Annex to 'Fixing the Care Crisis'

Social care in other countries

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Different social care systems

Social care systems around the world vary significantly, and have usually developed incrementally in the light of specific historical, cultural, political, and economic contexts. Most OECD governments have set up collectively-financed schemes for social care, but the schemes differ according to, for example:

- the main source of financing (e.g. tax or insurance contributions);
- eligibility for the schemes (both in terms of a needs threshold and a means-test);
- the level/type of assistance provided; and
- the role of family/informal support.

The OECD report *Measuring social protection for long-term care (2017)* provides a useful overview of the different types of social care systems in place:

> *Most countries provide some degree of public risk-pooling – or social protection – for people with LTC [Long-Term care] needs, but the level and type of coverage varies. Some countries, such as the Nordics, have universal, tax-funded social care systems, which provide comprehensive coverage of LTC costs, comparable to the universal health care systems which exist in most OECD countries. Other countries have dedicated social insurance schemes, which can provide relatively comprehensive (e.g. Netherlands and Japan) or partial (e.g. Korea and Germany) coverage of costs. A third group of countries (e.g. Austria, the Czech Republic and Italy) relies largely on cash benefits to support people with LTC needs. The United Kingdom and the United States both have means-tested, safety net systems, under which the poorest are fully covered but the richest get little or no support (Colombo et al., 2011).*[1]

Most countries do not have well-functioning private insurance markets to cover social care needs.

i) Country profiles

The independent Commission on the Future of Health and Social Care in England (the Barker Commission) commissioned a report on *The social care and health systems of nine countries*

[1] OECD Publishing, *Measuring social protection for long-term care*, *OECD Health Working Papers*, No. 93, T. Muir, 2017, para. 12

(2014).[2] The report describes the health and social care systems of nine developed countries, selected to represent a range of approaches, and to include countries that have undertaken interesting and novel reforms.

A summary of the profiles of the key features of the social care systems in a selection of developed countries is provided in the table below, together with the relevant pages of the report where you can find a more detailed overview of: how each system works, the entitlements, funding arrangements, approach to delivery, and key issues. It is important to note that the report relates to 2014 and may not reflect more recent policy developments in those countries.

Social Care

	Japan	Germany	Australia
Type of public coverage	Statutory Long-Term Care (LTC) insurance (c. 2000)	Statutory LTC insurance (c. 1995)	Means tested government assistance
Universal	Yes	Yes	No
Public funding source	Age 40+ employee/employer contribution, age 65+ pensioner contributions. General taxation	Employer/employee + pensioner contributions	General taxation
Private insurance role	Small market exists – plans available as alternative to public system, and to cover cost sharing in public system	Option to take private plan to fulfil statutory requirement (~9% have). Supplementary plans available for costs not covered by statutory LTC insurance (3.5% age 40+ have)	Wealthy pay out of pocket. Tiny LTCI market
Further information	Pages 35 to 38	Pages 27 to 34	Pages 17 to 21

Source: The King's Fund, Background paper for the Commission on the Future of Health and Social Care in England, The social care and health systems of nine countries, R. Robertson et al, 2014, Table 1

[2] The King's Fund, *Background paper for the Commission on the Future of Health and Social Care in England: The social care and health systems of nine countries*, R. Robertson et al, 2014

Japan

The Barker Commission comparative paper (2014)[3]

Population: The population was estimated to be nearly 128 million in 2014 with an average life expectancy of 82.7 years in 2011. Japan has an ageing population. In 2010, 23% of the population were aged 65 years and over and it is estimated that by 2050 this figure will rise to 40%.

Entitlements: A new compulsory long-term care insurance (LTCI) scheme (Kaigo Hoken) was introduced in Japan in 2000. Japanese over 40 are obliged to pay into the insurance scheme, which provides access to social care to those over the age of 65. Benefits are generous by international standards, designed to cover the costs of care less a 10 per cent co-payment[4] (reduced on a mean-tested basis for lower income people). LTCI provides older people with access to a variety of community-based services, and residential and nursing care. A third of accommodation costs are covered, with the remainder subject to a means test.

The LTCI scheme is primarily designed to cover the care needs of older people; for adults aged 40–64 the system only covers long-term care needs arising from age-related disease (such as dementia, osteoporosis, Parkinson's disease).

Funding: Roughly one-half of revenue for the LTCI scheme comes from general taxation, one-third from premiums from people aged between 40–64 (at a rate of 1 per cent of income) and one-sixth from people over 65 (according to a fixed tariff of premium rates). User co-payments account for the rest. A small proportion of the population have private long-term care insurance as an alternative to the public system.

Key issues: Following the introduction of the LTCI scheme, uptake of services was higher than anticipated; in 2000, 10% of the over-65 population were found to be eligible for social care services, this had risen to 16% by 2005. This has led to the introduction of a number of restrictions to entitlements.

OECD Economic Surveys: Japan 2017

The OECD report identifies the considerable economic pressures facing Japan due to its demographics, noting that "Rapid population ageing is putting upward pressure on spending, increasing the already large transfers to the elderly population that raise concerns about inter-generational fairness".[5]

The report highlights the need for reforms in order to achieve fiscal sustainability and, in particular, recommends that Japan should take long-term care out of hospitals, reduce long-term care insurance coverage for those with less severe needs, and further increase the co-payment rate.[6]

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3 The King's Fund, Background paper for the Commission on the Future of Health and Social Care in England, The social care and health systems of nine countries, R. Robertson et al, 2014, pp35-38

4 The level of co-payment has been subsequently been increased for some older people - see Section 2.2 of this paper.

5 The King's Fund, Background paper for the Commission on the Future of Health and Social Care in England, The social care and health systems of nine countries, R. Robertson et al, 2014, p12

6 The King's Fund, Background paper for the Commission on the Future of Health and Social Care in England, The social care and health systems of nine countries, R. Robertson et al, 2014, p13

The following extract summarises some of the challenges facing long-term care provision in Japan and the OECD recommendations:

> *Following the introduction of long-term care insurance in 2000, long-term care spending increased by 2.6 times by FY 2014, the most among social security programmes (Figure 2.14). The number of care recipients rose by 3.3 times over that period, reaching 17.8% of the elderly population, the fourth highest in the OECD and well above the OECD average of 11.8%. The long-term care insurance premium, which must be paid by everyone aged 40 and over, increased by 2.6 times for persons aged 40-64 over FY 2000-16 and by 1.9 times for those over 65. The government projects that the pace of increase in long-term care spending will continue to be the fastest among social insurance programmes (Figure 2.7).*
>
> *The share of long-term care recipients receiving care at home is high, reflecting generous insurance coverage for such assistance. Indeed, "living support" (i.e., housecleaning, shopping, cooking, etc.) is covered by insurance, with low co-payment rates of 10%. Day service – elderly persons visiting long-term care facilities for meals and bathing – is also popular. In some cases, it is just entertaining elderly persons, even including casino-type activities. The variation between prefectures in per capita spending for home care, living support and day service is larger than for care provided in long-term care facilities, even after adjusting for age composition (Hida, 2015). Around two-thirds of those using living support and day service have needs that are classified as "less severe" (level 2 or below). Living support and day services for those with less severe needs should be excluded from long-term care insurance, and should instead be provided by local governments. In addition, the scope for combining care not covered by insurance with that which is covered (so-called "double billing") should be expanded.*
>
> *A number of studies have found insurance-induced demand both for living support and day service (Yuda, 2005; Tajika and Yui, 2004) and for care at facilities (Hida, 2015). One reason is moral hazard between individuals who want to receive care and business entities that want to provide it (Tajika and Kikuchi, 2006). In addition, municipalities face a conflict of interest between encouraging such care, which boosts local firms and employment, and appropriately administering the insurance. Moreover, municipal governments have insufficient financial resources to act as insurers, a role that should be shifted to the prefectural level. Some supply controls should also be considered, including reintroducing volume control for facility-based services, which had been abolished in 2012.*
>
> *Increasing co-payments is another priority to limit the projected rise in long-term costs (Figure 2.7). Private expenditure covered 8.6% of long-term care spending in 2013, much lower than the 15.7% for total health spending. In 2015, the government increased the co-payment rate to 20% and it plans to raise it further to 30% in 2018, in addition to raising the monthly payment ceiling by 19% to 44 000 yen (USD 387) per household. However, these reforms apply only to elderly earning as much as the working-age population, who are likely to be relatively few. Further increasing the co-payment rate to the level applied to overall health spending is essential.*[7]

OECD Health Indicators 2017

Alongside 'Health at a Glance 2017: OECD Indicators', the OECD published some country-specific key findings. The factsheet for Japan highlights the following policy issues:

> ***Japan is taking a multi-sectoral and community-based approach to meet the care needs of the ageing population***

[7] OECD, *OECD Economic Surveys: Japan 2017*, April 2017, pp141-143

The success in achieving long life expectancy has led to Japan having the highest share of elderly people in the population. The challenge of dealing with age-related diseases such as dementia is therefore more acute in Japan than in many other countries. The Ministry of Health, Labour and Welfare has been taking a multi-sectoral approach to building communities which are sensitive to the needs of people with chronic conditions such as dementia, as well as their families. The strategy aims to improve coordination of care at the community level among medical care, long-term care and social services; promote public awareness and disease prevention; and create a safe and healthy living environment for the elderly.

The health care and long term care systems could be better coordinated and managed to promote more efficient and effective services

People in Japan are more likely to spend the night in hospital than in any other country. This is partly because people who could be cared for at home, because their needs are social, not medical, nevertheless end up in hospital. A large share of long-term care is still provided in hospitals compared to other OECD countries (11% of hospital spending compared to an OECD average of 4%). Furthermore, while significant progress has been made in reducing the length of hospital stays, they are still one of the highest among OECD countries.[8]

Nuffield Trust

The Nuffield Trust is currently conducting research into the care system in Japan. The research has not yet been published, but a recent blog - Looking to the long term: the Japanese approach (November 2017) – highlights Japan's emphasis on prevention:

Japan's response to these challenges is not dissimilar to our own. Are they restricting access to care services and increasing eligibility levels to reduce expenditure? Yes. Are they asking the population to contribute more to their care? Yes. But the big difference between the rhetoric in Japan and the UK is the emphasis on prevention.

There is acute awareness that, as eligibility for services has risen, it's leaving people with mild needs vulnerable and less able to access LTC support. But, instead of just waiting for those people to deteriorate to the point where they need care, the Japanese Government is encouraging municipal governments to invest in community facilities, volunteering and social support networks.

This has taken the form of small pots of money being used to develop facilities for volunteers to run. In some places, municipalities have taken over vacant buildings and transformed them into community facilities, creating an easily accessible support hub.

By harnessing the power of the community and volunteers, they are trying to embed and strengthen an informal social support network. With changes to the family structure and the rapid rise of older people living alone, this has become a top priority.[9]

The Nuffield Trust report - Caring for an ageing population: points to consider from reform in Japan (2013) - explores how Japan has tried to meet the needs of its ever-growing older population through a new social care system, looking at points of interest for England.[10]

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8 OECD, *Health at a Glance 2017: OECD Indicators – How does Japan compare?*, 2017

9 Nuffield Trust, *Looking to the long term: the Japanese approach – blog post by N. Curry*, 27 November 2017

10 Nuffield Trust, *Caring for an ageing population: points to consider from reform in Japan by N. Curry, H. Holder and Dr L Patterson*, 27 November 2013

Germany

The Barker Commission comparative paper (2014)[11]

Population: 82 million with an average life expectancy of 80.8 years. Germany has an ageing population.

Entitlements: A mandatory system of long-term care insurance (LTCI) covers the old and disabled people of working age. It is not intended to cover all costs, but to cover basic needs; individuals are expected to contribute private funds, or to apply for means-tested welfare payments. All working people must have some form of long-term care insurance, but individuals with higher incomes can choose to take out private insurance rather than participate in the government programme, and around nine million people do so.

The private LTCI market is highly regulated, premiums must match those in the public programme and insurers cannot usually charge higher premiums to those with pre-existing conditions. Individuals are usually insured for LTCI with the same insurer as for SHI (Statutory Health Insurance). Only around 0.5 per cent of the population are not covered by any long-term insurance.

People in need of social care are assessed by the Statutory Health Insurance Medical Review Board and, if they meet the threshold for care, are put into one of three levels, according to their needs. Eligibility for support is dependent on how often help is needed with personal care and housekeeping and also the amount of care provided by informal carers. There is a safety net in the form of means-tested social assistance administered by the Lander (federal state), for those who are not able to cover non-insured costs.

Funding: A universal pay-as-you-go social insurance system was instituted in 1995. Contribution rates were set at 1.7 per cent, but rose to 1.95 per cent of wages in 2008.[12] Contributions are collected as an income tax (which among the working population) is divided equally between employer and employee. Pensioners also make contributions. In 2005 an extra 0.25 per cent premium was imposed on people without children who are less likely to receive informal support from family in old age. Lower rates are paid by students, unemployed people and pensioners.

Key issues: the LTCI fund faces shrinking revenues and increasing expenditures. Many commentators believe further reforms will be necessary, one estimate is that the payroll tax rate for LTCI will have to increase to 4.5 and 6.5 per cent by 2055.

OECD Health Indicators 2017

Alongside 'Health at a Glance 2017: OECD Indicators', the OECD published some country-specific key findings. The factsheet for Germany highlights the following issues with regards to long-term care:

> *Long-term care should continue to be a priority*
>
> *Germany has one of the oldest populations across OECD countries (20.9% are currently older than 65 years and 5.6% are aged over 80, compared to an OECD average of 17% and*

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[11] The King's Fund, Background paper for the Commission on the Future of Health and Social Care in England, The social care and health systems of nine countries, R. Robertson et al, 2014, pp27-34

[12] According to the OECD Economic Surveys: Germany 2016 the long-term care contributions had increased to 2.35%, p.112

4.4% respectively) and, therefore, also a high prevalence of dementia. This will likely lead to a growing number of people with long-term care needs in the future. The Federal government has adopted a number of reforms in recent years to improve long-term care services for people, and to secure the future financial sustainability of the long-term care system. The scope and depth of the benefits package covered by long-term care insurance has increased, with a particular focus on the needs of patients with dementia. Support for informal carers has also been strengthened, for example, by introducing short-term paid leave to organise care for long-term care dependent relatives or offering longer respite care for carers.

Nevertheless, further efforts will be required to meet future demand for long-term care services. Although the number of long-term care workers has increased in Germany in recent years, it is currently still below many other OECD countries (5.1 compared to 12-13 workers per 100 people aged 65 and over in Sweden or Norway). However, it must be taken into account that in Germany a high number of people in need of long-term care have been exclusively taken care of by family members or relatives. Intensifying training and strengthening efforts to recruit and retain long-term care workers should hence continue to be a priority. The government has taken up measures to address these issues. Increasing capacity in nursing homes and further development of home-based long-term care models could also be considered.[13]

Australia

The Barker Commission comparative paper (2014)[14]

Population: 22 million. Average life expectancy: 82 years

Entitlements: The Australian social care system is not universal and government assistance focuses on those with low incomes. The services provided are based on an assessment of an individual's need, and charges are determined by a means test. A range of services is offered by national and local government.

Funding: Social care services are mainly financed through tax revenue and user charges. As in England, wealthier people often pay the full cost of their care out of pocket, up to a government defined limit. Two-thirds of government spending on social care goes towards the costs of residential care, while one third is spent on community, assessment and information services.

Key issues:

- Future funding—there are concerns about ongoing financial stability in the social care system. In 2011, the Australian Productivity Commission's Inquiry into Aged Care investigated three different options for the future funding of older people's care: encouraging working-age individuals to save to pay for care in older age; a home equity release scheme to allow older people to draw on the equity in their homes to pay for care; and long-term care insurance policies. The Commission recommended the establishment of a public equity release scheme.
- Perverse incentives in long-term care—The Australian social care system has a complex set of means-testing rules, which are difficult to understand, and can create perverse incentives. For example, differences in the means-testing rules for community and residential care

[13] OECD, *Health at a Glance 2017: OECD Indicators – How does Germany compare?*, 2017

[14] The King's Fund, Background paper for the Commission on the Future of Health and Social Care in England, The social care and health systems of nine countries, R. Robertson et al, 2014, pp35-38

mean people sometimes select a type of care based on financial rather than need-based criteria.

Social care reform

In April 2012 the Australian Government published Living Longer. Living Better which set out a package of aged care reforms. The development of the reforms was informed by the Productivity Commission's *Caring for Older Australians* public inquiry and consultations with older Australians, their families and with industry stakeholders.

The introduction to the Living longer. Living better policy paper sets out the rationale for the reforms:

> *Australia is at a crossroads in the way our community provides care and support to older people. While the aged care system has served us well, it is not well placed to meet the challenges ahead. It is not delivering enough care in the home, where people want it. Not enough nursing homes are being built and the sector is finding it increasingly difficult to recruit and retain the workers it needs. If action is not taken now, Australia's aged care system will increasingly struggle to deliver the standard of care older Australians need and deserve.*
>
> *Older Australians deserve greater choice and control over their care arrangements, more than the aged care system is currently able to give them. We need new and more equitable ways of meeting the ever increasing costs of aged care and ensuring that the most vulnerable in our society are fully protected. And the aged care sector needs to work more closely with the wider health system to tackle key health challenges in particular, the dementia epidemic, and support for end-of-life care.*
>
> *[…] In the current economic environment the cost of providing high quality aged care services has to be shared across the community. The focus of these changes is on making the structural reforms needed to ensure the future sustainability of Australia's aged care system.*
>
> *To ensure the continued financial viability of the aged care system, it is vital that people who can afford to contribute to the cost of their care do so. Given that the cost to the community of providing aged care will increase dramatically in the decades ahead due to an ageing population, it is necessary to strengthen means testing arrangements in order to achieve a more sustainable balance between public and private contributions. This will be achieved without changing the current treatment of the family home.*
>
> *A shared commitment to meeting the costs of aged care is also necessary if the most vulnerable in our community are to be protected. Access to aged care should be based on need and not the ability to pay.*[15]

Aged care reforms are being progressively implemented in three phases over 10 years, as outlined on the Australian Government's website:

> *2012-13 and 2013-14*
>
> *Years one and two delivered immediate, urgently needed improvements while laying the groundwork for further reform:*
>
> - *new Home Care Packages and supplements introduced in home care and residential care*
> - *My Aged Care including a national contact centre began operations*

[15] Department of Health (Australia), *Living Longer. Living Better. Aged Care Reform Package*, April 2012, pp 3-4

- *the Australian Aged Care Quality Agency was established*
- *the Aged Care Pricing Commission was launched.*

For more information about changes already implemented, see what has been achieved so far.

2014-15 and 2015-16

Years three and four are delivering improved access and choice for consumers, and stronger system sustainability. The 2015-16 changes build on those already achieved, including:

- *implementing the national voluntary quality indicators for aged care*
- *introducing a national fee framework for the Commonwealth Home Support Programme.*

2016-17 to 2021-22

Changes to be implemented in this phase will be developed in consultation with the aged care sector. This includes the development of a single quality framework that will increase the focus on quality outcomes for consumers. Additionally, the legislation mandates a five-year review be undertaken to look at the impact of reforms to date and where we need to take the system in the future.

By 2022, our vision is that Australia's aged care system will:

- *be sustainable and affordable, long into the future*
- *offer greater choice and flexibility for consumers*
- *support people to stay at home, and part of their communities, for as long as possible*
- *encourage aged care businesses to invest and grow*
- *provide diverse and rewarding career options.*[16]

ii) Country comparisons

OECD Indicators

The OECD publication *Health at a Glance* 2017 presents the most recent comparable data on the health status of populations and health system performance in OECD countries.[17] Chapter 11 of the publication considers 'Ageing and long-term care'.

The table below shows available OECD data on the percentage of GDP spent on long-term social care financed by Government or compulsory insurance schemes.

In terms of the OECD definitions of long-term social care, the UK spent around 0.26% of GDP in 2015. Data is only available for 15 countries and the UK ranks 7th among these countries, below the OECD15 average of 0.35% GDP.

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16 Department of Health (Australia) webpage Ageing and Aged Care [Accessed 15 February 2018]

17 OECD, *Health at a Glance 2017,* 10 November 2017

LONG-TERM SOCIAL CARE EXPENDITURE IN 2015 Financed by government and compulsory insurance schemes	
	% GDP
Netherlands	1.29
Finland	0.88
France	0.56
Sweden	0.53
Czech Republic	0.41
Portugal	0.37
United Kingdom	0.26
Denmark	0.22
Latvia	0.17
Japan	0.15
Luxembourg	0.12
Slovenia	0.11
Switzerland	0.11
Spain	0.05
Germany	0.02
OECD15	**0.35**

Source: OECD Health Statistics 2017

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Which social care systems are most effective?

What is deemed an "effective" social care system is clearly open to interpretation. It might include factors such as: high-quality services; universal access for all citizens; effective care for better health outcomes; efficient use of resources; and responsiveness to patient concerns. Furthermore, some of these factors might conflict, for example, there might be a trade-off between controlling public expenditure and offering choice and independence to care users.

International comparisons of factors such as these are notoriously difficult, particularly because of differences in data measurement and collection. The comparison of nine social care systems for the Commission on the Future of Health and Social Care in England (referred to above in Section 2) concluded that:

> *No one country or model of provision emerges as an ideal. In a comparative analysis of the extent to which health systems deliver cost-effective care, the OECD found more variation within groups of countries with similar characteristics than between them, and that no one model could systematically be viewed as the most effective (OECD 2010). Across the countries profiled in this report there is no one star performer.*[18]

[18] The King's Fund, *Background paper for the Commission on the Future of Health and Social Care in England: The social care and health systems of nine countries*, R. Robertson et al, 2014, p13