15% of annual contributions transferred to the Ministry of Health and the Ministry of Labour and Social Affairs to cover the cost of financing institutional beds, and 10% of annual contributions for the development of services. Israel devotes about 0.36% of the GNP to the Community Long-Term Care Programme.

Annual operating expenditures have outstripped contributions, and the deficit is now more than half the expenditures; this deficit has been financed with surpluses from other branches of the National Insurance Institute. The unexpectedly high cost of the CLTCI programme is due to the fact that demand for services has exceeded forecasts.

Efforts are being made to identify the reasons for the deficit and to address this problem. Various approaches are being tried. One approach has been to re-examine the reliability and validity of the assessment of eligibility for benefits. Another is to strengthen the periodic reassessment of functional status, so as to ensure that only those who are eligible for benefits continue to receive them. To date, however, reassessment has been problematic, for bureaucratic reasons. Furthermore, some have questioned the cost-
effectiveness of reassessment and the balance between the frequency of reassessment, its
cost, and the savings from the expected reduction in the number of beneficiaries (Zipkin &
Morginistin, 1998). The National Insurance Institute is now in the process of amending
eligibility criteria to include a newly defined sub-group of elderly people who will be
eligible to receive services for only a limited (2-month) period. These include people whose
profile indicates that their need for care may be short – such as those who are discharged
from an acute hospital and who have a threshold ADL score indicating that they need home
care services, but whose functional ability may improve over time. After 2 months, these
clients may reapply if they still need benefits. It is hoped that this reform will reduce the
number of beneficiaries over time and contain costs.

Issues in the Implementation of the Community Long-term Care Insurance
Law

When the law was passed, its overall objectives were to reduce unmet needs, lessen
the burden on family caregivers, and preclude unnecessary institutionalization of the
elderly. Several studies have examined the law’s effects in these areas.

Coverage of Community Long-term Care Services

The first effect of the law was to tremendously increase the resources earmarked for
community care. This resulted in a more balanced allocation of public resources between
institutional and community care. Prior to the law’s implementation, expenditures for
community services were limited, representing only 17% of public funds for long-term care
(Naon & Strosberg, 1995). Since 1994 (four years after the law’s implementation) public
funds for community care have constituted about half of public funds for long-term care.

The law has had a dramatic effect on the coverage of disabled elderly people. The
number of elderly receiving home care increased from 7,000 prior to implementation of the
law to 88,000 in 1999 – that is, from 2% to nearly 12% of the total elderly population.

The increase in the number of those receiving care reflects, in the main, the very
dramatic increase in the number of moderately disabled elderly people who have begun
receiving services. In the past, this group had “fallen between the cracks” due to budgetary
constraints and the division of service provision between the health and the social services
(Brodsky et al., 1993).

Informal Care

As expected, research has shown that the addition of services has had a positive
effect on the well-being of the elderly and has reduced their unmet needs. Because the
programme is intended to complement, rather than replace the existing system of service
provision and family care, benefits cover only a small portion of total needs. Policymakers
were nevertheless concerned initially that the increase in formal services might cause
families to relinquish their caring responsibilities; however, experience has not substantiated
this concern. In Israel, no evidence has been found of a decrease in the amount of informal
services because of the provision of formal services. It appears that community services have
supplemented rather than replaced informal care. Yet caregivers’ sense of burden has been
significantly reduced (Morginistin & Baich-Moray, 1992; Brodsky & Naon, 1993) because the
availability of formal services allows family members more choices about what type of care
they will provide. In addition, the knowledge that formal care is guaranteed by statute and
therefore reliably available gives families a sense of security that encourages them to
continue caring (Brodsky & Naon, 1993). There is also some evidence in the international
literature that service provision does not necessarily reduce family care (Hanley, Wiener, &
Harris, 1991; Muscovice, Davidson, & McCaffrey, 1998).
Despite the improvements brought about by the expansion of formal services, the elderly in Israel still have many unmet needs, and caregivers still feel burdened (Morginstin & Baich Moray, 1992; Brodsky & Naon, 1993). A recent legislative initiative has proposed expanding the number of benefit levels from two to three, which would improve the matching of needs to resources. Those recipients at the highest and middle benefit levels would receive more service hours, while recipients at the minimal threshold for benefits would face a cut in service hours (Zipkin & Morginstin, 1998).

After more than a decade of experience with a programme that ensures a basic level of home care for the elderly, many professionals believe it is time to increase the programme’s flexibility. Services purport to meet the needs of families, but in fact they are limited in scope and type. It is argued that families do not have sufficient choice about how to use the services to which they are entitled. For example, instead of receiving 3 hours of home care in one block of time, as is the current practice, an elderly person might prefer to receive home care for shorter intervals spaced throughout the day to correspond to informal caregivers’ work or other obligations. Or a family might prefer support services at night, freeing them to leave the house. No such services are currently available. At present, formal caregivers are not able to use their discretion in service provision, and the elderly and their families have limited choice among alternative services (Brodsky & Morginstin, 1999).

Before the final enactment of the CLTCI Law, a public commission was appointed by the Minister of Labour and Social Affairs to formulate guidelines for the operation of the law. A major issue considered by the commission centred on the type of benefits to be included: cash or in-kind (Mann, 1988; Morginstin & Shami, 1988). After considerable debate, the commission decided to maintain the focus on in-kind services, providing cash benefits only if no services are available in the community, and only if the beneficiary does not live alone. The logic behind this was that a disabled elderly person living alone would not be able to use the cash benefit effectively. In reality, very few people receive cash benefits.

After 11 years of implementation of the Community Long-term Care Law in Israel, debate has again arisen over cash allowances, and some have proposed providing cash rather than in-kind benefits. One factor behind the renewed debate is the increase in the number of elderly who employ 24-hour caregivers (usually foreign workers), at a cost well above the value of in-kind services provided under the law. At present, such caregivers must register with an agency that is licensed to provide services under the law; and the agency receives a payment for the caregiver from the Social Security Administration. The agency pays the caregiver half of what it receives from social security (taking part as profit and part to cover its expenses), and the family makes up the difference in the caregiver’s salary. If families were to receive a cash allowance directly from social security, they could purchase the services from non-organized workers at a lower cost. Therefore, the proposal is to provide a restricted cash allowance to families who can prove that they employ a caregiver around the clock, only for the purpose of paying this caregiver. The proposal is being discussed by the Knesset (Parliament).

**Substitution of Community for Institutional Care**

In order to examine whether the CLTCI Law has indeed enabled dependent disabled elderly people to remain at home and delayed or prevented their institutionalization, two studies have been conducted of rates and patterns of institutionalization before and after implementation of the law. The first was conducted one year after implementation of the law, and the second four years after implementation of the law. The studies monitored national data on institutionalization patterns, and did an in-depth investigation of applicants and entrants for institutional placement.
It is interesting to note that unexpectedly, there was a sharp increase in applications for institutional placement during the first year following implementation of the CLTCI Law. It appears that in determining eligibility for community services, the law “discovered” a sizable population of disabled elderly people who had not previously been in contact with the service system and who had not been referred to institutional services. The sharp increase in demand, and the fact that those who applied to institutions after implementation of the law were more disabled than those who applied before implementation of the law, led to the conclusion that, prior to implementation, the needs of a large number of people for community and institutional services were not being met. Thus, as awareness of existing services – particularly institutions – grew, the decline in need for institutional placement resulting from the law was offset by the increased demand for assistance resulting from the discovery of new cases among the very disabled. This implies that the law helped identify and refer severely disabled elderly clients – who had hitherto gone unrecognized by caregiving authorities – to institutional care (Naon, Factor, & Primak, 1993; Naon & Strosberg, 1995).

The second study, carried out four years after implementation of the law, revealed a significant change in the patterns of institutionalization of frail (moderately disabled) elderly. The total number of frail elderly residing in institutions and waiting for placement was 25% less in 1992 than in 1987 (prior to the law’s implementation). However, among the more severely disabled, there was no significant change. The study also showed that, following the law’s implementation, those frail elderly who applied for institutional placement suffered from more severe physical and cognitive problems, were older, and included a higher proportion of widows and widowers than did frail elderly applicants prior to the law’s implementation. However, there were no significant changes in the characteristics of the more severely disabled, whose condition was extremely serious even prior to the law’s implementation. Thus this study showed that significant changes in the patterns of institutionalization of the frail elderly indeed occurred following implementation of the Community Long-term Care Insurance Law in Israel. The use of services under the law enabled the less severely disabled to remain in their homes and avoid institutionalization (Naon & Strosberg, 1995). As noted above, after implementation of the law, the percentage of those receiving community care increased, particularly among the moderately disabled. Applications for institutionalization by elderly people with moderate disability have continued to decline. The lack of impact on the severely disabled has been attributed to the relatively low level of the benefit.

The Community Long-Term Care Insurance Law increased the resources earmarked for community care and created an infrastructure of community services. This resulted in a more balanced allocation of public resources to institutional and community care. After more than a decade of experience, revisions are being suggested to improve the programme, create adequate mechanisms to ensure coordination and continuity of care between acute and long-term care, enhance flexibility in meeting individual needs, and contain costs.

5. Japan

Background

Of all the OECD countries, Japan is experiencing the most rapid demographic aging. As of 1999, Japan had a population of 126,314 million, 20.8 million of whom (16.5%) were age 65 or over and nearly 8.5 million of whom (6.6%) were age 75 or over (International Data Base, 2000). It is estimated that the proportion of elderly people in the population will reach 21.5% by 2010, and 26.7% by 2025 (United Nations, 1998). In a mere 24 years, the proportion of elderly people in Japan has doubled. Comparable increases in the elderly populations of France, Sweden, and the United States took 115 years, 85 years, and 75 years, respectively.
The elderly support ratio in relation to the working-age population (that is, the number of persons age 65 and over per 100 persons age 20 to 64) stands at 26. It is expected that the elderly support ratio will reach 50 by 2025. Japan also has the greatest longevity in the world: Life expectancy at birth is 83.35 years for women and 77.02 for men (International Data Base, 2000). Disability-adjusted life expectancy at birth is 77.2 years for women, and 71.9 years for men; expectation of disability at birth is 7.1 years for women and 5.7 years for men (World Health Report, 2000).

The number of elderly who are disabled or need assistance with activities of daily living (ADLs) is also increasing – from 2 million in 1993 to a projected 2.8 million by 2000 (about 13% of the elderly), and 5.2 million by 2025 (about 16%) (Japan Ministry of Health, 1997 in: Ihara, 2000).

The dramatic increase in the elderly population and women’s changing roles in the family and in the labour force have raised public and governmental concern over care of the elderly in Japan. Although the three-generation patriarchal family in which a daughter-in-law looks after elderly parents is still prevalent in Japan, the proportion of elderly people living alone or with their spouse has more than tripled since 1960, especially in the cities (OECD, 1994).

The parent support ratio – that is the number of those age 80 and over per 100 persons age 50-64 – stands at 17, and it will reach 44 by 2025. This provides a rough indication of the expected burden of care. The parent support ratio by females (the number of those age 80 and over per 100 women age 50-64) stands at 34 and will reach 88 by 2025 (International Data Base, 2000). In other words, fewer women will be available to care for an increasing population of elderly.

The Development of the System of Care

Health and social services for the elderly have developed as an outgrowth of the enactment of several laws, some of which concern the total population, and others of which are directed specifically at the elderly (see Appendix for a chronological overview of the development of the system of care).

In 1922, Japan’s Health Insurance Law – the first social insurance programme in Asia – was enacted, although universal coverage was not achieved until 1961, when this law was entirely revamped. The 1963 Welfare Law for the Aged aimed to provide home help, respite care (short-term stay) and institutional care for the elderly with low incomes who had no one to care for them. However, as the demand for long-term care increased, coverage expanded. Before the implementation of the new long-term care insurance law (described below), elderly persons needing long-term care received it under this law (Ihara, 2000), and those who are not eligible for services under the new law can continue to receive services under it. Fees for long-term care are based on the recipient’s income level, and range from nothing to nearly full cost. Municipal governments decide who is eligible for such care, according to their income and the availability of a family caregiver.

Since 1973, medical care, including hospital care, has been free for those aged 70 or over (and those who are bedridden and age 65 or over); in other words, they are exempt from co-payments (Ikegami, 1997). It should be noted, however, that small co-payments were reintroduced. In 1983, when the Health Medical Service Act for the Elderly was enacted to provide comprehensive health and medical services for people age 70 and over, and to balance the burden of medical expenditures for the elderly among the various insurance schemes (Shoji & Hironari, 1999). Under this law, the national government contributes 20% of the cost of medical care for the elderly, the prefectures and primary local governments contribute 5% each, and health insurance associations cover the remaining 70%. Until the implementation of the new law, social services, including nursing homes and home care,
remained means-tested and targeted at those without family support (under the 1963 Welfare Law for the Aged).

The Ministry of Health and Welfare has primary responsibility for health administration, although decentralization underlies national policy. Japan is divided into 47 prefectures; local administration is conducted by these prefectures, and by municipal (city, town, village) governments. All prefectures are required by law to establish and run a national health insurance programme (administered by “local national health insurance associations”).

Hospitals are the main providers of care in Japan. To illustrate, in 1990 there were 13.6 hospital beds in Japan per 1,000 in the population – a far higher ratio than in most OECD countries. However, traditionally, the Japanese concept of hospitalization has differed from the Western one. Japan has no exclusively “acute” hospitals: Patients with chronic illnesses who in the West would find themselves in long-term care institutions have been treated as in-patients in Japanese hospitals (Nakahara, 1997). As a result of the lack of financial barriers for hospital-based long-term care, together with the absence of a negative stereotype associated with extended hospital care and the lack of general practitioner gatekeepers, hospitals have been extensively used for long-term care (Ikegami & Campbell, 1995; Ihara, 2000).

As a consequence, the average length of stay in a Japanese hospital is long. For example, in 1983, the average length of stay in a hospital in Japan was 39 days – much longer than that in other OECD countries. Lengths of stay are even longer for elderly patients, half of whom remain in the hospital for more than 3 months, and between one-quarter and one-third of whom remain in the hospital for more than a year.

The lack of a system of assessment or triage of elderly patients and the uniform fee system (which does not take into account the severity of a patient’s illness or disability) have resulted in the placement in hospitals and nursing homes of many patients who are only slightly disabled and need minimal care. To illustrate, a comparison of a cross-sectional sample of residents of long-term care institutions in five countries using the Minimum Data Set (MDS) revealed that Japan had the highest ratio of “light-care” cases (Ikegami, Morris, & Fries, 1997). Those nursing homes that exist are part of the special welfare system for the elderly. Their expansion has been curtailed by general expenditure constraints, such that their numbers have not increased concurrent with the increase in the number of hospital beds.

As in some other OECD countries, the rate of institutionalization of the elderly in Japan is about 6%. The problem is that a relatively high proportion of this 6% are in acute hospitals rather than in skilled nursing homes (which are less costly) (Ihara, 2000). In fact, this was one of the main factors contributing to the enactment of the long-term care law described below.

The proportion of elderly people receiving home help has remained small and, as noted above, this benefit has typically been targeted at people with low incomes or who lack family support. The development of community-based services was very limited until the introduction of The Gold Plan in 1989.

In response to the growing concerns of the Japanese public and government about care for the elderly, in 1989 the Ministry of Health and Welfare issued a Ten-Year Strategy for Promoting Health and Welfare Services for the Elderly (the so-called “Gold Plan”), which promoted home care for the frail elderly and assistance to family caregivers. Prior to enactment of this plan, nearly 90% of the Ministry’s budget for care of the elderly went to institutional care (Sodei, 1996). The Gold Plan defined specific goals to be achieved over a ten-year period. These included numerical targets for increases in facilities and staff (home caregivers, short-term beds, day care centres and nursing homes). Nevertheless, the increase
In services was expected to meet only half of the needs of the elderly population (Sakamoto, 1996).

In 1994, a New Gold Plan was introduced, to expand the variety of services for the home-bound elderly so as to improve the care of elderly suffering from dementia and reinforce home-based care for the frail elderly.

The perception that the system of care was not functioning efficiently, and that long-term care needs were therefore not being adequately addressed prompted the reform of Japan’s system of long-term care.

The Public Insurance Scheme for Long-term Care (Kaigo Hoken)

The most recent effort to improve long-term care is the Public Insurance Scheme for Long-term Care passed by the Diet (parliament) in 1997. Implementation began in April 2000. Under the law, long-term care is an entitlement, based on the insurance principle of personal eligibility.

**Insurers:** Under the new law, Japan’s 3,200 municipalities – which are already responsible for health insurance programmes for the self-employed and for retirees, and which provide social services – will share the responsibility of providing coverage with the national government and the prefectures. A national pooling mechanism (the Social Insurance Medical Fee Payment Fund) will be established, which will distribute funds to the municipalities. This is intended to address demographic imbalance among municipalities and ensure equitable allocation of resources.

**Eligibility criteria:** Eligibility levels will be determined through assessment of an individual’s functional and cognitive abilities. Neither the availability of informal care nor income will be considered for this purpose – a radical departure from traditional Japanese attitudes toward the family’s responsibility for providing care. All residents age 40 and over will be eligible for care, although eligibility will differ depending on age: Disabled people age 65 and over will automatically be eligible for long-term care, but disabled people between the ages of 40 to 64 will have to prove that they suffer from an “age-related” condition (such as dementia, cerebrovascular diseases, amyotrophic lateral sclerosis, Parkinson’s disease, spinocerebellar degeneration, chronic obstructive lung disease, rheumatoid arthritis, or osteoporosis with bone fracture) (Okamoto, 1999).

**Eligibility assessment:** Assessment of eligibility may be made in the community or in an institution. Applicants will be expected to require care for at least 6 months. Once care has begun, the recipient will be re-assessed every 3-6 months.

To ensure fair and equitable assessment, a national uniform standard of eligibility has been developed. Assessment will be made using an 85-item form that measures performance in activities of daily living (ADLs) and cognitive, sensory (visual and verbal), and functional abilities. Once eligibility has been established, an individual will be classified as being at one of six levels that determine the level of benefits. The points fixed for each level, which represent hours of care in an institutional setting (ranging from 25 minutes to 110 minutes), were derived from a care time study. The amount of care required to be eligible for the highest level seems low relative to the level of benefits granted at this level (Ikegami, 2000) 38.

Care managers - a new role established as an adjunct to the law - will be responsible for the initial eligibility assessment. These care managers may be employees of an organization that provides services. It has been argued that because of the overlap between their roles as care managers and providers, there may be a conflict of interest and the process
of eligibility determination may have a built-in bias towards severity, to favour providers. However, final decisions about eligibility will be made by an expert committee (Campbell & Ikegami, 2000).

Responsibility for planning care may reside with the individual and his family, or with a care manager, who will advise patients on planning their care (care plans must be approved by the patient or his family), coordinate service provision, and monitor services and claims. For practical reasons it is expected that this responsibility will rest primarily with the care manager, to prevent clients from having to pay for services out of their own pockets and wait for reimbursement.

As mentioned above, the care managers may be employees of an organization that provide services; therefore, it has been argued that the care planning process may have a tendency to favour certain providers. Professionals (e.g. physicians, nurses, social workers, physical therapists) with 5 years of experience and non-professionals (e.g. home caregivers) with 10 years of experience will be eligible to take a written qualifying examination given in each prefecture. Those who pass the exam will undergo 32 hours of intensive practical training, after which they will receive certification. Practice standards stipulate 16 mandatory requirements of care management (Ministerial Order No.38 "Practice Standards of Care Management Providers" issued on 31 March 1999) (Okamoto, 1999).

**Benefits:** The law will provide services in-kind, either in the community or in an institution:

- **Home care and community services** comprise visiting nurses, personal care and housekeeping services, including the possibility of multiple, brief (10- to 30-minute) visits around the clock; rehabilitation services at home or at a day care centre; medical management; respite care (in a geriatric hospital or geriatric ward of a general hospital); day care; group home services for people with dementia; assisted living; and minor home remodeling (e.g. widening doorways to admit a wheelchair).

- **Institutional services** comprise nursing homes and health service facilities for the elderly; and geriatric care hospitals (long-term care wards).

Benefit levels range from ¥61,500 (about $560) per month for the minimum level of assistance (e.g. up to two housekeeping visits per week, one nursing visit per week, up to two visits to adult day care per week, and up to two 1-week respite stays per year), to ¥358,300 (about $3,260) per month for the maximum level of assistance (e.g. seven housekeeping/personal care visits per week, two nursing visits per week, three visits to adult day care per week, and a 1-week respite stay every month) (Okamoto, 2000; Crume, 1997).\(^{39}\) Within this range, the recipient can freely choose different types of home care and institutional services.

One of the issues debated most while planning the law was whether or not to provide cash allowances for family care. Despite public support, the decision was made not to allow cash benefits (Okamoto, 2000). Professionals claimed that rapid expansion of formal

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\(^{39}\) Maximum monetary limits for home care (monthly, by level of disability) (US$1=¥109.8):

- **Needs support (level 1)**: ¥61,500 (US$560)
- **level 2**: ¥169,800 (US$1,510)
- **level 3**: ¥194,800 (US$1,774)
- **level 4**: ¥267,500 (US$2,436)
- **level 5**: ¥306,600 (US$2,792)
- **level 6**: ¥358,300 (US$3,263)

services should be the top priority, and this would necessitate a large demand for services in kind. Feminists argued that cash allowances would merely become part of the household budget while family caregivers continued to provide the bulk of care. Concern was also raised that if cash allowances were offered, there would be a rush on applications for benefits – yet the government is counting on a relatively low level of applications initially, since it wishes to phase in the programme gradually (Campbell & Ikegami, 2000).

Although the long-term care law does not allow cash benefits for family caregivers, in the last months prior to initiation of the programme, the government decided that a ¥100,000 grant will be awarded to beneficiaries who have applied for benefits under the law and have been classified as having a Level IV or a Level V disability; have little or no income (that is, are near the poverty line); and have not received services under the law for 1 year. It should be noted that this grant is not an insurance benefit under the long-term care law but, rather, will be financed out of general revenues (Okamoto, 2000; Campbell & Ikegami, 2000). This decision was a political decision and it is perceived as a compromise between those in favour and those against the provision of cash allowances (Okamoto, 2000).

**Providers and quality assurance:** Along with the implementation of the law, Japan is hoping to expand service supply, particularly through the participation of the for-profit sector in service provision; indeed, this is viewed as one of the prerequisites for successful implementation of the law. The municipalities have tended to prefer service providers that they operate or fund; rather than for-profit providers. The long-term care system will offer the same competitive conditions for public and private sector service providers. This is expected to enable the elderly and their families to have more choice among service providers (Ihara, 2000; Crume, 1997). However, it is not clear whether the development of services will actually meet demand, since there is a great deal of variation across regions and in types of service (Campbell & Ikegami, 2000).

Concomitantly, there is concern about assuring the quality of long-term care services, especially with the entry of for-profit providers. It is expected that the new role developed – care manager – will include attention to quality assurance. According to the practice standards, care managers are to monitor the provision of services to clients on an ongoing basis (Okamoto, 1999).

**Finance:** The law will be funded by premiums to be paid by everyone age 40 and over (estimated to be 65 million people by 2000). These will be collected through a combination of mandatory social insurance contributions (a payroll deduction and matching employer contribution for those who are employed, health insurance premiums for the self-employed, and deductions from pensions for retirees), which are projected to amount to half of the total cost after the co-payment, and contributions from the national government, prefectures, and municipalities (on a 2:1:1 ratio).

The premium will vary by age (i.e. one premium level for those age 40-64 and another for those age 65 and over) and income level. Persons age 40-64 will pay about 0.9% of monthly income, to be shared equally with their employer. For those 65 and over, the deduction from their public pension will be made according to a special sliding scale, and is expected to average about $26 a month (although some changes have been made in the past months prior to the initiation of the law, including a short term freeze on premiums to be financed by tax revenues) (Campbell & Ikegami, 2000)

As noted above, the premiums collected by insurers will be pooled into the Social Insurance Medical Fee Payment Fund, which will distribute the funds to municipalities.

In addition, there will be a 10% co-payment at the point of service provision. The co-payment for institutional care is estimated to be about ¥24,000 ($209) per month for residence in a skilled nursing home (the payment will be reduced or waived for people with very low incomes). Patients will also have to pay ¥23,000 ($200) per month for meals. Thus, combined
out-of-pocket expenses for residence in a skilled nursing home will be about ¥47,000 ($410) per month (Crume, 1997).

When the law was passed, it was estimated that 2.7 million elderly people, who comprise 12.4% of the elderly population, would be eligible for benefits in 2000. It was assumed that, of those living in the community, only one-third would apply for benefits, resulting in 1.35 million beneficiaries – 6.2% of the elderly population – during the first year of the law’s implementation (Campbell & Ikekami, 2000). However, as of 31 March, 2000, 2.5 million people had applied, 1.8 million of whom (8% of the elderly population) had already received a care plan (32% of the elderly applicants were in institutions). The government has not altered its spending forecasts, since it believes that not all of the benefits will be accessed because of the 10% co-payment demanded of beneficiaries (Ikekami, 2000). Thus, the estimated cost of the law during the first year of its implementation (2000) is ¥4.3 trillion (about $39 billion). Accordingly Japan will devote about 0.9% of the GNP to the long-term care law.

Issues in the Implementation of the Long-Term Care Insurance Programme

The implementation of the Public Insurance Scheme for Long-Term Care Law has just begun, and it is difficult to assess its impact. However, the passage of the law is evidence of a change in the Japanese people’s perception of long-term care – from a problem that can and should be resolved largely within the family, to one that demands the society’s attention and effort (Ihara, 2000).

According to Ihara (2000), the authors of the Public Insurance Scheme for Long-term Care expect it to significantly improve the system of long-term care, and to accomplish the following:

- Ensure a stable source of revenue for long-term care, which, given the rapid aging of the population, would be difficult to achieve with existing programmes.
- Stem the deterioration of the fiscal state of health insurance caused by the long-term hospitalization of elderly patients.
- Enhance service supply by creating equal, standard conditions for government providers, NGOs, and for-profit providers, thereby increasing competition and consumer choice. Though shortages in some areas are expected immediately following implementation, it is hoped they will disappear with the entry of for-profit providers into the long-term care market.
- Integrate the welfare, health, and long-term care insurance systems for the elderly, and balance service distribution across geographic regions.
- Introduce the concept of “care management” into the long-term care system so as to help consumers plan appropriate programmes of care and choose qualified providers.

The following issues have been raised concerning implementation of the new scheme:

- It is not clear whether the quality and quantity of home and institutional care will meet demand. Some of Japan’s municipalities have not yet established sufficient facilities or administrative systems to cope with the changes anticipated following implementation of the law (Gross, 1997; Seike, 1998).
- Concerns have been voiced that costs, and hence spending, will be higher than officially estimated (Campbell & Ikekami, 2000). In the event of a deficit, it is feared that benefits will be rationed and/or premiums will increase. Campbell and Ikekami argue that premiums are likely to increase anyway, at least initially. However, most of the spending for long-term care, particularly in the early years, will be replacing spending from health
insurance and social service budgets. Indeed cost replacement is expected to cover much of the cost of the new law and introduce more control over cost increases.

- There is concern about the objectivity of the assessment process: the initial assessment and care planning may be carried out by a care manager who works for a provider organization and therefore may face a conflict of interest in directing the client's choice of provider and an interest in overestimating needs. Although patients may refuse the care plan, it is likely that most will accept what is offered (Ikegami, 1997; Campbell & Ikegami, 2000).

- The fragmented provision of acute and long-term care may reduce the savings that the law is expected to effect through the prevention of over-utilization of acute care facilities. The criteria that will be used to determine when a patient who is receiving long-term care requires an acute care facility (covered by health insurance) will have to be made more explicit (Ikegami, 1997).

- The limitation on eligibility to age-related diseases for applicants age 40-65 was a compromise intended to keep costs down. However, it may be unfair to people who have paid long-term care insurance premiums and feel they need care but are deemed ineligible for it.

- The new legislation will be beneficial to middle-class elderly and their families, but its benefits for elderly people with low incomes are mixed. Previously, low-income recipients of services paid little or nothing for these services. According to the new system, premiums will be deducted from their pensions (on a sliding scale), and they will be required to make a 10% co-payment, which may be a hardship for them (Gross, 1997; Crume, 1997). Moreover, some recipients of long-term care services are not frail enough to qualify for the new programme, yet they will still be required to make this co-payment. Various steps have been taken to ease this situation, including allowing residents classified as non-eligible to remain in nursing homes for 5 years, and reducing the co-payment to 3% for those who have previously received services in the community (Campbell & Ikegami 2000).

Since the early 1990s when the first Gold Plan was enacted, the long-term care needs of the elderly have been a priority in Japan. Public feeling that the system of long-term care was inadequate led to major support for the new law: According to a 1995 government survey, 82% of Japan's population favoured its introduction (Ikegami, 1997). Japan's Medical Association also supported the law.

The situation in Japan is somewhat unique in that prior to the new law there was already a relatively high level of expenditure on care but the system was not considered efficient. Thus, the Japanese are offering a high level of potential benefits, but the government does not expect that major increases in financing will be needed.
Appendix


<table>
<thead>
<tr>
<th>Year</th>
<th>Law or Policy Enacted</th>
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<tbody>
<tr>
<td>1922</td>
<td>Health Insurance Law: provides full coverage, without co-payments, for some labourers</td>
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<td>1927</td>
<td>Factory and Mining Law: defines those covered by the Health Insurance Law</td>
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<tr>
<td>1938</td>
<td>National Health Insurance Law: establishes voluntary public insurance schemes based on occupational categories (e.g. farming, forestry, fishing, and the self-employed)</td>
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<td>1961</td>
<td>National health insurance extended to provide coverage for all citizens</td>
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<tr>
<td>1963</td>
<td>Welfare of the Aged Law: introduces modern aging policy in Japan</td>
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<tr>
<td>1973</td>
<td>Medical costs waived for people age 70 or over (no co-payments are required for those 70+)</td>
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<tr>
<td>1983</td>
<td>Health Services for the Aged law: an increase in medical expenditures for care for the elderly caused a financial imbalance between insurance schemes. This Act provided comprehensive health and medical care for those age 70 and over, and balanced expenditures for medical care for the elderly among insurance schemes (Shoji &amp; Hironari, 1999).</td>
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<tr>
<td>1986</td>
<td>Health and Medical Services Act for the Elderly revised.</td>
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<tr>
<td>1989</td>
<td>The Gold Plan introduced: ten-year plan to promote the health and welfare of the elderly; shifts the government’s emphasis from institutional to home care</td>
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<tr>
<td>1990</td>
<td>Social Service Act revised, effectively restructuring service provision</td>
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<tr>
<td>1991</td>
<td>Health Service for the Aged law amended, introducing a home-visiting skilled nursing care system for frail elderly</td>
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<tr>
<td>1997</td>
<td>Long-term Care Insurance Scheme enacted, to be implemented in April 2000</td>
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<tr>
<td>1999</td>
<td>Law for the Welfare of Employees Engaged in Infant Care or in the Care of Family Members (“Long-term Care Leave”): enables employees to take 3 months leave to care for a relative, without fear of losing their job</td>
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