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Summary of LTC in Developed Countries
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Comments

This Annex presents information focused on especial issues in LTC programs in developed countries, like financing, contributions and coverage of these programs.

It is worth commenting that information varies a lot in terms of dates and sources. The tables were derived according to information included in some documents which were published between 1995 and 2005. Obviously, information is scarce, non updated or unavailable for some countries and, moreover, this information could have changed.

With the aim to provide recent information to our members, the document could change in order to be updated or to incorporate new data and/or new countries.

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Table 1
Scope of the Systems

Country	Scope in population	Benefits		
		Care receiver in kind	Financial support or assistance to care receiver	Financial support or assistance to caregiver
Austria	<ul style="list-style-type: none"> • Universal through two programs 	<ul style="list-style-type: none"> • Institutional care 	<ul style="list-style-type: none"> • Cash allowance (unrestricted¹) 	<ul style="list-style-type: none"> • “Carer payment” and “Carers allowance” program providing. These programs are denominated “full cash” strategy (no in-kind home care benefit)
Canada	<ul style="list-style-type: none"> • Universal 	<ul style="list-style-type: none"> • Institutional care 	<ul style="list-style-type: none"> • Cash allowance (subject be used to purchase respite care services) 	
Germany	<ul style="list-style-type: none"> • All employees as well as individuals with some other kind of income have to be insured. • Voluntary insurance is offered to some groups • Civil servants are obligated to take private insurance • High income earners may choose to take private insurance • LTC insurance covers family members, who are included without having to pay extra contributions • Care provided is acknowledged in public pension and work injury insurance 	<ul style="list-style-type: none"> • Formal home based care • Institutional care • Formal home based care has a priority over institutional care • Respite care • Assistive devices 	<ul style="list-style-type: none"> • Unrestricted cash allowances • The aim of benefits in cash is to support private, family based arrangements (The cash sum is much lower than complementary payments made to professional care providers) 	
Israel	<ul style="list-style-type: none"> • Universal 	<ul style="list-style-type: none"> • Institutional care – but only day care • Home based care, day care, help in household, in-kind benefits for some physical limitations. Medical, para-medical and social support are not covered. 		

¹ Unrestricted cash allowance allows the individual to use the funds as they see fit. Restricted cash allowance may be used only to purchase services.

Table 1 (Continued)

Country	Scope in population	Benefits		
		Care receiver in kind	Financial support or assistance to care receiver	Financial support or assistance to caregiver
Japan	<ul style="list-style-type: none"> • Universal 	<ul style="list-style-type: none"> • Institutional and formal home based care • Grants for home rebuilding • Respite care • Benefits up to certain limit for home based care 	<ul style="list-style-type: none"> • No cash benefits 	
Netherlands	<ul style="list-style-type: none"> • Universal 	<ul style="list-style-type: none"> • Institutional care and formal home based care • Assistive devices • Respite care 	<ul style="list-style-type: none"> • 	
Sweden	<ul style="list-style-type: none"> • Universal 	<ul style="list-style-type: none"> • Institutional and formal home based care • Daytime community activities and other services 	<ul style="list-style-type: none"> • Personal needs allowances • Some municipalities give “vouchers” used to contract LTC providers 	Sometimes municipalities offer the client a grant to pay relatives for care at home
Unites States (Medicaid)	<ul style="list-style-type: none"> • Population with insufficient financial means 	<ul style="list-style-type: none"> • Institutional care in nursing homes • Different standards among states in formal home based care and community care • Respite care 		
United States (Medicare)	<ul style="list-style-type: none"> • Workers and pensioners 	<ul style="list-style-type: none"> • Institutional care in nursing homes and hospices • Sometimes formal home based care • There are limits based on time spent on the institutions 		
United Kingdom: Local authorities	<ul style="list-style-type: none"> • Population with insufficient financial means 	<ul style="list-style-type: none"> • Institutional and formal home based care • Respite care 		
United Kingdom: National Health Service	<ul style="list-style-type: none"> • Universal 	<ul style="list-style-type: none"> • Institutional and formal home based care (nursing care in all care settings) 		

Table 2
Source of Finance of LTC

	Mandatory LTC insurance	General taxes	Other features
Austria		<ul style="list-style-type: none"> Founded by general (income) taxes 	<ul style="list-style-type: none"> Co payments for institutional care
Canada		<ul style="list-style-type: none"> Founded by general (income) taxes 	<ul style="list-style-type: none"> Co payments for non medical home care
Germany	<ul style="list-style-type: none"> 1.7% of Income Tax, employers and employees pay the same percentage of the wage, subject to a wage ceiling; retirees also contributes to insurance. 		<ul style="list-style-type: none"> Co payments for institutional care
Israel	<ul style="list-style-type: none"> Long term care insurance, through payroll taxes. 		
Japan	<ul style="list-style-type: none"> 50 % from taxes and 50 % from insurance premiums The tax revenues: 50% from national taxes, 25% local and regional taxes each 0.6% of wages (up to a ceiling), shared equally between workers ages 40-64 and employers. Income-related premium for persons 65+, deducted from pensions 		<ul style="list-style-type: none"> A co payment is imposed on the individual amounting 10% of care cost, with some exceptions
Netherlands	<ul style="list-style-type: none"> 10.25% of taxable income up to a wage threshold; with no employer contribution. 		<ul style="list-style-type: none"> Co payment for all services
Sweden		<ul style="list-style-type: none"> Local income taxes Grants from federal government to municipalities (in function of flat, age related grant and cost adjustments) 	<ul style="list-style-type: none"> Municipalities may charge some fees which varies according to type and amount of medical care There is a cap on out of the pocket expenditures Co payments
United States	<ul style="list-style-type: none"> From Medicare 	<ul style="list-style-type: none"> From Medicaid 	<ul style="list-style-type: none"> Medicare: pensioners should contribute (nevertheless few pay these premiums)
United Kingdom: Local authorities		<ul style="list-style-type: none"> Government grants and private property taxes 	<ul style="list-style-type: none"> Shared cost: varies according to locality. It is free in Scotia
United Kingdom: National Health Service		<ul style="list-style-type: none"> From NHS 	

Table 3
Requirements to Get the Contributions

Country	Requirements	Assessment process	Comments
Austria	<ul style="list-style-type: none"> Disability in FADL and 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) 	<ul style="list-style-type: none"> Type of assessment: structured, uniform nationwide Assessment responsible: Insuring agent 	<ul style="list-style-type: none"> Seven levels of care provided, by hours of care per month
Canada	<ul style="list-style-type: none"> Disability in FADL and IADL. Without age limit for eligibility. Respite care allowance is subject to mean-tested. 	<ul style="list-style-type: none"> Community Care Access Centers are responsible for assessment in both care allowances and medical assistance. 	
Germany	<ul style="list-style-type: none"> Disability in two or more ADL (forecast need for care for at least six months); need for at least 1 1/2 hours assistance per day Five years of contributions Benefits are not dependent on the income of individual 	<ul style="list-style-type: none"> Type of assessment: structured, variation among provinces The nursing agent is responsible for assessment 	<ul style="list-style-type: none"> Three levels of need are distinguished
Israel	<ul style="list-style-type: none"> Women 60+, men 65+ Disability in ADL and/ or need for constant supervision Need for at least two hours assistance per day if living alone or 2 and a half hours if not living alone Means tested Living alone adds points toward eligibility 	<ul style="list-style-type: none"> Type of assessment: Structured, nationwide Assessment responsible: National Insurance Institute 	<ul style="list-style-type: none"> Two level provided measured by hours of care per day
Netherlands	<ul style="list-style-type: none"> Functional disability 	<ul style="list-style-type: none"> Type of assessment: Discretionary Assessment responsible: Regional assessment board 	<ul style="list-style-type: none"> A package of services for each case
Japan	<ul style="list-style-type: none"> Persons 65+, and those 40-64 with age-related illnesses Difficulty in FADL, cognitive ability, sensory ability (forecast need for care for at least six months) 	<ul style="list-style-type: none"> Type of assessment: structured, nationwide Assessment responsible: Municipality 	<ul style="list-style-type: none"> Home based benefits provided in different levels of need
Sweden	<ul style="list-style-type: none"> Problem to carry out activities of daily living or dementia. No age limit for both non-medical home care and institutional care 		

Table 3 (Continued)

Country	Requirements	Assessment process	Comments
United Kingdom	<ul style="list-style-type: none"> • Eligibility age varies, depending on allowances 	<ul style="list-style-type: none"> • Non medical home care and Institutional care are mean-tested 	
United States (Medicaid)	<ul style="list-style-type: none"> • Insufficient financial means 	<ul style="list-style-type: none"> • Mean-tested 	<ul style="list-style-type: none"> • Limit for eligibility as well as scope of services covered are set at state level • Varies across states.
United States (Medicare)	<ul style="list-style-type: none"> • Medicare for homebound persons 65+ and disabled persons under 65. • For institutional care: insured has been treated in a hospital • For formal home based care: need of skilled nursing care 		

Table 4
Brief Description of the Provision

Country	Provision
Austria	<ul style="list-style-type: none"> • Austria is unique in providing a “full cash” strategy, i.e., providing an allowance that may be used to purchase formal home care services, pay informal caregivers, or for any other purpose.
Canada	<ul style="list-style-type: none"> • In 1996 the Ministry of Health and Long-Term Care of Ontario established the Community Care Access Centers (CCACs), which are local agencies that provide information about care for seniors. CCACs are not the provider, however they can provide it. CCACs helps persons to define the need and situation, determining the eligibility for government-funded services and subsidies, locating providers and applying for care • In case of non eligibility determined by CCACs senior can apply to care centers directly.
Germany	<ul style="list-style-type: none"> • Public sick funds contract with care providers: non profit nursing homes, private companies and formal caregivers (paid via voucher)
Israel	<ul style="list-style-type: none"> • Public and private providers, varies by the type of service
Japan	<ul style="list-style-type: none"> • Private companies not allowed to participate in nursing homes, most providers are non for profit institutions and some are managed by local authorities. • Private provider are allowed to participate in community care but market still dominated by public and non for profit organizations.
Netherlands	<ul style="list-style-type: none"> • Government, non profit and private for profit organizations
Sweden	<ul style="list-style-type: none"> • Institutional and home based care and other support mainly provided by local public monopolies. • Private providers have in total a small share of the market but that varies considerably within regions. • Municipalities are the “payers” of the system. • Provider mainly designed by municipality but there are some cases in which individuals are given a “voucher”.
United States	<ul style="list-style-type: none"> • Nursing homes mainly provided by private profit companies (66%), non profit organizations (30%) and the rest are state owned with differences within states. • Residential care provided by community care centers. • Private formal home based services.
United Kingdom	<ul style="list-style-type: none"> • Public and private providers, mainly public but private are increasing over time.

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