Searching for a Balance of Responsibilities: OECD Countries' Changing Elderly Assistance Policies

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Abstract

The rapid aging of OECD country populations and the now five-year-long financial crisis in Europe are causing many OECD countries to reconfigure their assistance programs for the elderly, particularly their long-term care (LTC) policies. Debates about intergenerational responsibilities are evident in recently published research papers that examine how countries are revising programs for the elderly. Building financial sustainability into program reforms has suddenly become a priority. Until just recently, reform efforts focused on creating efficiencies and better quality of services. What emerges from the recent literature is a strong sense that the OECD countries are responding to the financial crisis and the rapid aging of populations in very similar ways. Given the countries' different histories of how they provide assistance to their elderly citizens, the convergence of policy responses is not something we might have foreseen. The United States could learn much from the OECD countries' choices.

INTRODUCTION

Organisation for Economic Cooperation and Development (OECD): 24 European countries plus the United States, Canada, Japan, South Korea, Mexico, Chile, Australia, Israel, Turkey, and New Zealand

Long-term care (LTC): generally includes some nursing care, physical therapy, and assistance with some ADLs; provided in nursing homes or a beneficiary's home

Every industrialized country is facing the same daunting problem: the aging of its population. As of 2011, Japan is leading the Organisation for Economic Cooperation and Development (OECD) countries with 23% of its population 65 years of age and older. Germany, Italy, and Sweden are close behind with 20–21%; Belgium, the Netherlands, Portugal, Spain, France, Austria, Hungary, and the United Kingdom have 16–18%; and the United States has just over 13% 65 years of age and older. Projections to 2030 (and beyond) foreshadow rapid and substantial aging of all the OECD countries' populations: One in five Americans will be 65 years of age or older, while in Japan the ratio will be one in three, Germany more than one in four, and South Korea, Italy, Sweden, France, and the Netherlands about one in four (57).

The current financial crisis in Europe, with spillover effects on the United States and other countries, has greatly heightened concerns about financing the aging populations' needs for health care, income support, housing subsidies, and long-term care services. It has provoked emotional and difficult debates about intergenerational responsibilities and needs for investments that will maintain productivity growth in the future, in part to be able to pay for the expected needs of a larger elderly population. The fiscal situations of many OECD countries in 2012 have increased fears that the elderly will be particularly hurt just when they will be requiring more assistance. The austerity measures imposed in 2012 by Spain and Portugal, for example, include cost-sharing for health care even for the elderly. England has again shelved efforts to revamp how it finances long-term care (LTC), bypassing the recommendations of the July 2011 Dilnot Report (11). Spain also has slowed full implementation of its 2006 reforms of LTC.

The debates about intergenerational responsibilities are evident in recently published research papers that examine how countries are revising programs for the elderly. Building financial sustainability into program reforms has suddenly become a major issue. This is a significant shift in priorities; until just recently, reform efforts focused on creating efficiencies and better quality of services. What emerges from the recent literature is a strong sense that the OECD countries are responding to the financial crisis and the rapid aging of populations in quite similar ways.

The convergence of policy responses is not something that we might have foreseen. The OECD countries' histories of how they provide assistance to their elderly citizens vary considerably (cf., 14). Categorizing one country or another as being culturally more inclined toward believing families—rather than society—are responsible for older people is no longer a satisfactory classification scheme when it comes to assistance for the elderly. The converging policy approaches reflect the fact that neither individuals nor nations comprehended the combined effects of the past 50 years' increases in longevity and falling birth rates. Individuals and countries have been caught short by inadequate financial planning for the needs of an aging population, made worse by the current worldwide financial downturn. The OECD countries are under pressure to change their various elderly assistance policies. Most are increasing patient/family cost-sharing responsibilities, encouraging home-based LTC rather than building more nursing homes, providing more choice and creating competition among providers, and focusing on the long-run financial viability of their elderly assistance programs.

Regardless of their current policies, five themes dominate the debates in these countries over how to provide services for the elderly:

- How should responsibility for caring for an elderly person's needs be shared among society, the person, and his/her family?
- Should society assist only low-income elderly (a welfare assistance approach) or people with specific needs regardless of income (a social insurance approach)? Or should assistance programs provide

assistance only after a person's out-of-pocket expenses exceed a threshold (catastrophic social insurance)?

- What are the roles of the national and local/municipal governments in selecting the services that are to be covered by an assistance program, determining criteria for who needs assistance, and organizing the delivery of services?
- How should assistance programs for the elderly be financed—with general revenues or dedicated taxes and contributions (creating social insurance)? Should prefunding be required to safeguard funds for younger generations?
- How can income, housing, and LTC assistance programs be better coordinated so services are provided efficiently and more elderly people are able to remain in their homes?

Overlaying these themes is a growing belief that everyone is at risk for needing expensive assistance in old age. This risk involves both the possibility that a person will need assistance in performing activities of daily living (ADLs) and the chance that the amount of assistance needed (such as requiring aides 24 hours a day seven days a week or nursing home care for many months or years) will be very expensive. Mounting evidence indicates that everyone faces the risk of needing costly assistance. Several studies have found that close to 70% of people need some type of assistance after age 65, and—significantly—16% need more than $100,000 (in 2005 dollars) of care in their lifetime after age 65 (11, 34).

In this article, I review papers written in English about how different OECD countries are addressing these questions. Unfortunately, it is beyond the scope of this article to review the hundreds of papers in the non-English literature. Constructing a picture of the OECD countries' elderly assistance programs based on English-language research must be done with care because most research papers concentrate on only one or at most three countries. In this review I focus on Japan, South Korea, and the Western European countries in the OECD that have more-established elderly assistance programs and high fractions of their populations who are elderly. Far more has been written about their programs to provide LTC and other services for the elderly.

The plan of this review is as follows. In the next section, I briefly describe the LTC services, income, and housing support provided to the elderly in need of assistance. In the third section, I discuss what is known about how different countries are addressing the five themes outlined above. I conclude by discussing the policy implications of the research findings about the OECD countries' approaches to assisting their elderly citizens. By understanding the OECD countries' reasons for revising their elderly assistance programs and why they are increasingly similar, the United States could avoid repeating unintended consequences. Given the projection that one in five Americans will be 65 years of age or older by 2030, the United States has no time to lose in revising its elderly assistance programs so that these programs are fiscally sustainable for future generations.

Activities of daily living (ADLs): the basic tasks of everyday life, such as eating, bathing, dressing, toileting, and being able to move from a chair to a bed

TYPES OF SERVICES PROVIDED TO THE ELDERLY WHO NEED ASSISTANCE

Assistance for the elderly is provided in a variety of forms among the OECD countries. Most countries offer assistance in three key areas:

- LTC services that include nursing care, physical therapy, and assistance with some ADLs (such as aides who help a person bathe), and sometimes renovations to enable a person to remain in his/her home;
- income support for those whose annual income from pensions and savings is less than some minimum level; and
- housing subsidies, especially where rental housing is the norm among the elderly.

LTC encompasses different services in different countries. The differences stem primarily from whether rehabilitation services

(for example, physical and occupational therapy) are covered by health insurance, and whether nursing home room-and-board costs are considered housing and living expenses independent of LTC. In general, LTC is interpreted as a set of medical, social, and personal care services provided on a regular basis for people who need help with ADLs. In most OECD countries, local governments or nongovernment (often religious) organizations provide many of these services under the aegis of community services. [Nutrition and social services are also often in the mix of community services provided to needy elderly people (24), but they have received far less attention among researchers and are not reviewed here.] Local control of community services contributes to LTC differences within and across countries; it has enabled regions to reduce services provided or focus services only on the elderly with the greatest needs when an economic downturn occurs (2, 45). Despite formal LTC programs existing in many OECD countries, a substantial majority (60–70%) of people who need LTC receive it informally from relatives or friends in all the countries (18, 33, 34, 59).

The numbers of people with private LTC insurance are very small in almost all OECD countries (14). France is the exception. In 2009, there were 3 million policy holders (of all ages) relative to a population of 14 million over the age of 60 (18). By comparison, there were ~8 million policy holders (of all ages) in the United States in 2005 (52) relative to a population of about 50 million over the age of 60 (57). France's LTC insurance benefits are structured as an annuity (cash benefits), whereas LTC insurance benefits in the United States are primarily payments proportional to costs of LTC services (18). Germany has a fledgling market for additional private LTC insurance, which covers the copayments required when people use formal LTC. Only 2.2% of all the people who paid for mandatory social or private LTC insurance purchased the additional LTC insurance in 2008 (59). Uncertainties about who will need LTC three or four decades into the future and how much such care might cost prevent an efficient private LTC insurance market from developing (1, 19).

Income support specifically for the elderly is available in many OECD countries, similar to that provided through Supplemental Security Income (SSI) in the United States (42). In Europe, such income assistance (frequently referred to as social assistance or social security) is often provided to elderly who cannot cover the costs of copayments for health care and LTC services, especially those tied to nursing home room-and-board costs (14). Most countries' income support programs have a long history of being locally funded; however, when some areas have larger shares of their population who are elderly and/or in need of LTC assistance, the disparate financial strain of such costs has caused national governments to help fund programs.

Rental housing support is generally available in the OECD countries for anyone whose income is below a minimum threshold, which can be low. Although renting is quite common in the Netherlands, Sweden, and Germany, home ownership in OECD countries has become far more common in recent decades compared with before 1970, when at most, half of homes were owned (26). Thus, adaptations of homes or apartments that enable elderly with health problems to age in place is increasingly viewed as a form of housing assistance that avoids expensive nursing home care (30, 36, 44). A number of OECD countries (particularly Sweden, Denmark, Germany, and the Netherlands) have expanded housing assistance to include planning and renovations of neighborhoods to make them more hospitable for elderly (3, 29, 30, 46).

CHANGES RELATED TO FIVE THEMES

Most OECD countries do not have separately funded, discrete government-sponsored LTC insurance programs; the Netherlands, Germany, Japan, South Korea, and Spain are

the exceptions.[1] The rest provide LTC services as part of their health insurance and other social security programs, financed through a mixture of national and municipal/local taxes. Nonetheless, the rapid aging of the populations and the financial crises of 2008 to the present (late 2012) are causing all the OECD countries to change how they are financing and organizing services for the elderly. In this section, I describe the changes taking place along the five themes outlined above.

Individual or Social Responsibility—Shift Toward Shared Responsibility

The high fraction of elderly who receive informal (unpaid) assistance from relatives (about 70% in OECD countries) provides one indication that most people believe families have a responsibility to care for aging relatives who cannot live independently. Germany and France have laws requiring adult children to be responsible for their aging parents. Since 2005, because of concerns about the fiscal sustainability of its original LTC scheme, Germany has required childless adults to pay an additional 0.25% of their income to the mandatory LTC insurance program; the additional payment is to offset costs that children otherwise would have provided. Among countries in the south of Europe (Portugal, Spain, Italy, and Greece), the family is the primary caregiver for elderly people, with the public sector viewed as a last resort for very poor people and those without family (12, 13, 17). Even so, Spain began implementing a LTC scheme in 2007. And although the legal codes in Sweden and Norway explicitly indicate that children are not responsible for their elderly parents' costs of living or health care, the fractions of older Swedes and Norwegians receiving assistance from relatives are no different than those of other OECD countries (33).

The belief that individuals and families are responsible for aging relatives is being challenged, however, by several significant changes in medicine and societies over the past four or five decades. One is that life expectancy at age 65 has increased dramatically among the OECD countries since 1960 (43). Unfortunately, increased life expectancy is associated with greater numbers of elderly with conditions and diseases that can require far more than simple care by relatives and can therefore be very expensive. People with neurological diseases such as Parkinson's or conditions such as congestive heart failure or Alzheimer's often need constant attention and levels of care that can have adverse health consequences for family caregivers. In addition, when formal caregivers are involved, the costs can quickly exceed most people's financial resources. Ten percent of people in England who reach age 65 were recently estimated to be likely to spend more than $160,000 out-of-pocket on LTC in their remaining lifetimes (11). Another change is that higher proportions of women 25–54 years of age are in the labor force than was the case before 1980 (42). This fact had a role in Germany and Japan's decisions to create compulsory LTC social insurance programs (4, 6, 28, 32). A third change is that multigenerational households have declined in industrialized countries. This is due to both rising incomes, which enable generations to live separately, and an increasing proportion of people living some distance from their parents (4, 15, 16, 31, 42).

These changes are causing increasing numbers of people to know that caring for elderly relatives who need assistance can be financially calamitous. As a result, there is growing interest among the OECD countries in establishing a more formal scheme of shared responsibility between individuals and government programs that provide assistance to the elderly when they can no longer live independently (8).

The trick, of course, is to achieve a balance in the shared responsibility. Every country has concerns about potential moral hazard

[1] Spain's program was to be implemented between 2007 and 2015, but the implementation is now uncertain beyond 2015 because of the country's financial crisis and reliance on limited regional funding.

incentives embedded in decisions to cover services that families currently provide informally. Shifting responsibility for some services to social programs could cause families to reduce their willingness to supply such services and increase the social programs' costs beyond expectations. Another moral hazard problem is lurking here, too—one that is rarely discussed: Social programs can encourage each generation to off-load expenditures onto the next generation. This can become unsustainable, as we are witnessing now. Thus, an increasingly important concern about shared responsibility involves the optimal balance of government expenditures on programs that benefit different age cohorts.[2]

Welfare Assistance or Universal Coverage or a Mixed Approach?

Debates about how to share responsibility for elderly who need assistance can be seen in the ways the OECD countries currently structure their assistance programs: Do they target only the poor (welfare assistance)? Are they for people with particular needs regardless of income (universal coverage)? Do they follow a mixed approach (safety net), whereby everyone with a need is eligible but income-based cost-sharing requirements apply? Although the countries set different income maxima for defining eligibility, they all provide income and housing assistance to their elderly poor. They all provide health insurance to their elderly poor, although they have different health insurance schemes. They currently differ most in their approaches to providing LTC assistance.

With the exception of the United States, health insurance in all the OECD countries reviewed here is required of all citizens.[3] The countries differ in terms of whether the insurance is a single-payer type national program or whether people can choose different insurers and plans in government-regulated markets, and whether the insurance is financed by taxes or a combination of income-based contributions and taxes.[4] Low-income people of all ages receive subsidies to help pay for their health insurance and any medical care copayments, creating a health insurance program with aspects of welfare assistance. The elderly are covered by the same health insurance system; distinctions between the elderly and nonelderly are generally nonexistent.

The greatest diversity in OECD countries' approaches to assisting the elderly exists in how they have structured LTC policies (7, 14, 20, 24). The variations are a major reason that so many research publications about LTC are country-specific or compare only two or three countries. **Table 1** provides a summary of five features of LTC programs in the OECD countries reviewed here:

- universal versus income-based, welfare approach,
- one LTC option or a choice of insurers in a quasi-market,
- whether people have a choice of caregiver providers,

[2]The political power of the elderly could be problematic in future allocations of government spending on different age cohorts. Recent evidence from Sweden, however, suggests that although population aging in municipalities is positively related to total LTC spending, spending per elderly person is slightly lower (25). The Swedish political process appears to adjust the share of elderly entitled to LTC so that the people receiving it are those deemed most in need.

[3]This will change in 2014, when the US Affordable Care Act will be fully implemented.

[4]In most of the European OECD countries, premiums are what people pay for private insurance, whereas contributions are payments that go to a public insurance system. Contributions are calculated as a percentage of income (sometimes with a maximum) and all but the poor pay the same percentage. The term contribution implies solidarity among all the people in a program because everyone pays the same rate and contributions are pooled in a public program. In contrast, premiums are viewed as individual-specific (based on age, gender, perhaps where one lives or works, and perhaps one's health status). The idea that premiums might be pooled just as contributions are pooled is unfamiliar; risk-pooling and solidarity among people are not consistent with premiums. Japan, however, finances its LTC social insurance program in part through premium contributions that are based on five income bands; those in the highest income band pay 50% more of the standard premium and those in the lowest income band pay half the standard premium; each municipality has the discretion to decide the standard premium (32).

Table 1 Basic information about ten OECD countries' LTC policies. Sources: Ref. 7 (ch. 7), US Census Int. Data Base; other references cited in the text

Issue	United States	Japan	Germany	Italy	Sweden	Spain	France	England–United Kingdom	Netherlands	South Korea
Population 2011 (millions)	311.6	127.5	81.5	61.0	9.1	46.8	65.3	62.7[a]	16.7	48.8
Percent of population age 65 and older	13.3	23.1	20.6	20.3	19.7	17.1	17	16.5	16	11.4
Year implemented LTC policy	Medicaid, 1965	2000	1994	n/a[b]	Late 1940s	2006[c]	Late 1980s	None	1968	2008
Year of latest change in LTC policy	2010	2009	2008	n/a	2009	n/a	2002	2011 proposal	2007, 2012	2008
Universal or for low-income people	Low-income	Universal	Universal	Low-income	Universal	Universal	Universal	Low-income	Universal	Universal
Compulsory LTC program or LTC services provided by mix of programs?	Mix	Compulsory	Compulsory	Mix	Compulsory	Compulsory	Mix	Mix	Compulsory	Compulsory
Choice of LTC insurers?	Yes	No	Yes	n/a	No	n/a	Yes	n/a	Yes	No
Choice of caregivers?	Limited	No	Yes	n/a	Yes	n/a	Yes	No	Yes	No
Financing: taxes versus contribution	Taxes	Contribution	Payroll tax	Taxes	Local tax[d]	Taxes	Taxes	Taxes	Both	Both
National and local taxes?	Yes	Local	No	National	Yes	Yes	Yes	Local	Yes	National
Means testing for eligibility?	Yes	No	No	No	No	Yes	Some	Yes	No	No
Need-based eligibility determination?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Local need-based or national standard?	Local	National	National	National	Local	National	Local	Local	National	National
Means tested cost-sharing?	No	Yes	Yes	n/a	Yes	Yes	Yes	Yes	Yes	No[e]
Home-based services covered?	Yes	Yes	Yes	Means-tested	Yes	Limited	Yes	Yes	Yes	Yes
Cash allowance for individual?	No[f]	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Limited
Payment to relatives?	Yes[f]	No	Yes	Yes	Yes	Yes	No	Yes	Yes	No
Geographic variation in services?	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

[a]The population figures are for the United Kingdom, but the rest of the information about the LTC scheme is specific to England.
[b]Italy does not have a formal LTC policy; it has the "indennita' di accompagnamento," enacted in 1980, which provides cash to low-income people to pay for formal and family care workers.
[c]Spain's LTC program was to be fully implemented by 2015, but it has been delayed.
[d]85% local tax, 3–4% user fees, 11–12% government grants
[e]South Korea requires a copayment of 20% for nursing home care and 15% for home-based care, but the poor are exempt from these copayments.
[f]"Cash and Counseling" demonstration projects are testing Medicaid provision of cash allowances.

- financing, and
- compulsory LTC social insurance or a mix of systems (including health insurance) that cover some LTC services.

The LTC policy changes that are being contemplated by the OECD countries will affect the extent to which elderly people in future decades will receive assistance with LTC services. The countries are reaching similar conclusions about how to change their LTC policies, even though they have different policies now. Because the issues driving these changes are also issues being debated as part of the larger question of how to assist the elderly, it is helpful to focus briefly on the five features that differentiate the OECD countries' current LTC policies.

Universal versus income-based approach to LTC. Sweden, Norway, Germany, the Netherlands, Japan, and South Korea each have a compulsory program providing universal LTC coverage: Anyone assessed to have a need for LTC is provided with services regardless of income. Taxes or contributions fund the programs, and cost-sharing through copayments and deductibles is the norm, with income-based limits on cost-sharing to protect poor elderly. Over the past decade, the levels of cost-sharing have risen substantially in countries with universal programs. Other OECD countries have income-based programs that provide assistance only to poor elderly who also have a demonstrated need for help with ADLs. England and the United States are the two countries that most clearly fit this description.

Choice of LTC insurers. France is the only OECD country besides the United States that has a private LTC insurance market with a large number of policy holders (3 million) and a choice of private insurance companies. Sweden, Norway, Denmark, Spain, Japan, and South Korea do not have a choice of LTC insurers as part of their social insurance systems. In Germany, people in the government-run social health insurance system choose a sickness fund (health insurer), and then their LTC insurance is administered by the same sickness fund. The 10% of the population with private health insurance can in theory choose a different LTC private insurer, but because LTC insurance is administered by the health insurers, people generally choose the same insurer for both types of insurance. There is virtually no price competition in LTC insurance because benefits and reimbursement rates are the same for all insurers, and there is a system of financial balancing of high-cost cases among the insurers.[5] In contrast, the Dutch are automatically registered for the LTC system when they choose an acute care health insurer (49). In each of the 32 regions in the Netherlands, a single health insurer (usually the largest) administers the LTC insurance for all individuals, regardless of which acute care insurer they have chosen (49–51). Essentially, the Dutch have a single-payer LTC scheme funded through income-related contributions that are pooled nationally, and insurers are not at risk for LTC expenses. England has neither a social insurance LTC system nor a market for private LTC insurance.

Choice of caregiver providers. Many Americans imagine LTC in Europe, especially in Scandinavian countries, as involving little choice and being available only in government-run nursing homes. This image, however, is far from how LTC services are provided in the OECD countries today. The Scandinavian countries were, in fact, early adopters of providing home- and community-based care as an alternative to nursing home care. The impetus

[5] There is very little demand for supplementary or additional LTC insurance policies in European countries, even when cost-sharing expenses are high. In Germany, where out-of-pocket copayments have grown to be about half of aggregate LTC costs, a market for "additional," voluntary private LTC insurance to help cover copayments has developed. However, as of 2008, only 2.2% of all LTC insurance members (excluding people who do not pay a contribution) had purchased additional policies (59). In the Netherlands, insurers have failed to attract enough demand for such policies (51). As of 2008, Austria has about 40,000 people covered by private LTC policies (55).

for this shift from government-built nursing homes is what also caused other countries to provide home- and community-based care: People wanted to remain in their homes and to have more choice in how they received assistance. It is also generally cheaper for most elderly to receive services in their homes rather than in nursing homes (30). The obvious problem with covering home-based LTC services is that many more people may want such care instead of relying on family to provide assistance. To restrict this potential increased demand, countries use similar assessment processes to determine people's needs and whether they qualify for home services (5).

As LTC costs have risen, countries are increasingly interested in strategies that might introduce competition among LTC providers and thereby generate efficiencies and lower costs of providing services. One strategy has been to allow more agencies to qualify as providers of LTC services, as Sweden and Denmark have done (33). A second strategy has been to provide people with "cash for care" (rather than in-kind services) or personal care budgets and allow them to purchase and organize their own care services from a variety of sources (including friends and relatives) rather than receiving services only from government-qualified agencies (21, 38). Sweden, France, the Netherlands, and Germany have pursued variations of this strategy (22, 47, 49, 51). The objective of reducing costs by allowing people more choice and creating competition has not materialized, however. Starting in 2012, the Netherlands is moving to restrict the use of personal care budgets by 2014 because personal care budget spending increased 23% per year between 2002 and 2010 (58).

LTC financing. As **Table 1** indicates, although the ways countries currently finance LTC vary, such differences have been narrowing over the past decade. Almost all countries rely to some extent on tax revenues to help fund their LTC programs. With the exception of the Scandinavian countries, which rely only on taxes, contributions are a common source of funding. They are calculated as a percentage of income and are collected from working people as young as 15 (in the Netherlands) as well as from the elderly. People with low incomes may be totally subsidized, and some countries set a limit on the income subject to the premium contribution. Some countries collect the contribution as payroll taxes; in Germany, the contribution is shared equally between workers and employers.

Cost-sharing is required in all the countries, in part to discourage people from seeking formal care in place of care provided by relatives. As LTC costs have risen, however, cost-sharing has shifted more costs to those who need assistance. In Japan, everyone who uses LTC services pays a 10% user fee, regardless of income, although poor beneficiaries are subsidized (32). South Korea requires a 15% copayment for home-based care and a 20% copayment for nursing home care (35). In most European countries, cost-sharing requirements are income-based and can be substantial, particularly because "hotel" or room-and-board expenses connected to nursing home care are typically not considered part of LTC services. In Germany, half of aggregate LTC costs are currently funded by copayments (59). In the Scandinavian countries, out-of-pocket payments generally cannot exceed an amount indexed to inflation (33).

Some countries create perverse incentives for nursing home versus home-based care by counting the value of a person's home or income when determining cost-sharing amounts (27, 40). When the home value is used to determine a person's nursing home copayments but is ignored when calculating cost-sharing for home-based care, people have an incentive to stay out of nursing homes. When cost-sharing is income based, local governments have an incentive to prefer higher-income residents in nursing homes, as has happened in Norway (40). This practice may not always lead to the most efficient use of services for individuals, and income-related inequities in service delivery may occur.

Stand-alone LTC program or mix of programs. Whether responsibility for LTC belongs to a LTC social insurance program or is shared among health insurers and other government programs differs by country. Some countries have tensions between their health insurance and LTC programs because of financing inefficiencies. In Germany and the Netherlands, for example, LTC insurers are not at risk for expenses; they are fully reimbursed. Because health insurers (which also manage the LTC insurance) are at risk for costs related to health care, they have an incentive to shift some services to LTC. France has a mix of complementary public programs and private LTC insurance in which some people enroll. LTC services directly related to health care are covered by the public health insurance, whereas another public program, Allocation Personnalisée à l'Autonomie (APA), is the primary payer of LTC services; it provides an allowance to people deemed in need of LTC services (18, 37). The allowance amount depends on the degree of need (dependency). Only those who are poor are exempt from copayments, which can account for up to 80% of the costs of services (18, 37). The private policies help pay for the copayments required. Japan and South Korea's LTC social insurance programs operate as stand-alone programs, although they are managed by the same government levels that manage health insurance. In Japan, municipal governments are in charge, whereas in South Korea the National Health Insurance Corporation manages both insurance programs and local governments do not have an administrative role (6, 35, 54).

What Level of Government Determines Need and Organization of Services?

In general, the OECD countries have devolved responsibility to municipal and local governments for determining eligibility criteria for receiving assistance and for organizing it. However, because municipal governments are usually responsible for most of the funding of such services, regional variations in services provided to the elderly are a concern in almost every country.

Variations in spending per person on LTC services have been the focus of researchers since the late 1990s as more elderly began using home-based services rather than moving to nursing homes. Disparities in spending per person could arise from many factors. Chief among these are differences in the age distribution and degrees of need for assistance in the local elderly population, availability of relatives nearby to provide informal care, and the financial well-being of both the elderly and the local government. Some factors are themselves correlated—the paucity of relatives nearby could reflect poor local economic conditions, for example—making it difficult to evaluate reasons for differences in spending per person. Similarly, determining whether such variations affect outcomes such as health or longevity is problematic when people who need assistance are in their later years of life. Researchers are just now trying to collect morbidity rates among the elderly and quality-of-life indicators such as happiness.

Regional variations in public spending per person are increasingly drawing attention given the growing realization that everyone faces the risk of needing expensive LTC. Sweden, with six decades of experience with publicly financed LTC, has been especially concerned about variations, partly because of the severe recession it experienced in the 1990s and the subsequent reductions in LTC assistance. Large variations in availability of services were noted during the 1990s (56), and since 1993 the national government has provided grants to municipalities to adjust for differences in income tax bases, costs of providing care, and demographic factors beyond the control of municipalities (33). More recently, researchers have concluded that variations in levels of home- and community-based services for the elderly are highly correlated with differences in levels of need among municipalities rather than with differences in financial resources or decisions by municipal agencies regarding eligibility (23, 48). A different interpretation of the past decade's smaller

variations in spending by municipality is that the national government has stressed the need for systematic assessments of elderly applicants to ensure fairness in decisions about services to be provided (56). The national authorities also are providing the public with data on quality indicators of LTC services by municipality, which may be reducing municipal variations in the 2000s (56).

In France, the financing of the APA is taking ever-larger portions of local governments' budgets just when there is a shortage of home-based service providers in many regions, raising concerns about disparities in meeting the needs of elderly across the country (18, 37). England published a national framework for eligibility criteria for publicly funded social care in 2002 in an effort to reduce variations across the country (9, 10). Even so, the local councils still can decide which level of eligibility a person is assigned, and the support provided can still depend on local budget considerations and whether informal care by relatives is available (9).[6]

Thus, most of the OECD countries are experiencing growing tensions over the historical convention of local governments both organizing assistance services and determining eligibility for such services. The need for coordination of income and housing assistance with LTC service provision has become serious with the recognition that home-based care is less expensive than nursing home care for most elderly in need of assistance and is greatly preferred by them (30). Moreover, given regional disparities in financial resources and shares of the population who are elderly and need assistance, pressures are mounting for sharing resources among regions. All the OECD countries appear to be moving (albeit at different speeds) toward having national eligibility standards and greater national funding but letting regional and municipal governments determine who meets the eligibility criteria and organize how assistance is offered.

Financing of Assistance and Long-Run Sustainability

Deciding how to finance elderly assistance programs is directly related to determining how the national and local governments should share responsibility for such programs. At the most basic level, the financing issue reflects the extent to which a country wants a program to be universal in terms of eligibility criteria and provision of services to those deemed eligible. Strong beliefs that a program should be universal lead to national funding and distribution of funds to areas where the needs are greatest. Programs that have weak commitments to universality or have originated in some areas of a country with more support than in other areas are more likely to have shared funding from national and local resources.

As noted earlier, the OECD countries differ in how they currently fund LTC. Relying on general tax revenues has the advantage that countries can continually assess the needs of the elderly relative to the country's resources, especially when there are economic recessions. However, this also has the potential for instability in funding, as Sweden experienced during its severe recession in the 1990s, and also highlights concerns about intergenerational conflicts if demographic distributions change (as they are now) or if needs change unexpectedly with medical advances or increased prevalence of debilitating conditions such as Alzheimer's. Dedicated taxes or contributions to an LTC social insurance fund have the advantage that everyone pays into a program over many years so future obligations are at least partly paid by people who will need assistance.

The pressing issue facing countries now is how to structure LTC financing so it will be sustainable as the elderly share of their populations grows and remains high through at least the mid decades of this century. The uncertainties surrounding how much LTC services

[6]Similarly, Medicaid spending on home- and community-based services (as well as nursing home care) per person varies substantially by state in the United States; a primary reason for such disparities is the joint federal–state financing of Medicaid (53).

will cost in the future have already caused Japan and Germany to alter their LTC financing. Originally Japan required anyone over the age of 40 to contribute to its LTC scheme, but in 2006 it lowered the compulsory age threshold to 20 years of age; in 2008, Germany raised the contribution rate by 0.25% (from the 1.7% established in 1995). The increased rate was supposed to secure Germany's LTC funding until 2014, but the European economic crisis makes this dubious (47). Like other countries, Germany also has not raised reimbursement rates for some types of LTC services (particularly nursing home care). This strategy effectively shifts more costs to individuals and their families—and makes the assistance more income based and less of a social insurance program. This outcome is at odds with the growing recognition that everyone is at risk of financial ruin from very expensive LTC, and social insurance is the most efficient way to address this risk. The Dilnot Report (11) responded to this situation by recommending that the English government create a catastrophic LTC social insurance program that would cover a person's LTC expenses only when they exceed a threshold such as $50,000 after 2 years.

Researchers who worry about the financing of LTC increasingly agree that some amount of prefunding of future LTC obligations should be in the mix of financing (7, 8, 28, 47, 59). Fully funded systems are likely impossible, given the uncertainties around future LTC costs and the types of services that will be needed. Trying to prefund LTC fully could be intergenerationally harmful to at least one generation when cohorts following a large cohort are smaller, as is the case among most OECD countries today (39). Thus, requiring people during their working years to prefund a program that could then partially pay for costs of LTC when they are elderly is a route that needs to be seriously considered. Otherwise, LTC assistance is going to become simply a program for poor elderly and elderly who become impoverished by paying for LTC services (as is the case in the United States with Medicaid eligibility).

Coordination Among Agencies Providing Assistance to Elderly

In European countries, programs that provide LTC services do not cover the costs of room and board in nursing homes and payments required for capital upkeep of nursing homes. As noted previously, these costs are covered either by the individual (or family) or by income and housing-assistance programs for low-income individuals. These programs are managed by municipal or regional governments, and the sharing of responsibility for nursing home expenses can cause agencies to work at cross purposes when funding for one program or the other is reduced. If housing-assistance funding were cut back, for example, a poor elderly person could be forced to move to a nursing home for LTC care, and then the income-assistance program would have to pay the much higher room-and-board costs of the nursing home.

Similar coordination issues exist when the health insurance system is at risk for the costs of health services that could be considered LTC services under some conditions and the LTC insurance system is fully reimbursed for the costs of providing such services. As noted earlier, the Netherlands and Germany have this problem, especially for care of people with chronic diseases (50, 59). Norway's national health insurance pays more of LTC costs when they are provided at home than when provided in nursing homes, so municipalities encourage people to obtain care at home, especially because cost-sharing in nursing homes is income based and municipalities have to pay nursing home copayments for poor people (40). Similar coordination problems exist in the United States for people who are beneficiaries of both Medicare and Medicaid.

Coordinating incentives from various government authorities so people can age in place and receive care efficiently is a goal that may require restructuring how assistance to the elderly is financed and organized. It may also require thinking beyond the assistance programs for the elderly and considering how

urban planning and renovations of town designs and buildings could encourage elderly people to walk more and possibly be healthier, thereby reducing health and LTC spending (30). Municipalities in some countries have been innovative in such planning, but these efforts have occurred outside the agencies that manage income-assistance, health, and LTC programs. Nonetheless, the realization that greater coordination is needed among agencies and programs provides a catalyst for restructuring how various forms of assistance for the elderly are organized.

LESSONS AND POLICY IMPLICATIONS

Three conclusions can be drawn from how most OECD countries are addressing the growing need for providing assistance to their rapidly aging populations. The first is that in spite of the substantial differences in how they provide assistance currently, they are converging on quite similar strategies for how such assistance should be organized and provided going forward. The convergence can be seen in the shifts toward enabling people to age in place rather than providing LTC only in nursing homes, toward allowing people to have more choice in care providers, and toward distributing more funds from the national government to local levels to reduce disparities in the delivery of services to people with similar needs.

The second conclusion is that every country is working to dramatically slow (if not halt) the growth in LTC expenditures because without these measures the programs that provide assistance to the elderly are not sustainable. So far, most of the efforts to slow LTC spending have involved freezing the services covered, restricting care to those deemed in greatest need, and not raising reimbursement rates to care providers (which reduces the number of providers of LTC services). These actions have caused costs of care to be shifted to individuals and their relatives as well as to other programs that provide income and housing assistance to elderly who cannot afford the cost-sharing required of people receiving LTC services. In effect, the moves to slow the growth in LTC spending are pushing countries back to the situations they were in at least two decades ago when municipal governments' budgets were straining from pressures to fund more assistance to the elderly and families were exposed to the risk of financial ruin because of the costs of caring for their elderly relatives.

These moves also run counter to the growing recognition that everyone faces the risk of financially catastrophic LTC expenses (8, 11, 34). A growing number of citizens have seen firsthand the high costs of caring for elderly people who have seriously debilitating conditions, so there is strong support to maintain social insurance for LTC expenses. Efforts to create social insurance LTC programs in more OECD countries have been deferred while countries confront the current financial crisis.

The third conclusion is that the sustainability of financing LTC services and other assistance for the elderly is an urgent matter among OECD countries. The current financial crisis is causing historically high numbers of younger age cohorts to be unemployed or underemployed and therefore unable to pay higher taxes to support the elderly while saving monies for their own retirement years. Efforts to increase the age of retirement modestly in order to continue tax payments and contributions to pensions by baby boomers before they retire have met with resistance in a number of countries (for example, France, Greece, and Belgium). It is strikingly clear that most countries are unprepared for the coming costs of assisting the rising numbers of elderly in their populations and that the current economic crisis is making it far more difficult to create financing mechanisms that will enable such programs to be sustainable beyond the current decade.

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