

An international comparison of long-term care funding and outcomes: insights for the social care green paper

Foreword

Sometime during 2018 the Government is planning to publish a Green (consultation) Paper about the future of social care in England. With this in mind, towards the end of 2017 Age UK commissioned a project from Incisive Health. We asked them to explore the characteristics, including funding mechanisms, and outcomes of the social care systems operating in some other developed countries, with a view to seeing what lessons could be learned and potentially applied here. These countries were Italy, Spain, France, Germany and Japan.

I would like to thank Mike Birtwistle and his colleagues at Incisive Health for turning this ambitious project around in record time, and for the important insights that their work yields.

To date countries have responded to the challenges and opportunities of ageing in different ways and with varying degrees of urgency. However, to a great extent the issues are similar worldwide. For example, more older people inevitably means increased need for 'social care'.

This report makes clear that governments can take very different approaches to organising and funding this help for older people, and that indeed they do. No doubt to the disappointment of policymakers, the authors did not find a 'magic bullet' solution – every country is facing some problems. Moreover, cultural preferences also partially determine the 'best' approach for different societies.

France's system emerges as the most progressive from this analysis and Germany's the system in strongest financial health. Japan's approach is admirable for how it has tackled the need to improve and expand care as part of a very positive policy on ageing. Spain's social care system appeared to be doing reasonably well - until the State disinvested when its economy stalled, leading to long waiting lists for help. Italy's system is notable for being highly localised, with a lot of the spending on long term care taking the form of cash benefits to families; it is reported that in the poorer South especially, much of this supplements family incomes rather than actually being spent on formal care services for older people.

And what of England - how do we compare? Rather badly, is the honest answer. Here we arguably get the worst of many of the different elements the report looks at, partly because no government is yet to really grip the issues.

Most obvious of all is the fact that the financial deal for citizens with care needs is often a lot more generous in these other countries, compared to the offer here. As the report points out, these other nations generally either provide some non-means tested basic level of support, and/or cap the amount of co-payment to be made, and/or use a more gradual means-test.

It will be worth bearing this in mind when appraising the Green Paper, once it appears: will its proposals make England even more of an outlier than it already is, or bring us closer to these other developed countries in terms of the balance of contribution between the individual and the State?

The report is also notable for tackling a misconception; the evidence suggests that roughly similar levels of informal caring exist here as in other European countries. So much then for the suggestion from some policymakers that English families should follow the example of those in other countries - it turns out they already do, but here generally with very low levels of State support.

Organising and funding social care in ageing societies is a big policy challenge and this report tends to confirm that tackling it requires determination from politicians, plus a willingness on their part to be bold and to deploy the full force of the State in various ways. This is certainly true of Japan, the country among this cohort which arguably has the most sophisticated and developed overall approach.

Another lesson from Japan is that the sooner you embrace the challenge of increasing and improving social care to meet the needs of an ageing population, the sooner you start to overcome it. Delay only makes this harder because of the demographics. Japan embarked seriously on the process of reform a generation ago and Germany did so even earlier; here in England we have been painfully slow to get going but I sincerely hope that 2018, with a much anticipated Green Paper to come, will be the year we finally do.

Introduction

The challenges facing long-term care systems are well known, if not widely understood: with an ageing population and increasing care costs, how to finance a system that is fair to both recipients and the taxpayer whilst also providing equitable access to high quality care?

This problem is not confined to England, but it is particularly acute here. From 1996 to 2017 in England, there have been four independent reviews, five consultations and seven government policy papers attempting to answer these questions.¹ A Green Paper, previously the responsibility of the Cabinet Office but later passed to the newly renamed Department for Health and Social Care, is set to add to this list.²

While England has a long history of exploring sustainable solutions to long-term care, there has been little consideration of what can be learned from other countries. In light of the Government's Social Care Green Paper, Age UK commissioned Incisive Health to prepare a comparative analysis of long-term care funding models and outcomes in France, Germany, Spain, Italy and Japan. These five countries face similar demographic challenges to England and represent a diverse range of approaches to organising a long-term care system and could inform the overall debate around the Green Paper. This paper sets out:

- A definition of long-term care (page 3)
- That these are different systems, but a with shared demographic and financial challenges (page 4)
- A summary of the long-term care systems in each country (page 7)
- A comparative analysis of long-term care in relation to:
 - Service structures (page 9)
 - Funding levels (page 15)
 - Funding models (page 18)
 - Outcomes (page 21)
- Our conclusions (page 25)

Profiles for each of the five countries have been included at annex 1. A discussion of the definitions used throughout this report has been included at annex 2.

¹ The King's Fund, [A short history of social care funding](#), May 2017

² GOV.UK, [Government to set out proposals to reform care and support](#), 2017

A definition of long-term care

Crucial to any study of multiple countries is ensuring that the analyses are comparable, accurate and relevant. In long-term care there is a particular need for comparable definitions. The boundaries between 'social care', 'social-health care' and 'health care' are opaque. Unsurprisingly, different countries account for them in different ways according to the needs and structures of their own systems.

In international definitions, long-term care is subdivided into long-term care (health) and long-term care (social). In the OECD's Standard Health Accounts, long-term care (health) is defined as:

- "Medical or nursing care... [which] can include preventive activities to avoid deterioration in long-term health conditions or rehabilitative activities to improve functionality; and
- Personal care services which provide help with activities of daily living such as eating bathing, washing, dressing, getting in and out of bed, getting to and from the toilet and managing incontinence"

They define, long-term care (social), as:

- "Assistance services that enable a person to live independently. They relate to help with instrumental activities of daily living such as shopping, laundry, cooking, performing housework, managing finances and using the telephone"³

For the purposes of this report, and to ensure alignment with international literature and data sources, we refer to 'long-term care' throughout. We recognise the potential challenges of this approach; however, it is essential in accurately comparing between different nations.

In an English context this includes all of what is traditionally considered 'social care' (i.e. care in a nursing home, care home or at home) as well as some 'health' services (i.e. Continuing Healthcare). According to the Office for National Statistics, in 2016, England spent £45bn on long-term care, £36bn of which was classified as long-term care (health). In other countries (and according to shared international definitions⁴) much of what is considered social care in England is therefore accounted as long-term care (health).⁵

Where necessary, we are clear whether we are referring to long-term care in totality or to long-term care (health) specifically.

An additional discussion of definitions has been included at annex 2.

³ OECD, [Accounting and mapping of long-term care expenditure under SHA 2011](#), 2018

⁴ OECD, [Accounting and mapping of long-term care expenditure under SHA 2011](#), 2018

⁵ ONS, [Expenditure on long-term care \(health\) and long-term care \(social\) by financing scheme, 2015 and 2016](#), 2018

Different systems, but a shared demographic and financial challenge

The population is ageing in all economically developed countries.⁶ Longer life expectancies, combined with lower birth rates, are creating populations with increasingly high proportions of older people, as set out in Figure 1.

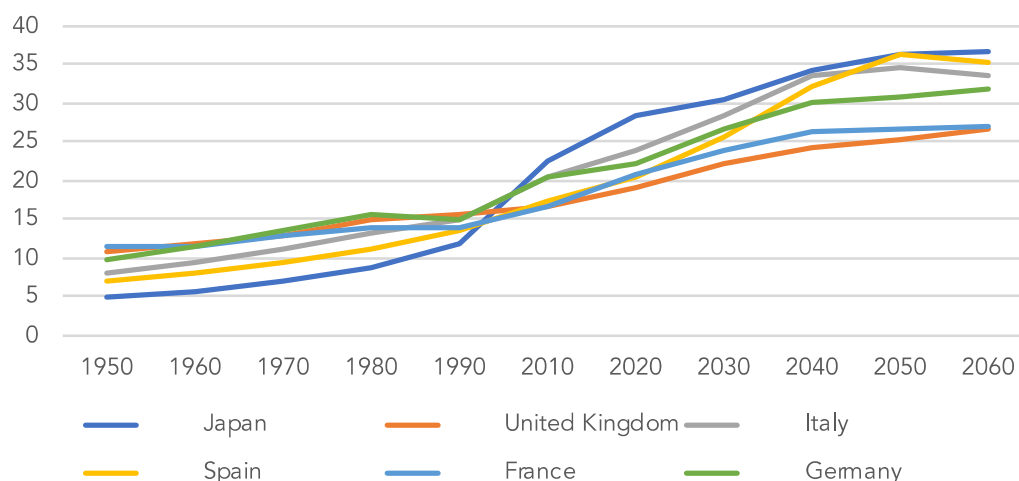


Figure 1: The percentage of the population aged over 65 years⁷

Across the six countries included in this report, the average population aged over 65 was 8.7% in 1950. By 2020 it will have reached 22.4% and by 2060, 31.8%. These are seismic shifts in the balance between working age and older people who are more likely to need long-term care in societies. As a result, there is a shared challenge in terms of long-term care.

Whilst all of the countries included in this study have ageing populations, the scale of the challenge differs by country. In the UK, the number of over 65s will have just under doubled between 1950 and by 2020, from 10.8% to 19.0%. By contrast, in Japan the proportion of over 65s has increased by nearly a factor of six, from 4.9% to 28.2%.

Looking to the future, of the six countries, Spain can expect to see the greatest rise in its population over 65 in the next 40 years to 2060, from 20.4% to 35.3%, a rise of 73%.

Whilst the older population is increasing as a proportion of total population, the oldest old (over 80 years of age) are the fastest growing group, as shown in Figure 2. Comparable data only exists from 1990 but the proportion of over 80 years olds is predicted to increase from an average of 3.3% in 1990 to 14.5% in 2060 across the six countries. Again, Spain is the country predicted to see the most dramatic increases from 2020 to 2060 with a 178% increase in the proportion of its population being over 80, from 6.4% to 17.8%.

⁶ International Monetary Fund, [Demographic upheaval](#), Finance & Development, Vol. 53/1, 2016

⁷ United Nations, Department of Economic and Social Affairs, Population Division (2017). [World Population Prospects: The 2017 Revision](#), custom data acquired via website.

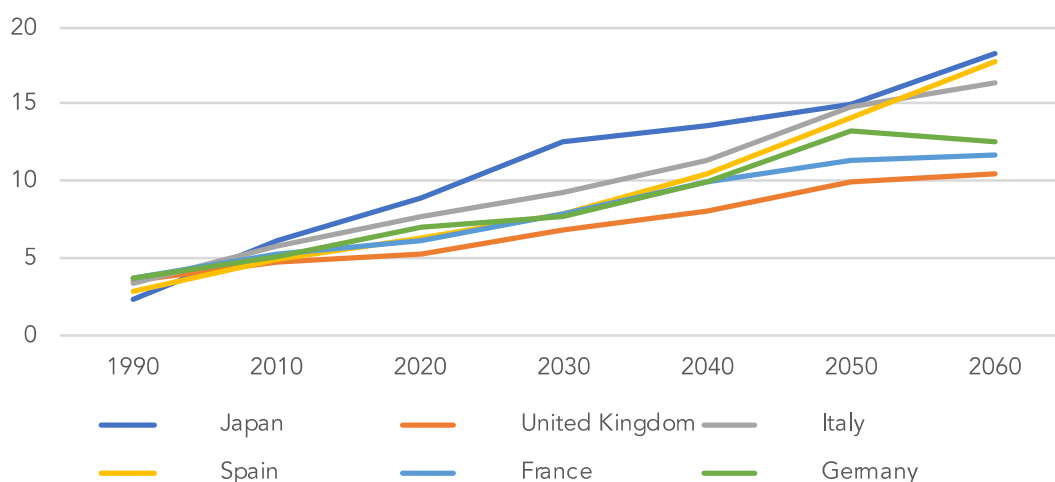


Figure 2: The percentage of the population aged over 80 years⁸

This has particular implications for long-term care because the likelihood of acquiring serious health conditions requiring long-term care increases with age. The chance of a person developing Alzheimer’s disease doubles every five years over the age of 65.⁹ Similar ratios apply for other long-term conditions like heart disease and diabetes.¹⁰ The higher the proportion of older people in a population, particularly those over 80, the greater the need for long-term care services.

At the same time that populations are ageing, and with that the number of people likely to be in need of long-term care, the cost per recipient of long-term care is stable. Long-term care services are labour intensive with a need for dedicated care and support and so are inherently costly. Across the EU, from 2013 – 2060 the unit costs (the cost per recipient as percentage of GDP per capita) for residential care, home care and cash benefits are all due to decline by only marginal amounts (by 2%, 3% and 2% respectively).¹¹ Productivity improvements will not be enough to offset the costs of the rising number of people in need of care.

As a result of increasing need for long-term care and stable costs per recipient, the cost pressure on long-term care services will increase substantially in the coming years. To take England as an example, the Institute for Fiscal Studies recently found that, even with above inflation increases to local tax rates, almost half of all local tax revenue could be taken up with funding adult social care services by 2035.¹² In countries with more comprehensive systems, the issue is potentially magnified.

⁸ United Nations, Department of Economic and Social Affairs, Population Division (2017), [World Population Prospects: The 2017 Revision](#), custom data acquired via website.

⁹ Alzheimer’s Society, [Risk factors for dementia, Factsheet 450LP](#), 2016

¹⁰ American Heart Association, [Prevalence of coronary disease by age and sex](#), 2015 and Healthline, [Type 2 diabetes statistics and facts](#), 2017

¹¹ European Commission, [Joint Report on Health Care and Long-Team Care Systems & Fiscal Sustainability](#), 2016

¹² Institute for Fiscal Studies, [Adult social care funding: a local or national responsibility?](#), 2018

International long-term care system summaries

This report compares the long-term care systems of France, Germany, Spain, Italy, Japan and England. More information on each of these countries can be found in the country profiles at the end of this report but we have included a short overview for each comparator country below.

France

In 2002, France introduced a universal, mandatory long-term care insurance scheme, The Allocation Personnalisée Autonomie (APA). The APA provides assistance to all residents who have care needs (as defined by the Government). The APA is national insurance model, funded through general taxation.

The APA is funded through income tax and a sharply income adjusted co-payment. In residential care recipients pay their own accommodation costs, but poorer recipients receive financial support. For home care, recipients in the highest income bracket are required to pay 90% co-payment, while those in the lowest bracket are not required to share costs. The requirement for high levels of co-payment from those with the highest incomes has resulted in the largest private insurance market of any of the countries examined in this report.

Germany

Germany's long-term care system is delivered primarily through public health insurance. While mandatory for all working people, individuals can opt out of the government programme and take private health insurance instead. Germany's long-term health insurance is designed to cover only basic needs and not the full cost of care. Users are expected to pay some of the costs – particularly for institutional accommodation – through private funds, private insurance schemes or, if required, means-tested welfare payments. Benefits can be claimed by people of all ages and are distributed in either cash payments or in-kind professional services.

Italy

In Italy, eligibility criteria and service provision of long-term care vary regionally although some benefits are provided and organised nationally. Care is delivered through overlapping national, regional and local institutions with close to half of spending dedicated to a cash benefit that does not have to be used for long-term care services. Funding is generated primarily through general taxation, though regional variation in per-capita taxation is significant.

Japan

In 2000, Japan's rapidly ageing population prompted a new approach to care provision through a national long-term care insurance system. Benefits cannot be taken as cash and are awarded through age-based grading. Insurance is compulsory for all those aged over 40. Services are coordinated by over 4,000 'community comprehensive support centres' supported by regional and large-city governments.

Japan's long-term care system is financed by a blend of general taxation, age-based premiums and user co-payments. Insurance payments are compulsory, and users are also obliged to contribute 10% of the costs of their care as a co-payment when they need them, although payments are capped for low earners. Fees for accommodation costs in residential care are also paid in addition.

Spain

Spain's long-term care system was overhauled in 2006 with the introduction of the System for Promotion of Personal Autonomy and Assistance for Persons in Situation of Dependency (SAAD). Under this system, long-term care is a legal entitlement calibrated according to levels of dependency and delivered as in-kind services and cash payment benefits. In-kind services, such as residential care or home care, require a co-payment, calculated in relation to income levels, which can be as high as 90% of the total cost. Similar to Italy, services are managed and coordinated on a regional basis.

A comparative analysis of long-term care

In order to compare the long-term care systems in different countries, we have examined each system across four areas:

- Service structure – how are services delivered?
- Funding level – relative to the other countries, what public and private resource is dedicated to long-term care?
- Funding model – is the system funded through general taxation, a public insurance scheme or private payments?
- Outcomes – what available measures are there to examine the performance of the system? Does it provide high-quality coverage to the people who need it? And at what cost to individuals and the taxpayer?

We examine each of these in turn below.

A comparative analysis of service structures

Each of the five systems we have examined in this report structure their long-term care services in different ways. However, they can be broadly divided according to the following characteristics:

- Those with a primarily national model (for example nationally defined eligibility or entitlements) vs those with a more devolved model with substantial regional variation in how services are organised or provided
- Whether each system provides universal access to long-term care services
- The extent of risk pooling in a system
- The extent to which each system relies predominantly on cash benefits vs in-kind benefits
- The proportion of in-kind services carried out in an institutional setting vs a domestic setting
- The extent to which long-term care services are integrated with healthcare services vs those which are differentiated from health services

We will examine each of these in turn, highlighting national case studies and relevant learnings where appropriate.

Summary

The summary table below reflects a broad characterisation of each system, rather than a nuanced picture. More detail is explored below, with a full analysis included in the appendices.

| | | England | France | Germany | Italy | Spain | Japan |
|--------------------|------------------------|----------|----------|----------|----------|----------|----------|
| Service structures | National vs devolved | National | National | National | Devolved | Devolved | National |
| | Universal access | No | Yes | Yes | No | Yes | Yes |
| | Degree of risk pooling | Low | Medium | High | Low | Low | High |
| | Cash / in-kind | In-kind | Both | In-kind | Cash | Cash | In-kind |

| | | | | | | | |
|--|-------------------------------------|------|------|---------------|----------|----------|----------|
| | Institutional / home care | Both | Both | Institutional | Domestic | Domestic | Domestic |
| | Healthcare integration (low / high) | Low | Low | Low | High | Low | High |

National vs devolved

All long-term care systems can be assessed on a scale between a full 'national long-term care service' and a fully devolved system. While service management and delivery is often local, a fully national system would usually consist of a national level:

- Funding model
- Access criteria
- Service provision

The summary table above sets out how each of the countries models their service. It is, perhaps, no surprise that Italy, with by far the greatest level of devolution, also sees the most variation in service provision across the country.

Summary

The greater the long-term care devolution, the greater the potential for variance in the quality and funding of services.

Reliance on local fund raising in combination with local discretion over access criteria, as in Italy, in particular risks major variations in quality.

Universal access: access criteria

The way in which access to long-term care systems is controlled is very important in determining outcomes. With increasing demographic pressure and rising costs, many countries have sought to control who can access the services they provide. Different approaches include:

- Universal access, with eligibility criteria based on need (public)
- Universal access, with eligibility criteria based on means (public)
- Buy-in, through insurance systems (public or private)
- Buy-in, through personal means (private sector model)

All of these models, ultimately, control or mediate access to the long-term care system and attempt to limit costs for individuals or the state.

Eligibility criteria based on means are generally more closely associated with countries which fund their long-term care systems through general taxation rather than national insurance schemes. This may be because it is harder for national insurance schemes to change 'the terms' of the service which people have been contributing to in an insurance model. By contrast, taxation funded systems, such as Spain and England,

have been consistently tempted to tighten eligibility criteria to control demand and save money. In England, means and eligibility criteria reduce the number of people eligible for state assistance for their long-term care needs.

Means testing for services can involve considering a number of factors. England has a stricter means test than the other countries examined in this report:

- England has a fixed means test limit for all long-term care services, meaning anyone with savings or assets above £23,250 has to pay all of the costs of their long-term care (with means tested support available to those with savings and assets between £23,250 and £14,250).¹³ Those with savings and assets below the threshold will still be expected to pay a contribution towards the costs of their care. Local authorities set their own charging policy, guidance only states that individuals should not be left with less than the personal expenses allowance in a care home or see their income reduce below the level of the charging minimum income guarantee.¹⁴ Other countries have more progressive systems, either providing a non-means tested basic level of support (Germany), capping the level of co-payment for all (10% in Japan), or using a more gradual means test (France). If co-payment levels are too high they can become unaffordable, restricting access to long-term care services.
- England considers the informal care provided by the families of older people when setting out an individual's care and support plan, unlike France and Japan which conduct "carer blind" assessments that do not consider informal care when deciding what level of service to provide.¹⁵

Whilst eligibility criteria are designed to restrict access to long-term care systems formally, waiting lists and under-provision of services restrict access informally. In Spain, the waiting list for long-term care benefits has risen to over 400,000 people at points in the last five years.¹⁶

Summary

Systems designed for universal access often deploy methods to restrict access for financial considerations. Eligibility criteria based on needs and means are common, as is rationing services through waiting lists and under provision.

Unlike England, most countries seek to control out of pocket expenses for the individual as well as cost to the state.

The requirement for co-payments or user charges can encourage poorer families in need of long-term care to either avoid services all together or to accept cash benefits. In both circumstances there is increased risk that vulnerable older people will not get the care they need.

¹³ Age UK, [Paying for care - the means test explained](#), accessed April 2018

¹⁴ Age UK, [Paying for permanent residential care](#), 2018

¹⁵ The King's Fund, [The social care and health systems of nine countries](#), 2014

¹⁶ L Pena-Longobardo et al, [The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act](#), 2015

Risk pooling

Linked to access, the extent to which risk is pooled in a long-term care system is an inherent part of a system's structure:

- In systems with universal coverage, risk is pooled across the whole population, with people who find themselves in need of long-term care expected to bear less of the cost in out of pocket expenses
- In predominantly means tested systems, risk is greater for the individual with public support limited to those on the lowest incomes

England has a system with noticeably less risk pooling than other countries for the non-health aspects of universal care. In England, long-term care needs which are covered by the NHS are covered totally with risk completely pooled, whereas needs that fall under the 'social care' system have very limited coverage with risk largely borne by the individual. This stands in contrast to the other countries included in this report which have more comparable health and long-term care systems.¹⁷

Cash vs in-kind benefits

The benefits provided by a system for long-term care can either be in-kind services or cash benefits. In England, long-term care is largely provided through in-kind services – i.e. services directly commissioned by local authorities or the NHS – although people have a right to access direct (cash) payments.

Cash benefits for long-term care are distinct from welfare benefits, as they are provided in lieu of all or part of an in-kind service. The purpose of welfare benefits is primarily to provide income protection to people living with poor health or disabilities and carers, including meeting the extra costs of having a disability such as transport. Many countries, including England, offer additional welfare benefits to those living with long term illness or disability outside of the long-term care system. The delineation between cash benefits as part of a long-term care system and welfare payments is opaque with different countries and systems accounting for them in different ways. Welfare payments are excluded from this analysis, unless explicitly stated. A full explanation of the classification of activities is included in the Standard Health Accounts for 2011.¹⁸

In a long-term care system, there are perceived advantages for in-kind services to predominate over cash benefits, those cited commonly include:

- Ensuring control over the quality of care through use of professional, regulated services
- Ensuring that informal carers, often women, have the opportunity to choose to be in paid work
- Ensuring that lower-income families are not incentivised to choose cash benefits as a supplement to income over professional, in-kind services for their relatives

Whilst some evidence suggests a higher use of in-kind benefits can be correlated with how progressive a system is,¹⁹ the perceived advantages of cash benefits are that they can be cheaper for the state, as they may be levied at a fixed amount and insulated from variations in market costs and provide greater choice for the

¹⁷ The King's Fund, [The social care and health systems of nine countries](#), 2014

¹⁸ OECD, [Accounting and mapping of long-term care expenditure under SHA 2011](#), 2018

¹⁹ European Centre for Social Welfare Policy and Research, [Paying for Long-term Care](#), 2015

service recipient. Germany recognises this, allowing people to claim their insurance as a cash benefit, but at a lower value than the equivalent in-kind benefit.²⁰

In Spain, there are controls meaning that cash benefits have to be spent on long-term care services or used to reimburse informal carers.²¹ By contrast, in Italy there are no constraints on how cash benefits are spent.²²

In Japan, the system is explicitly designed to shift more responsibility for care from families to the state, therefore there are no cash benefits for that reason.

Summary

Systems that rely on cash benefits are often able to provide at least some support to high proportions of the people who need them.

However, an over-reliance on cash benefits, particularly where in-kind services are not available (Italy) or unaffordable (Spain) risks leaving older people without the professional care they need.

Institutional vs domestic

In-kind services can either be primarily delivered in institutional, such as a care home or nursing home, or domestic or community settings. The optimal balance between institutional and domestic/community settings is contentious. A low level of institutional provision can indicate that there is an under provision of services, with people with serious conditions such as advanced Alzheimer's unable to be treated in the appropriate setting.²³ However, there is also evidence that caring for people in their own homes, for as long as possible, has long-term health benefits as well as costing less for long-term care systems.²⁴ Figure 3 shows the variation in provision of long-term care accommodation across the countries studied.

²⁰ The King's Fund, [The social care and health systems of nine countries](#), 2014

²¹ European Commission, [Spain: Health Care & Long-term Care Systems](#), 2016

²² European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

²³ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

²⁴ J Mansell et al. [Deinstitutionalisation and community living – outcomes and costs: report of a European Study](#), 2014

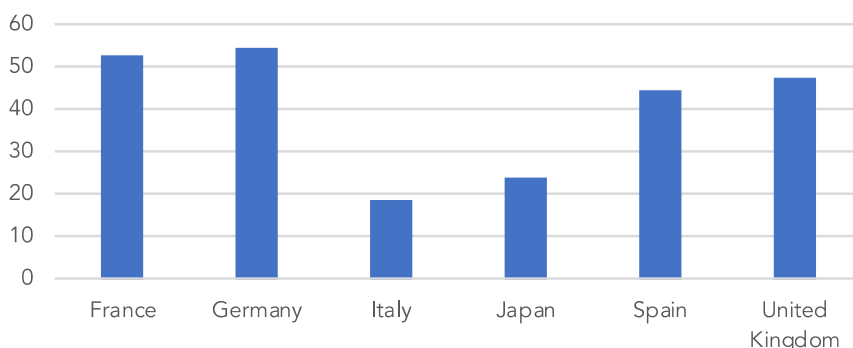


Figure 3: Number of residential long-term care facilities per 1,000 population aged 65 years old and over²⁵

Summary

An under provision of institutional care capacity can leave people living with severe disabilities to be cared for in inappropriate settings.

However, an over reliance is costly and can lead to the institutionalisation before it is strictly necessary and may suggest that domiciliary and community based services are lacking, hard to access or expensive.

Integration with healthcare

All countries recognise that quality would be improved, and services made more efficient, by increasing the level of integration or coordination with healthcare services. No country has achieved seamless integration, with different financial models between long-term care and healthcare often presenting an insurmountable challenge, but notable examples include:

- In Italy, Alzheimer's Evaluation Units enable GPs to refer suspected cases of dementia to units with healthcare, long-term care and community workers who can design integrated care plans²⁶
- In Japan, although there is no pooled funding between the long-term care insurance scheme and the health insurance scheme, there are more than 4,000 community comprehensive support centres to coordinate long-term care services, which employ care managers, social workers, and long-term care support specialists²⁷
- In Spain, some regional centres have utilised coordinated health and long-term care records to offer telecare services to patients to drive efficiency and allow for a lower level of institutionalisation²⁸

²⁵ OECD Stat, [Long-term Care Resources and Utilisation – Number of residential long-term care facilities per 1,000 population aged 65 years old and over](#), data extracted March 2018

²⁶ Alzheimer Europe, [Italy: Background information about the National Dementia Strategy](#), 2013

²⁷ The Commonwealth Fund, [The Japanese health care system](#), accessed March 2018

²⁸ The Guardian, [Telecare: The UK should learn from Barcelona's example](#), 2015

Summary

All societies and systems recognise that integrated health and long-term care will lead to a more efficient system and better outcomes for patients.

However, no country included in this study has succeeded, with differing financial models often proving to be an insurmountable challenge.

For integration to be driven further in England, a solution will have to be found which allows recipients to seamlessly transition between the currently 'free' health services and 'paid for' long-term care services.

A comparative analysis of funding levels

The level of funding available to a system is an important indication of the likely outcomes for long-term care systems.

Summary

The table below reflects a broad characterisation of each system, rather than a nuanced picture. More detail is explored below, with a full analysis included in the appendices.

| | | England* | France | Germany | Italy | Spain | Japan |
|--|----------------------|----------|---------|---------|---------|---------|---------|
| Relative percentage of GDP spent on long-term care | High / average / low | High | Average | High | Low | Low | High |
| Percentage of GDP spent on long-term care through voluntary / out of pocket payments | High / average / low | High | Low | High | Average | Average | Average |

**The UK has a devolved system for social care and spending figures will relate to the UK as a whole for comparison purposes. However analysis as far as possible seeks to understand and compare with the system in England, which accounts for the bulk of spending.*

Overall funding from public sources

The level of funding dedicated to long-term care varies widely by country, as shown in Figure 4. The overall funding shown below includes funding from public sources and compulsory insurance schemes, using the OECD definition, combining long-term care (health) and long-term care (social) spending.

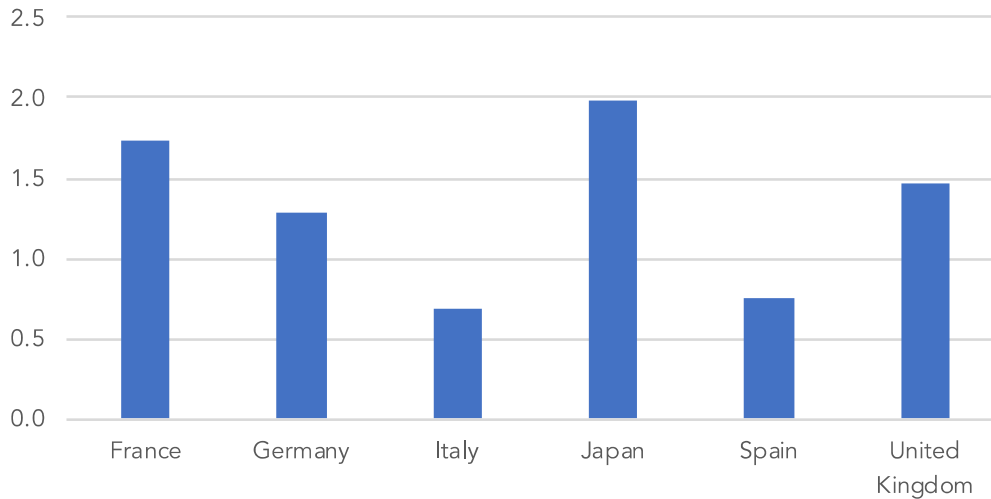
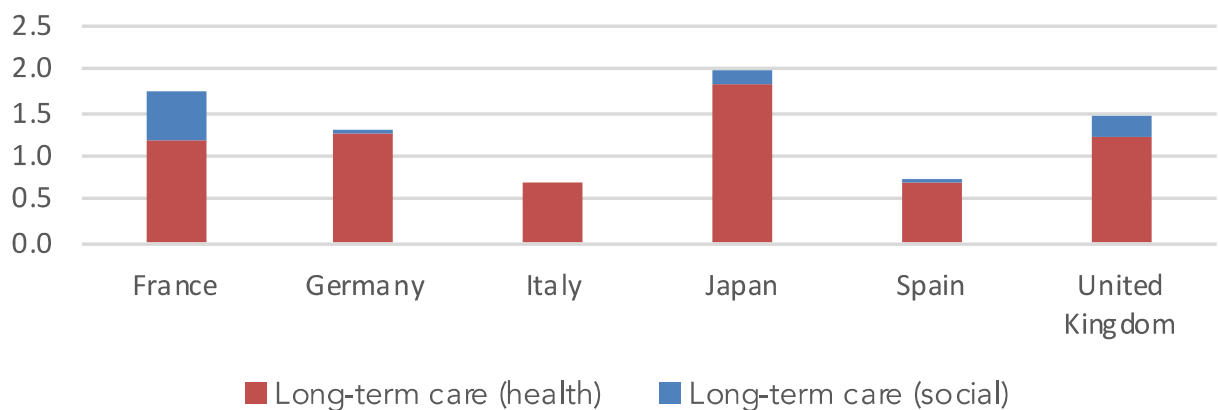


Figure 4: percentage of GDP dedicated to long-term care by government and compulsory insurance schemes, 2015²⁹

Figure 5 shows these figures broken down into their long-term care (health) and long-term care (social) components. Germany, Spain and Italy contribute very little public funding from the government or compulsory insurance systems to long-term care (social). This compares to France which spends over a third of its total long-term care spend on long-term care (social). This means that, in Germany, Spain or Italy if residents need long-term care (social) support they will have to pay for it out-of-pocket or have it provided by informal carers.



Figure

5: Long-term care expenditure broken down by (health) and (social) components, by government and compulsory insurance schemes, as a share of GDP, 2015³⁰

Whilst these definitions are useful to highlight the total government or compulsory insurance contribution to long-term care, they exclude two important sources of funding: welfare cash payments which are not directly

²⁹ OECD Stat, Health at a Glance 2017: OECD indicators - Chapter 11. Ageing and Long-Term Care, Figure 11.24. Long-term care expenditure (health and social components) by government and compulsory insurance schemes, as a share of GDP, 2015 (or nearest year)

³⁰ OECD Stat, Health at a Glance 2017: OECD indicators - Chapter 11. Ageing and Long-Term Care, Figure 11.24. Long-term care expenditure (health and social components) by government and compulsory insurance schemes, as a share of GDP, 2015 (or nearest year)

tied to long-term care services; and out-of-pocket or voluntary payments. Many countries also offer disability and sickness related welfare benefits in addition to long-term care services. These are not usually accounted for as part of a country's long-term care system, however in some countries the payments are included to reflect how they are viewed in the country. Of the countries considered in this report, this primarily affects Italy, where cash payments from the Ministry of Social Security, primarily to pay for home care, add an additional 0.9% of GDP to the long-term care spending registered by the OECD (the EU Commission do include this, and record Italy's spend as 1.8% of GDP).³¹ These payments, known as attendance allowances, are not means tested, are given equally to all recipients who pass a needs test, and do not have to be spent by the recipients on long-term care services. The very high level of non-care related cash payments in Italy highlights the extent to which the Italian system relies on cash payments rather than in-kind service provision.³²

Attendance Allowance benefits in the UK have also been excluded for the purposes of this analysis as a welfare benefit. However The UK spends £5.5bn annually on attendance allowance equating to approximately 0.3% of GDP.³³

Out-of-pocket expenditure

As explained above, the total spent by government's or compulsory insurance systems on long-term care is not reflective of the total funding dedicated to long-term care. Some countries, notably England and Germany, rely on their residents making high levels of out-of-pocket payments to fund their own care, as set out in Figure 6. In the UK, this amounts to 33% of overall spend on long-term care (health). In Germany, mandatory social care insurance covers the costs of basic care with out-of-pocket expenditure expected to pay for anything additional. As in England, this can lead to care being unaffordable for individuals at the point of need.

France has negligible out-of-pocket spending on long-term care (health) because it is the only country with an established private insurance market in long-term care, amounting to 15% of the total market.

It should also be noted that Figure 6 excludes long-term care (social) spending which may also require out of pocket payments depending on the nature of the system and what is included. As individual country analysis set out, out-of-pocket payments may be higher in total than those shown: for example, as already noted, Germany provides no public funding for long-term care (social) meaning that out-of-pocket payments will be higher than those shown.³⁴ Likewise in England the needs test excludes many individuals with care needs who will either have to pay privately for support or rely on other forms of informal help.

³¹ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

³² European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

³³ Office of Budget Responsibility, [A Guide to Welfare Spending: March 2018](#), 2018

³⁴ The Financial Times, [UK social care inquiry looks to Japan and Germany for solutions](#), 2017

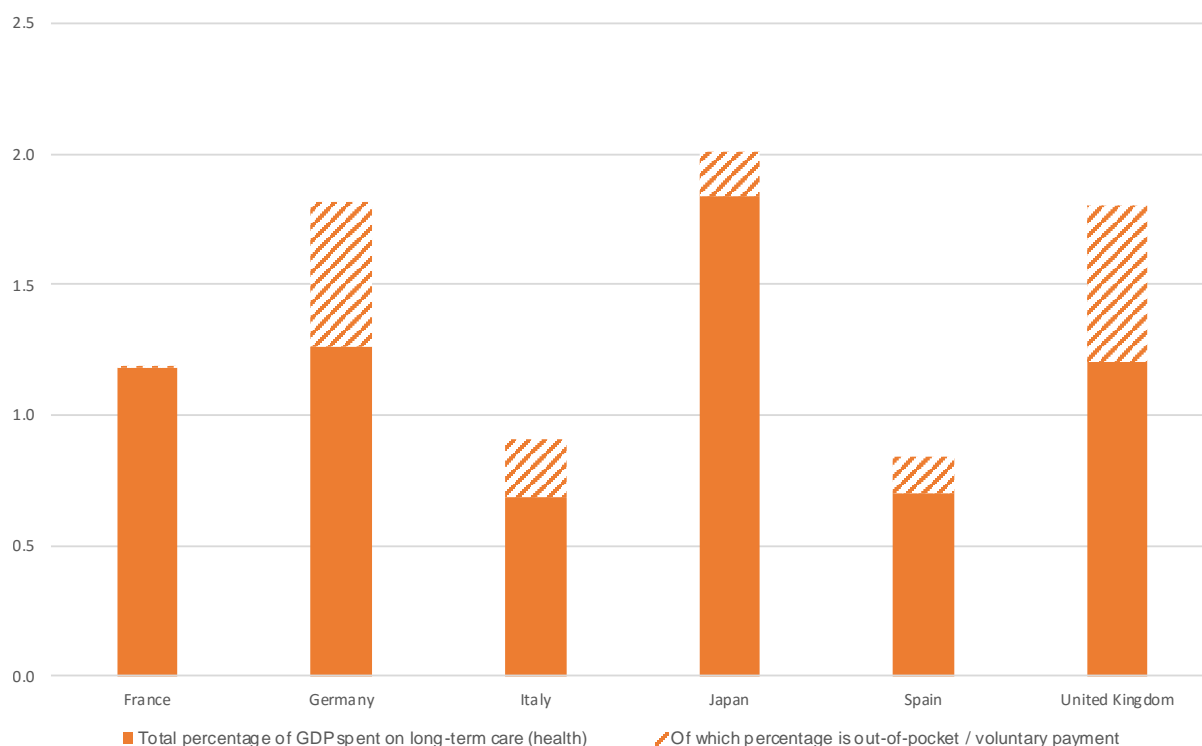


Figure 6: Percentage of GDP spent on long-term care (health) through voluntary schemes/ household out-of-pocket payments compared to total percentage of GDP spent on long-term care, 2015³⁵

Summary

With the exception of France and its established private insurance market, no country completely limits out-of-pocket expenditure on long-term care (health).

However, England has the 'harshest' means test of any country included, exposing a larger proportion of people at a lower threshold to out-of-pocket payments for care.

Funding per capita

Figure 7 shows total long-term care (health) funding per capita of the whole population. Assessing the total level of long-term care (health) funding against the whole population is important because it reflects the fact that long-term care is a societal cost. Per capita, these GDP figures (still excluding Italian social security cash benefits but including out-of-pocket payments), highlight that Germany has the best funded long-term care system, by far. Given Germany's comparatively high usage of institutional care, this is unsurprising and may indicate a scope for efficiencies – with more people receiving care in community settings and at home. Of course, it could also indicate that other countries maintain cheaper systems by providing insufficient institutional services for their populations' needs.

³⁵ OECD Stat, [Health expenditure and financing. Long-term care – GDP](#): voluntary, data extracted March 2018

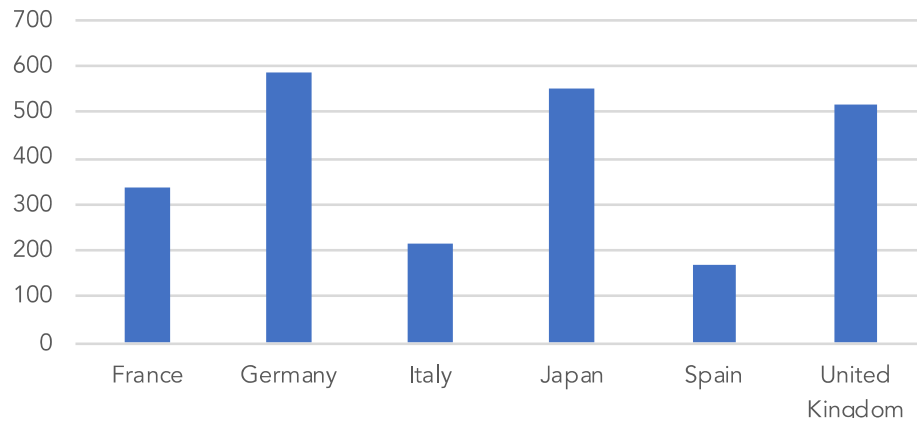


Figure 7: Total long-term care (health) funding per capita, current prices (£) 2015³⁶

³⁶ OECD Stat, [Health expenditure and financing. Long-term care](#) – per capita, data extracted March 2018. Conversion, Euro – Sterling: 0.87, Yen – Sterling: 0.0068

Funding models

The model of funding plays a significant role in determining the long-term care system a country can implement and can affect the quality of care that system will be able to give.

Summary

The summary table below reflects a broad characterisation of each system, rather than a nuanced picture. More detail is explored below, with a full analysis included in the appendices. Where we refer to taxation, it refers to the states share (e.g. the funding model in England).

| | | England | France | Germany | Italy | Spain | Japan |
|---------------|----------------------|----------|-----------|-----------|----------|----------|-----------|
| Funding model | Taxation / insurance | Taxation | Insurance | Insurance | Taxation | Taxation | Insurance |

Taxation based systems

England, Italy and Spain all have systems based on taxation. All three combine funds raised from national taxation with funds raised through regional taxation. However, there are some important differences:

- In Spain, regional and national taxation are combined centrally before being allocated back to the regions to pay for long-term care. Regions also have the option to raise additional funds to pay for further long-term care services, but the basics of the universal system are allocated centrally³⁷
- In Italy, with a much more devolved system, the majority of the funding for long-term care comes from taxes raised locally with some centrally raised funds used as a top up³⁸
- England, historically, followed a model closer to Spain's, with a large proportion of long-term care funding being allocated to councils as part of the Revenue Support Grant from central government. However, as the Grant has been cut in recent years, the proportion of long-term care funding being raised locally, from council tax, has increased. The IFS estimate that, even with above inflation increases to local taxes, the proportion spent on adult social care will increase from 30% today to over half by 2030³⁹

Summary

Taxation funded systems are vulnerable to the changing state of public finances.

In Spain, Italy and England, the general deterioration in public finances following the 2008 recession has seen a tightening of eligibility criteria; an increased use of 'cheaper' cash benefits in Spain and Italy; and less access to services generally.

Insurance based systems

Germany, Japan and France all have insurance-based funding models:

³⁷ European Commission, [Spain: Health Care & Long-term Care Systems](#), 2016

³⁸ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

³⁹ Institute for Fiscal Studies, [Adult social care funding: a local or national responsibility?](#), 2018

- In Germany, the insurance is primarily collected as a 2.55% income tax, with half paid by the employer. Germany has the only system in this paper which can be said to be in financial good health – in 2015 the scheme collected more than it spent.⁴⁰ There are several noteworthy policies.
 - Firstly, childless adults pay 0.25% more as they are less likely to receive informal support from family and may therefore need more services
 - Secondly, there is a contribution ceiling per month of €4,350⁴¹
 - Thirdly, pensioners make contributions to the scheme
- In Japan half of the funding for its national insurance scheme for long-term care comes from general taxation, one-third from premiums from people aged 40-65 (at a rate of 1% of income). A flat co-payment rate of 10% is required⁴²
 - The system has struggled with financial viability, having to remove accommodation costs from the package of support in 2005. Premiums have also increased and are scheduled to increase further⁴³ This is more likely due to other factors of the Japanese system, such as the inability for benefits to be taken as cash (discussed on page 12), rather than the model's inability to raise revenue
- France has the most progressive model. Insurance payments are collected as part of income taxation funding basic care. For home care, recipients are then expected to make a co-payment for services. For recipients with the highest income level from pensions, employment or other income streams (€2,927.66 or more per month, about 3.5% of recipients) a 90% co-payment applies, while the poorest 23% (those with monthly incomes of €734.66 or less) have no cost-sharing requirements.⁴⁴ There is a substantial private insurance market (15% of population aged 40+) to cover these co-payments.⁴⁵ Residential care is not funded by the APA except for those with the lowest means.⁴⁶

Summary

Insurance funded systems are also vulnerable to the changing state of the national environment. Lower than expected insurance contributions or higher than expected population long-term care needs can leave national insurance funds facing financial problems, as has happened in France and Japan.

⁴⁰ The Financial Times, [UK social care inquiry looks to Japan and Germany for solutions](#), 2017

⁴¹ Lexology, [Germany – Rise of minimum wage and new ceilings for social security contributions](#), 2017

⁴² PSRRU, [What works abroad? Evaluating the funding of long-term care: international perspectives](#), 2011

⁴³ The King's Fund, [The social care and health systems of nine countries](#), 2014

⁴⁴ P Doty et al, [Long-Term Care Financing from France](#), The Milbank Quarterly, 2015

⁴⁵ The King's Fund, [The social care and health systems of nine countries](#), 2014

⁴⁶ P Doty et al, [Long-Term Care Financing from France](#), The Milbank Quarterly, 2015

A comparative analysis of outcomes

Outcomes in long-term care are notoriously hard to quantify and compare, objective measures rarely exist, and causality is often hard to establish. However, some measures, or proxy measures, are available for at least some of the countries studied:

- Coverage – how many of the people who need long-term care are receiving it?
- User satisfaction – are the people who do receive care happy with what they receive?
- Female workforce participation – what proportion of women are part of the labour force, a proxy measure for the availability and quality given that informal caring often falls to women who remain at home or reduce hours to care for relatives?⁴⁷
- Overall quality – what measures or systems do countries use to ensure long-term care services are of a high standard?

We examine each in turn below.

Summary

| | | England | France | Germany | Italy | Spain | Japan |
|----------|---|---------|---------------|---------------|---------------|---------------|-------|
| Outcomes | Coverage levels of people who need care | High | Low | Low | High | High | High |
| | User satisfaction | 65% | Not available | Not available | Not available | Not available | 61% |
| | Female workforce participation | High | High | High | Low | High | Low |
| | Overall quality and variation | Medium | High | High | Low | Low | High |

Coverage levels of people who need care

Comparative data on the number of people receiving long-term care in each country is unavailable and difficult to collect. This is often because it is challenging to prevent double counting recipients of multiple services. The latest useable data from the OECD for England is from 2004, for example.

One alternative to total coverage levels is to estimate the percentage of people who need care who receive coverage – is the system providing care to the people who need it? Figure 8 highlights the range of coverage levels across the five European countries.

⁴⁷ M Moussa, [The relationship between elder care-giving and labour force participation in the context of policies addressing population ageing: a review of empirical studies published between 2006 and 2016](#), 2018

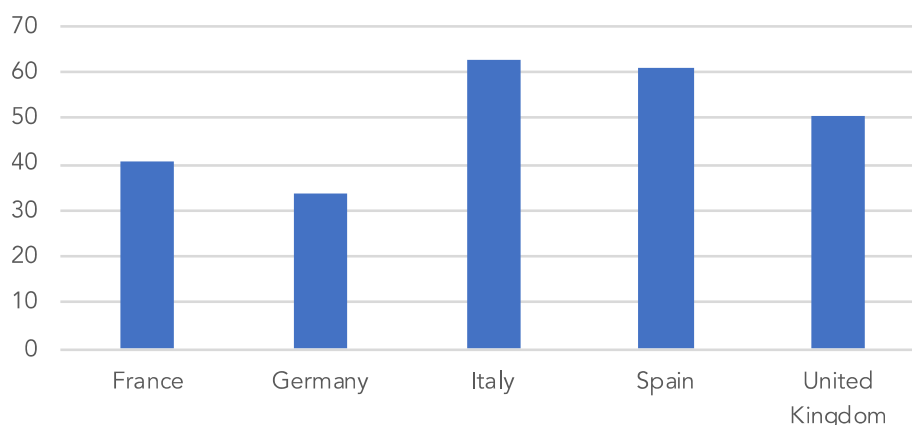


Figure 8: Percentage of people who need care receiving formal long-term care (cash or in-kind) from states⁴⁸

It is worth noting that coverage levels in Italy and to some extent Spain are high because their systems rely on cash benefits, rather than in-kind services.

Cash benefits, particularly in Italy, are no guarantee that recipients are receiving any kind of formal long-term care. A significant number of recipients of long-term care in Italy employ unqualified domestic help.⁴⁹ This is relatively cheap for the state, and ensures high levels of at least some support, but has highly questionable outcomes for both recipients of care and migrant workers.⁵⁰

Coverage levels in Japan, although not directly comparable with the European data included in figure 8, are very high. Less than 10% of the population avoid paying the mandatory insurance contributions which allow them to access the system.⁵¹

Summary

High coverage rates, particularly when reliant on cash benefits, do not necessarily equate to quality long-term care.

In Italy, cash payments are not means tested and recipients have no obligation to spend them on long-term care services.

User satisfaction

User satisfaction, measuring whether the people who use long-term care services are happy with their treatment and experience, is a powerful measure. However, very few countries assess long-term care outcomes in terms of user satisfaction and the measures that are available are problematic. Recipients are likely to rate their care compared to those around them and people who need care but do not receive it will naturally be excluded.

⁴⁸ European Commission, [Health Care & Long-term Care Systems](#), 2016

⁴⁹ S Rugolotto, [How migrants keep Italian families Italian: badanti and private care of older people](#), 2017

⁵⁰ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

⁵¹ The King's Fund, [The social care and health systems of nine countries](#), 2014

In England in 2016/17, the Adult Social Care Survey (ASCS), which seeks the views of all social care service users over the age of 18, found that 64.7% of those surveyed were extremely or very satisfied with the care and support services they receive. In Japan, the only other country with a comparable survey, satisfaction levels at 61% are very similar.⁵²

Female workforce participation⁵³

Female workforce participation is a crucial proxy outcome measure for long-term care because it is indicative of the level of informal caring in a society.⁵⁴ Figure 9 highlights that labour participation rates are much lower in Japan and Italy than the other four countries.

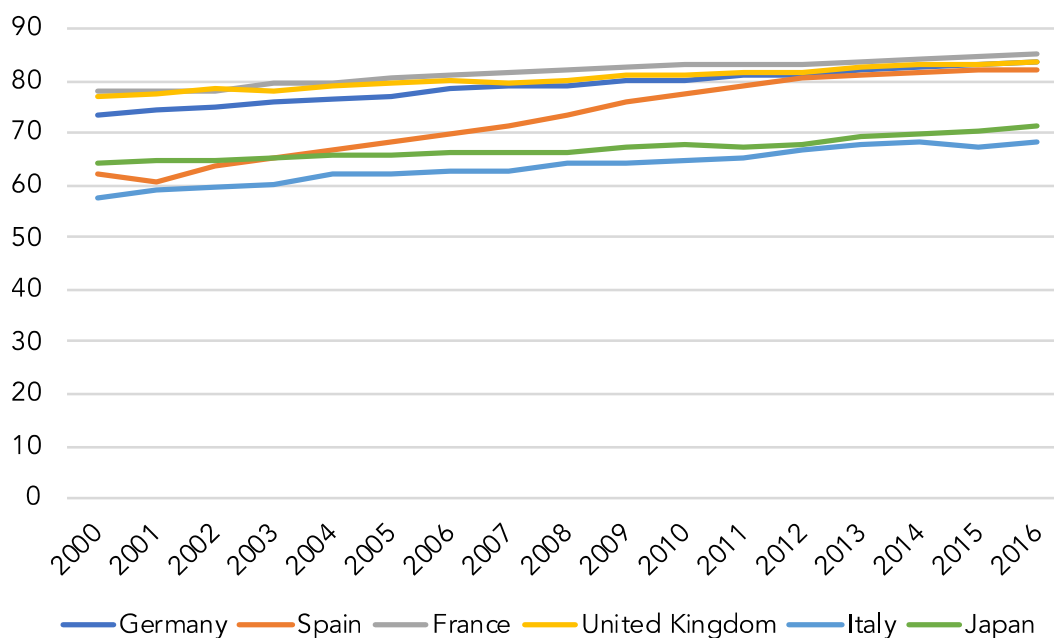


Figure 9: female labour force participation

In Italy, this is largely explicable by two factors:

- Firstly, the reliance of the Italian system on cash benefits, without any requirement for them to spent on long-term care services, incentivises families to informally care for their relatives and use the cash to supplement their income
- Secondly, the devolved Italian regional system has dramatically disparate standards and level of coverage. The long-term care system in the relatively poor South provides a lower quality of care with higher eligibility criteria than the richer North

⁵² Centre for Policy on Ageing, [Foresight Future of an Ageing Population. Japan – International Case Studies](#), 2016 and NHS Digital, [Personal Social Services Adult Social Care Survey, England – 2016/17](#), 2017

⁵³ All statistics taken from The World Bank Open Data, [Ratio of female to male labor force participation rate \(%\) \(national estimate\)](#), accessed March 2018

⁵⁴ M Moussa, [The relationship between elder care-giving and labour force participation in the context of policies addressing population ageing: a review of empirical studies published between 2006 and 2016](#), 2018

In Japan, the situation appears to be more closely linked to broader societal factors, such as a culture of long working hours and limited flexibility, rather than long-term care related factors.⁵⁵ Although, increasing premiums in Japan are placing pressure on working age people to leave their jobs to look after relatives, few appear able to actually do so suggesting that care factors are less relevant to female workforce participation.⁵⁶

Case study

The increase in the female labour participation rate in Spain closely follows the creation of the comprehensive long-term care system in 2005.

Similarly, the tightening of the eligibility criteria for social care in 2012 mirrors a slowdown in the rate of female labour force participation.

Quality and variations

'Quality' is the hardest metric to quantifiably compare long-term care systems by. Quality is naturally subjective. Objective, comparable assessments are non-existent. What is comparable however, are the variations in quality within nations.

Quality is controlled in different ways by the different nations. The most notable examples are:

- In Japan, the price of services is set nationally with recipients able to choose provider. A national market exists in quality, but not in price. The literature suggests that this approach, where the prices set nationally are high enough to support sustainable services, keeps quality high with providers unable to undercut each other⁵⁷
- In England, the Care Quality Commission (CQC) is an objective determinant of service quality. However, with the provider market under severe financial strain, recipients of social care have limited to no ability to choose between providers. Providers compete financially rather than on quality.⁵⁸
- In Italy a devolved system of provision varies dramatically from one region of the country to another with limited national standards. For example, in 2010 the number of over 65s receiving home health-care services ranged from 2.7 to 89.0 per 1,000 inhabitants by region⁵⁹

⁵⁵ The Financial Times, [Japan: Women in the workforce](#), 2015

⁵⁶ The Financial Times, [UK social care inquiry looks to Japan and Germany for solutions](#), 2017

⁵⁷ J Campbell et al, [Lessons from public long-term care insurance in Germany and Japan](#), 2010 and Centre for Policy on Ageing, [Foresight Future of an Ageing Population – International Case Studies](#), 2016

⁵⁸ The London School of Economics and Political Science, [What the NHS can learn from the introduction of markets in social care](#), 2013

⁵⁹ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

Summary

In financially distressed social care markets, quality is better ensured by a system based solely on service standards, rather than price competition.

Conclusion

Organising sustainable long-term care systems to meet the demand of ageing populations is an unsolved challenge across advanced economies. Fundamentally, in every country we examined, increasing numbers of people need long-term care which is expensive, labour intensive and resistant to productivity improvements.

In this report we have compared six very different approaches to overcoming these problems. None have been wholly successful. Finding the perfect balance for a system that is financially fair to both recipients and the taxpayer, whilst providing equitable access to high quality care, is one of the most pressing challenges of our times.

However, from the countries we have analysed, there are a number of interesting examples and approaches which may be helpful to long-term care policymakers in England.

Most importantly, any discussion should start from first principles. Jeremy Hunt, as part of the process of developing the Green Paper, has outlined the seven principles that will “guide the Government’s thinking.”⁶⁰

From our analysis, there are also three key questions which the Green Paper will need to address:

- Should a system provide at least basic universal care, free at the point of use?
- Should the financial cost of that care be borne by the state or by recipients?
- To what extent should progressive means be used to finance that care?

These are questions which would lead to challenging but productive conversations for the future of long-term care policy in England. We hope the international examples and analysis in this report helps inform the discussions in the Green Paper and that a sustainable, high quality and fair long-term care system can be created in England.

⁶⁰ The Rt Hon Jeremy Hunt MP and the Department of Health and Social Care, [We need to do better on social care](#), 2018

Annex 1: country profiles

Italy: Key facts

Funding

- Relatively low funding levels, 0.91% of GDP
- Cash benefits expenditure raises this to 1.8%

Funding model

- Largely funded by general taxation
- Medium level of co-payment for formal service, 24% of total spend

System model

- Entitlement to long-term care guaranteed by law
- Regionally fragmented system with different eligibility criteria
- Entitlement to different services from different regional and national organisations, including in the form of cash benefits or services in-kind. Nearly half of spending is on cash benefits, much higher than other countries
- Data on informal carers is limited, but surveys suggest over 2.5 million informal carers, primarily women
- Informal carers are regularly supplemented or replaced by domestic help, preserving the familial model of Italian long-term care but allowing for increased female labour participation

Outcomes

- 4.8% of the population aged 15+ receive long-term care support, higher than the EU average
- A much higher proportion of this support comes in the form of cash benefits however professional and institutional support is low
- Large regional variations in budgets and standards of care
- People in poorer regions, often in Southern Italy, are far more likely to use cash benefits to supplement their incomes rather than using it to pay for domestic support
- Female workforce participation is the lowest of the countries included, at 68%



Introduction

In Italy, social-health services are, at least theoretically, more closely integrated with long-term care services than in other countries. However, the Italian system is deeply fragmented with lower levels of professional coverage for long-term care than other countries. Italy, at 22.6%, has the lowest percentage of disabled people who receive formal institutional or home care in the EU.⁶¹

⁶¹ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

This is a result of the deeply fragmented system and means Italy still has a high reliance on informal carers and unqualified, often migrant, household assistants.

Demographics

At 25.4%, the percentage of the Italian population who have a long-standing illness or health problem is significantly lower than the EU average (32.5% in 2013). However, Italy is exposed to demographic change, primarily due to its higher than average life expectancies. 4.6 million Italian residents were living with limitations due to health problems in 2010. By 2060 this will have increased by 51% to nearly 7 million.⁶²

Service structures

In Italy, long-term care is fragmented with responsibility divided between national, regional and local authorities. Individual households also play a big role, both providing informal care and paying for home help directly. Households' role, particularly in the more industrialised north of the country, often consists of paying migrant workers to help in the home.⁶³

There are multiple, overlapping parts of the system:

- Long-term social-health services provided by the public health system
- Social services provided by municipalities
- Payments for home care, known as 'attendance allowances', paid by the National Institute of Social Security

Although a minimum provision of long-term care is a legal right in Italy, there are no single eligibility criteria to access services. Local health units of the National Health Service are responsible for assessments, but they do not use the same assessment criteria or processes in different regions of the country.⁶⁴ By contrast, access to cash benefits, provided by the National Institute of Social Security, is standardised, with one national eligibility criteria. Other key features of the system include:

- No single eligibility criteria, with variations by region and by type of benefit
- Very large proportion of care services come in the form of cash benefits (47%)⁶⁵
- Cash benefits, unlike other in-kind benefits, are not means tested and have standardised national eligibility criteria. The cash benefit does not have to be used to pay for a professional long-term care service
- The allowance amounts to around €500 a month for 12 months⁶⁶
- In 2014, cash benefits formed nearly half (47%) of all long-term care spending in Italy, the equivalent of nearly 0.9% of GDP⁶⁷

⁶² European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

⁶³ ENEPRI Research Report, F Tediosi and S Gabriele, [The Long-term care system for the elderly in Italy](#), 2010

⁶⁴ ENEPRI Research Report, F Tediosi and S Gabriele, [The Long-term care system for the elderly in Italy](#), 2010

⁶⁵ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

⁶⁶ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

⁶⁷ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

- Attendance allowances are often used to fund home assistance from migrant labourers. The Ministry of Social Security estimated in 2012 that the number of migrant domestic workers in Italy stood at 807,000⁶⁸
- Long-term care services, run by the National Health Service through local health units, are free of charge
- Long-term care services, run by municipalities, are means tested with co-payment expected, up to 100%
- Long-term care services are theoretically coordinated with those provided by the National Health Service but, in reality, this is not always practicable⁶⁹
- Providers include both public and private providers of health and personal long-term care. Private providers amount to 65% of the market⁷⁰

Relative funding levels

The Italian long-term care system is markedly under resourced in comparison to the other countries. However, the system is better than most other European countries at limiting the need for out-of-pocket payments.

- Total funding of long-term care in Italy is 0.91% of GDP, the second lowest of the countries compared in this report.⁷¹ However, if cash benefits from the Ministry of Social Security are included this rises to 1.8% of GDP⁷²
- Per capita, the former is equivalent to £214.10, the second lowest country⁷³
- 24% of the long-term care spending comes from voluntary and out-of-pocket payments⁷⁴

Funding model

The system is funded by general taxation (both national and local) with wide variations between different regions. One study suggested that the regional funding varied from €34 to €253 per capita by region.⁷⁵

Outcomes

⁶⁸ S Rugolotto, [How migrants keep Italian families Italian: badanti and private care of older people](#), 2017

⁶⁹ ENEPRI Research Report, F Tediosi and S Gabriele, [The Long-term care system for the elderly in Italy](#), 2010

⁷⁰ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

⁷¹ OECD Stat, [Health expenditure and financing. Long-term care](#), data extracted March 2018

⁷² European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

⁷³ OECD Stat, [Health expenditure and financing. Long-term care](#) – per capita, data extracted March 2018 Conversion, Euro – Sterling: 0.87

⁷⁴ OECD Stat, [Health expenditure and financing. Long-term care](#), data extracted March 2018

⁷⁵ ENEPRI Research Report, F Tediosi and S Gabriele, [The Long-term care system for the elderly in Italy](#), 2010

The fragmented Italian system, with a heavy reliance on cash benefits and domestic workers, provides generally lower levels of professional care than other countries:

- Investment in residential care is weak, which can create issues when very disabled people (such as those in the latter stages of Alzheimer's) continue to be cared for at home due to the lack of residential capacity. Italy, by far, has the lowest number of beds in residential care facilities per 1,000 population over 65, with only 18.5. By contrast, France and Germany both have over 50⁷⁶
- Italy also has comparatively low levels of recipients of long-term care at home with 5.5% of over 65s receiving some kind of service, compared to 9.3% in Germany and 6.7% in France⁷⁷
- 4.8% of people over 15 receive support as dependent persons, either in-kind or as cash benefits, higher than the EU average of 4.2%. However, the vast majority of these receive cash benefits⁷⁸
- Since 2013, the proportion of long-term care spending dedicated to cash benefits is predicted to have risen, from 47% to nearly 49%⁷⁹
- Large variations in care provision by region, in 2010 the number of over 65s receiving home health-care services ranged from 2.7 to 89.0 per 1,000 inhabitants⁸⁰

Alzheimer's Evaluation Units

- There are around 500 Alzheimer's Evaluation Units in Italy
- The Units coordinate support GPs in caring for people with dementia
- Over 2,000 staff work in these units, primarily healthcare workers but also social workers
- They play a central role in supporting the care of people with dementia

⁷⁶ OECD Stat, [Long-term Care Resources and Utilisation](#), data extracted March 2018

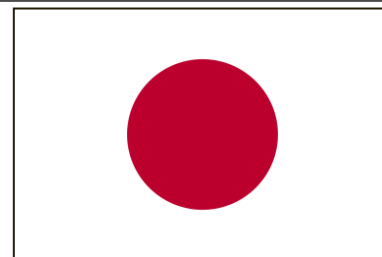
⁷⁷ OECD Stat, [Long-term Care Resources and Utilisation](#), data extracted March 2018

⁷⁸ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

⁷⁹ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

⁸⁰ European Commission, [Italy: Health Care & Long-term Care Systems](#), 2016

Japan: Key facts



Funding

- Funding amounts to 1.8% of GDP

Funding model

- Users are expected to contribute a 10% co-payment towards the cost of their care, capped for those on the lowest incomes
- Roughly one-half of revenue for the long-term care insurance scheme comes from general taxation, one-third from premiums from people aged between 40-64 (at a rate of 1% of income) and one-sixth from people over 65

System model

- For adults aged 40–64 the system only covers long-term care needs arising from age-related disease. Full entitlement to long-term care support occurs when people reach 65
- Benefits cannot be taken in cash. This decision was taken in part to protect female participation in the workforce
- Assessments for levels of support are carer-blind and do not take informal care provided by an individual's community into account

Outcomes

- Eligible people select the services they need from an array of for-profit and not-for-profit providers
- The Long Term Care Insurance system (LTCI) in Japan has been generally well received, with 61% saying they appreciate the programme
- There are more than 4,000 "community comprehensive support centres" to coordinate services, particularly for those with long-term conditions

Introduction

Until relatively recently, caring for the older generation was solely a family responsibility in Japan, but with the working age population in decline and Japanese society rapidly ageing, the government had to adopt a new approach to long-term care.

Demographics

As the world's fastest ageing society, long-term care is a key issue in Japan.⁸¹ Recent figures show that the current population of the country stands at 127 million⁸², and the number of people aged 65 or older accounts for 26.7% of the population – currently the world's highest proportion of over-65s.⁸³ This is compared to 16.7% in OECD 35 countries. It is estimated that this figure will rise to 40% by 2050.⁸⁴

The total economic costs of chronic conditions are \$5.7 trillion USD in Japan.⁸⁵ Health spending averages \$4,519 per person, slightly higher than the OECD average. Health spending as a share of GDP is now 10.9%, the sixth highest among OECD countries. Japan has a high number of beds per capita, often occupied by older patients in need of long-term care.

Service structures

Until 2000, publicly-funded long-term care was non-existent in Japan. Established in 2000, Long-term care insurance (LTCI) was designed to socialise the care of older people, shifting responsibility away from family and into the public domain. The key features of the system include:

- Compulsory long-term care insurance for those aged 40 and over
- 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)
- On turning 65, people become entitled to wide-ranging long-term care support, from home-based help with cooking and dressing to residential respite, intermediate and permanent care. Unlike more narrow definitions of, long-term care in Japan includes some nursing and medical care for long-term conditions also
- A third of accommodation costs are covered, with the remaining subject to a means test
- Assessments for levels of support are carer-blind and do not take informal care provided by an individual's community into account
- Benefits cannot be taken in cash, as is often the case in other countries; they must be taken as formal services in-kind. This decision was taken in part to protect female participation in the workforce
- Benefits such as institutional, home and community-based services, can be accessed through a care manager
- Results of a standardised questionnaire on activities of daily living and a report from the individual's physician are reviewed by a local committee to determine the beneficiary's level of need. Need levels are reassessed every two years or upon request following a change in health

Relative funding levels and model

Total funding of long-term care in Japan is 1.8% of GDP. Roughly one-half of revenue for the LTCI comes from general taxation, one-third from premiums from people aged between 40-64 (at a rate of 1% of income) and one-sixth from people over 65 (according to a fixed tariff of premium rates). User co-payments account for the rest.

⁸¹ The Financial Times, [UK social care inquiry looks to Japan and Germany for solutions](#), 2017

⁸² The World Bank, [Population total](#), Accessed March 2018

⁸³ The Japan Times, [Japan census report shows surge in elderly population, many living alone](#), 2016

⁸⁴ The King's Fund, [The social care and health systems of nine countries](#), 2014

⁸⁵ D Bloom et al, [The economic burden of chronic diseases: estimates and projections for China, Japan, and South Korea](#), 2017

While the scheme does provide support to all those above a certain level of need, irrespective of their financial situation, Japan has struggled with financial viability of the model. The package originally included cover for accommodation costs but this was cut in 2005 and eligibility criteria have been tightened to keep costs in line with the growth of the ageing population.⁸⁶

The total costs of the LTCI was 3.6 trillion yen when it started in 2000, but this grew to more than 10 trillion yen in 2015. The average contribution amount for those over 65 years old (per month) increased from 2,911 yen to 5,514 yen in the same period.⁸⁷ Insurance premiums are expected to rise further to 8,165 yen in 2025.

- Users are expected to contribute a 10% co-payment towards the cost of their care - the costs are generally seen as affordable and the scheme is extremely popular
- In 2005, means-tested fees for accommodation in institutional care were introduced and home help was restricted to those with severe disabilities, or those who lived alone
- Around 10% of the population evade their compulsory insurance payments and so do not have the insurance cards needed to access treatment

Outcomes

Reforms in 2014 and 2015 made a large number of changes including:

- Revising the assessment mechanism
 - Improving coverage for people with dementia
 - Introducing an earnings replacement scheme for up to 10 days to allow family caregivers to organise care
 - Introducing rehabilitation benefits to avoid or delay the need for long-term care
 - Improving access to short-term and respite care and improving quality assurance for care services
- In 2009, benefit rates for people in institutional care ranged from around £1,500 to £3,250 a month
 - The value of home and community care services ranged from around £380 to £840 a month for those with lower care needs and £1,270 to £3,000 a month for those who require more intensive care
 - Older eligible Japanese people select the services they need from an array of for-profit and not-for-profit providers. Since service prices are set by government and are the same for each region, selection is on the basis of convenience and perceived quality
 - The LTCI in Japan has been generally well received, with 61% saying they appreciate the programme (23% saying they do not)
 - The majority of LTCI home care providers are private. In 2014, 64% of home help providers, 40 percent of home nursing providers, and 58% of day care service providers were for-profit, while most of the rest were nonprofit
 - Costs for long-term care services in non-LTCI private nursing homes and group homes are partly covered by LTCI⁸⁸

⁸⁶ D Bloom et al, [The economic burden of chronic diseases: estimates and projections for China, Japan, and South Korea](#), 2017

⁸⁷ E Tajika, [The long-term care insurance of japan: institution and finance](#), 2017

⁸⁸ The Commonwealth Fund, [The Japanese health care system](#), accessed March 2018

- There are more than 4,000 “community comprehensive support centres” to coordinate services, particularly for those with long-term conditions. Funded by the LTCI, they employ care managers, social workers, and long-term care support specialists. Currently, there is no pooled funding between the Statutory Health Insurance Scheme and the LTCI
- Regional and large-city governments are required to establish councils to promote integration of care and support for patients with 306 designated long-term diseases.
- The LTCI has provided benefits to over five million people aged 65 and older⁸⁹

⁸⁹ Japan Health Policy NOW, [Long-term Care Insurance](#), accessed March 2018

Germany: Key facts

Funding

- Relatively low at 1% of GDP

Funding model

- Contributions are collected as an income tax at a rate of 2.55%

System model

- Long-term care insurance (LTCI) benefits are not expected to cover the full costs of care, and the scheme does not cover the cost of accommodation in institutional care
- Benefits can be given in-kind or by cash payments directly to the individual

Outcomes

- The LTCI has three levels of care based on the severity of an individual's health condition
- The expenditure for institutional services makes up 57% of public LTCI expenditure
- Overall, 3.6% of the population (aged above 15 years) receives formal LTCI in-kind and/or cash benefits



Introduction

LTCI is the fifth branch of the long-term care insurance system in Germany and was introduced in 1995. Launched at a time of welfare cuts, it was created to deliver financial sustainability. A series of reforms since 2008 have also extended the scheme to provide coverage for people with cognitive impairments such as dementia.⁹⁰ The demand on governments to provide long-term care is rising. Statistics show that there were 2.9 million Germans in need of care at the end of 2015, 8.9% more than in 2013.

Demographics

Germany has a population of 82 million and average life expectancy is 81 years. Healthy life years are, however, below the EU average. This in part is due to limited cross-country comparability of the healthy-life years indicators.⁹¹ 21% of the population is over the age of 65.

The percentage of the German population having a long-standing illness or health problem is considerably higher than other EU countries (38% in Germany versus 33% in the EU). In 2013, it was estimated that there were 7.4 million residents living with strong limitations due to health problems, and an increase of 11% is estimated by 2060. While this increase is less steep than that in the EU as a whole, dependents are becoming a larger proportion of the population.

⁹⁰ The London School of Economics and Political Science, [What can England learn from the German approach to long-term care funding?](#), March 2018

⁹¹ European Commission, [Germany: Health Care & Long-term Care Systems](#), 2016

Service structures

Mandatory long-term care insurance (LTCI) covers both older and working age people living with disabilities in Germany. While it is not intended to cover all costs (as health insurance is), it is meant to cover basic needs. Individuals are expected to contribute private funds, or to apply for means-tested welfare payments if extra support is needed.

All working people must have some form of LTCI, but individuals can choose to take out private insurance rather than participate in the government programme.

People in need of long-term care are assessed by the Statutory Health Insurance Medical Review Board. If they meet the threshold for care, they 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.

- LTCI benefits are not expected to cover the full costs of care, and the scheme does not cover the cost of accommodation in institutional care, so people are advised to buy supplementary private insurance to cover these costs
- Pay-as-you-go LTCI funds are managed by health insurance schemes
- Benefits can be claimed by people of all ages. Eligibility thresholds were developed to fit the funds available, but there is no means testing and no account is taken of individual circumstances
- There are two ways in which benefits are distributed: cash payments to the person needing care who then pays a family member, volunteer or paid carer; and in-kind professional services. Cash payments are more popular and significantly cheaper than services. Levels of benefit are based on dependency and range from £283 a month (the lowest cash benefit) to £1,784 a month (the highest in-kind payment)⁹²

Relative funding levels and model

Germany spends 1% of its GDP on long-term care. In 1995 a national care insurance fund was created, funded out of deductions from pay, with employers matching these individual contributions. It is currently in good health: in 2015, it took in €31bn and spent €29bn, while its reserves grew to €8.3bn⁹³

- The individual contribution rate is currently 2.55% of wages payable up to a contribution ceiling. Since 2005, childless adults pay 0.25% more as they are less likely to receive informal support from family in old age
- Contributions are collected as an income tax (which among the working population) is divided equally between employer and employee. Pensioners also make contributions
- Lower rates are paid by students, unemployed people and pensioners
- Approximately €28 billion was spent on care insurance in 2015 – 56% more than in 2005⁹⁴

Outcomes

⁹² The King's Fund, [The social care and health systems of nine countries](#), 2014

⁹³ The Financial Times, [UK social care inquiry looks to Japan and Germany for solutions](#), 2017

⁹⁴ The Financial Times, [UK social care inquiry looks to Japan and Germany for solutions](#), 2017

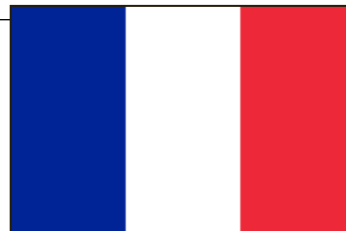
Reforms in 2014 and 2015 made a large number of changes including: revising the assessment mechanism; improving coverage for people with dementia;⁹⁵ introducing an earnings replacement scheme for up to 10 days to allow family caregivers to organise care; introducing rehabilitation benefits to avoid or delay the need for long-term care; improving access to short-term and respite care and improving quality assurance for care services⁹⁶

- The LTCI insurance has defined three levels of care based on the severity of the health condition. Level I provides for extensive care of at least 90 minutes per day. This care duration is extended to at least 3 hours in level II (severe care) and at least 5 hours in level III (most severe care)
- The system does not pay out until someone has needed care for six months
- In 2011 2.5 million people, (3.1% of the population of Germany) were entitled to benefits from LTCI. Of these around 70% received care at home and 30% were in residential care
- Nearly all long-term care, including institutional and home care, is delivered by private providers – either for-profit or non-profit organisations
- The expenditure for institutional services makes up 57% of public LTCI expenditure. 43% being spent on long-term care services provided at home
- Overall, 3.6% of the population (aged above 15 years) receives formal LTCI in-kind and/or cash benefits (Approximately 69% of the benefits were in-kind, while 31% were cash benefits)

⁹⁵ European Commission, [Germany: Health Care & Long-term Care Systems](#), 2016

⁹⁶ Centre for Policy on Ageing, [Foresight Future of an Ageing Population. Germany – International Case Studies](#), 2016

France: Key facts



Funding

- 1.8% of GDP is spent on long-term care

Funding model

- Long-term care is funded by income adjusted general taxation at central and regional levels

System model

- France has a universal mandatory long-term care insurance scheme, Allocation Personnalisée Autonomie (APA), introduced in 2002
- Needs are categorised on a six-point scale that accounts for capacity to conduct daily activities and mental health status
- The government covers between 0 and 90% of the cost of a person's home care package with residential care paid for from their own contributions (often using private insurance)

Outcomes

- 40.7% of dependents are receiving formal, in-kind services or cash benefits for their long-term care
- 15% of the population aged 40+ have private LTCI to cover cost-sharing obligations in the public system
- Individuals must have relatively high levels of impairment to qualify, and many higher incomes pay large amounts out-of-pocket due to co-payment tiers

Introduction

France introduced a mandatory LTCI scheme in 2002. While coverage in France is not considered to be comprehensive, expenditures have exceeded projections given the increasing demands of an ageing population.

Demographics

France has a population of 65.6 million, this is expected to grow by 15% by 2060.⁹⁷ The average life expectancy is 82 years, one of the highest in the OECD. The percentage of the French population having a long-standing illness or health problem is higher than in the EU (36.2% versus 32.5% in 2013).⁹⁸ 17% of the population are over the age of 65.⁹⁹

⁹⁷ European Commission, [France: Health Care & Long-term Care Systems](#), 2016

⁹⁸ European Commission, [Germany: Health Care & Long-term Care Systems](#), 2016

⁹⁹ P Doty et al, [Long-Term Care Financing from France](#), The Milbank Quarterly, 2015

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing.

Service structures

France has a universal mandatory LTCI scheme, Allocation Personnalisée Autonomie (APA), introduced in 2002. It provides varying levels of assistance to all residents aged over 60 who have care needs above a government determined threshold.¹⁰⁰

- Needs are categorised on a six-point scale that accounts for capacity to conduct daily activities and mental health status
- The needs assessment for the scheme are carer blind
- The means test is based on taxable income and some assets, but do not include the value of an individual's home, as long as a close family member (spouse, child, grandchild) is still living there
- The government covers between 0 and 90% of the cost of a person's care package
- The APA cannot be used to pay a spouse or partner for providing informal care, it can be used to employ another relative or carer to perform specific tasks that are part of a defined care package
- The range of types of care available is broad. It comprises help with daily activities (cooking, cleaning and laundry, etc.), help with personal activities (bathing, getting dressed, etc.)

Relative funding levels and model

Public spending on long-term care is above the OECD average at 1.8% of GDP.¹⁰¹ The APA is funded by general taxation at central and regional government level. Since 2005, various financing reform proposals have been debated, ranging from a newly covered risk under the social security system to targeted subsidies for private LTCI.¹⁰²

The insurance scheme is steeply income adjusted: recipients at the highest income level (€2,927.66 or more per month, about 3.5% of recipients) must pay a 90% coinsurance, while the poorest 23% (those with monthly incomes of €734.66 or less) have no cost-sharing requirements.

Outcomes

France reformed its long-term care system in 2002, introducing a universal social insurance scheme in which care and support are provided based on need and financial means. These reforms were driven by social values and the view that financial risks of long-term care faced by older people should be mitigated communally by the welfare state.

- 40.7% of dependents are receiving formal in-kind long-term care services or cash benefits for LTC
- 15% of the population aged 40+ have private long-term care to cover cost-sharing obligations in the public system¹⁰³

¹⁰⁰ The King's Fund, [The social care and health systems of nine countries](#), 2014

¹⁰¹ The King's Fund, [The social care and health systems of nine countries](#), 2014

¹⁰² K Chevreur, K Brigham, [Financing long-term care for frail elderly in France: The ghost reform](#), Health Policy, 2013

¹⁰³ K Chevreur, K Brigham, [Financing long-term care for frail elderly in France: The ghost reform](#), Health Policy, 2013

- Individuals must have relatively high levels of impairment to qualify, and many pay large amounts out-of-pocket. Someone earning more than £26,000 a year would pay 90% of their care package costs. Although private insurance to cover co-payments is relatively widespread
- France has a large focus on institutional care in comparison to other EU states - the expenditure for institutional (in-kind) services makes up 68.6% of public in-kind expenditure
- In 2003, about 75% of APA recipients received care from a family member. The majority of informal carers were women (62%, average age of 58 years old)
- It is estimated that by 2020 1,203,116 people will receive care at home

Spain: Key facts

Funding

- Low funding levels, 0.84% of GDP

Funding model

- Largely funded by general taxation
- Relatively low level of co-payment, 16% of total spend
- Funding seriously affected by the 2008 recession



System model

- Entitlement to long-term care guaranteed by law
- Entitlement determined based on level of dependency
- Entitlements come in the form of cash benefits or services in-kind, over a third of services are cash benefits, higher than other countries
- Telecare an important service in-kind and the only service that has continually grown since 2008
- System regionally implemented
- Over 2 million informal carers, primarily women
- Informal carers are recognised under the Spanish social security system and receive a payment

Outcomes

- 3.2% of the population aged 15+ receive long-term care support, lower than the EU average
- Access to benefits has stalled with large numbers of eligible people yet to receive benefits
- Large regional variations in waiting lists and standards of care. Some regions have waiting lists of as long as 40%
- Intensity of home aids varies by region from 35.86 to 6.39 weekly hours
- Poorer families have been far more likely to take up informal care cash benefits than richer families who use professional services
- Female workforce participation is high, equivalent to Northern European countries at over 80%

Introduction

The long-term care sector in Spain has undergone radical transformation since the mid-2000s. In 2000, Spain spent under 0.1% of GDP on long-term care, less than £20 per capita. Only 12% of older dependents received any kind of support that was publicly financed.¹⁰⁴

¹⁰⁴ European Commission, [Spain: Health Care & Long-term Care Systems](#), 2016

The system relied heavily on unrecognised informal care, primarily from female relatives of dependent persons. With an ageing population and increased female workforce participation reform was needed.

The response was major legislative reform and the creation of the “fourth pillar” of the Spanish welfare state.¹⁰⁵

Demographics

The percentage of the Spanish population having a long-standing illness or health problem is lower than the EU average (31.6% and 32.5% respectively in 2012).¹⁰⁶ However, Spain is particularly exposed to demographic change. Less than 2.5 million Spanish residents were living with limitations due to health problems in 2010. By 2060 this will have increased by 64% to nearly 4 million.¹⁰⁷

Service structures

The 2006 introduction of the Promotion of Personal Autonomy and Assistance for Persons in Situation of Dependency Act (DA) created a new system of long-term care based on universal entitlement. The new system, known as the System for Promotion of Personal Autonomy and Assistance for Persons in Situation of Dependency (SAAD), grants access to long-term care based on the assessed level of dependency. The new law represented such a comprehensive change that it was described as the creation of the “fourth pillar” of the Spanish welfare state.¹⁰⁸ Its key features include:

- Legal entitlement to long-term care support for those who meet the dependency eligibility criteria
- Support in the form of services or cash benefits for informal care: 34.6% of recipients receive the cash benefit; 14.4% residential care; 15.8% home care; 14.6% telecare; and day care centres 8.45%¹⁰⁹
- The cash benefit is paid to the person requiring long-term care, rather than the family member providing the informal care
- Cash benefits ranged from €255.77 to €442.59 depending on the level of assessed disability. Following government spending cuts in 2012, the range for new recipients is from €153.00 to €387.64¹¹⁰
- A minimum standard of support is mandated by the central government, but regional authorities have the option to fund more comprehensive services

¹⁰⁵ L Pena-Longobardo et al, [The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act](#), 2015

¹⁰⁶ European Commission, [Spain: Health Care & Long-term Care Systems](#), 2016

¹⁰⁷ European Commission, [Spain: Health Care & Long-term Care Systems](#), 2016

¹⁰⁸ L Pena-Longobardo et al, [The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act](#), 2015

¹⁰⁹ L Pena-Longobardo et al, [The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act](#), 2015

¹¹⁰ L Pena-Longobardo et al, [The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act](#), 2015

- For in-kind services, a co-payment is required for the benefits they receive. The level of co-payment is calculated based on economic status, up to 90% of the total service cost
- Informal carers are recognised by the system and receive social security protection and payment

Relative funding levels

The Spanish long-term care system is markedly under resourced in comparison to the other countries. However, the system is better than most other European countries at limiting the need for out-of-pocket payments.

- Total funding of long-term care in Spain is 0.84% of GDP, the lowest of the countries compared in this report¹¹¹
- Per capita, this is equivalent to £169.80, 21% lower than the next lowest country (Italy)¹¹²
- 16% of the long-term care spending comes from voluntary and out-of-pocket payments, lower than all the other European countries besides France¹¹³

Telecare

- Access to telecare has been guaranteed in Spain since 2006
- Calls are designed to ease the burden on health and social services
- In some areas, such as Barcelona, telecare is heavily funded by regions
- Telecare is considered a success story, although relies on a degree of integration between health and long-term care to coordinate support needs

Funding model

The system is funded from a combination of taxation (national and regional) and co-payment. The reliance on general taxation left the system exposed to the 2008 recession which particularly impacted the Spanish tax base.

The Spanish Dependency Care Observatory found that annual public spending per long-term care recipient decreased from €8,648 in 2009 to €7,401 in 2011 and €6879 in 2013. Concurrently, the estimated annual co-payment grew from €961 in 2009 to €1,614 in 2013, although it has fallen since. As a percentage of total payments, co-payment rose from 17% of total spend in 2010 to 21% in 2014. However, it saw a subsequent reduction in 2015 to 16%.¹¹⁴

Estimates from the State Association of Social Services Directors and Managers found an accumulated budget cut of €2,865 million for long-term care from 2012 – 2015.¹¹⁵

¹¹¹ OECD Stat, [Long-term Care Resources and Utilisation](#), data extracted March 2018

¹¹² OECD Stat, [Long-term Care Resources and Utilisation](#), data extracted March 2018

¹¹³ OECD Stat, [Long-term Care Resources and Utilisation](#), data extracted March 2018

¹¹⁴ L Pena-Longobardo et al, [The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act](#), 2015

¹¹⁵ L Pena-Longobardo et al, [The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act](#), 2015

The private insurance market is a non-factor in Spain. Only 0.08% of the Spanish population aged 18 and over have private health and long-term care insurance.¹¹⁶

Outcomes

The 2006 long-term care service reforms, whilst leading to significant improvements in long-term care in Spain, have failed to meet their early promise:

- 3.2% of people over 15 receive support as dependent persons, lower than the EU average of 4.2%, indicating the possible under-provision of services. This equates to 837,321 people with a further 375,601 on the waiting list¹¹⁷
- Since 2012, the proportion of over 65s receiving in-kind services has declined. Only telecare services have consistently increased¹¹⁸
- The financial crisis seriously impacted the taxation funded services. The intensity of support offered was reduced in 2012, and conditions for entitlement to monetary benefits were hardened to coincide with a 15% reduction in allocated funding
- A “dependency limbo” has developed with, at points, over 400,000 people assessed as eligible for services yet to receive any benefit
- Monetary benefits (cash) have taken a greater role than originally conceived, 63% of social services consist of in-kind services and 37% cash benefits
- Poorer families prefer the cash benefit as a source of income and because there is then no-requirement to contribute the co-payment cost for professional services
- There are large regional variations in the provision and quality of services: waiting lists vary by region from 10% to 40%; public residential services vary from 2.44 places to 0.5 per 100 individuals; and intensity of home aids varied from 35.86 to 6.39 weekly hours. Some regions have provided no home aid at all since the inception of the Act
- It is widely recognised that transparency, data collection and systematic evaluation of the various regional programmes is seriously lacking¹¹⁹

¹¹⁶ European Commission, [Spain: Health Care & Long-term Care Systems](#), 2016

¹¹⁷ European Commission, [Spain: Health Care & Long-term Care Systems](#), 2016

¹¹⁸ L Pena-Longobardo et al, [The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act](#), 2015

¹¹⁹ L Pena-Longobardo et al, [The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act](#), 2015

England: Key facts

Funding

- 1.8% of GDP is spent on long-term care in the UK

Funding Model

- The long-term care system is largely funded through general and regional taxation
- Co-payments account for 33% of total funds
- Central government cuts have resulted in 7% decrease in local authority spending since 2010

System Model

- Local authorities and private providers overlap with the NHS to provide long-term social care

Outcomes

- The Care Quality Commission (CQC) indicates a decline in standards of long-term care, with one in five services declared in need of improvement
- Surveys show that user satisfaction remains high, but falling



Introduction

England's care service faces the challenge of an ageing population, with over two-thirds of the 870,000 adults receiving long-term support in 2015/16 aged 65 or older.¹²⁰ Although some aspects of long-term care in England are provided free-of-charge by the NHS (mainly residential and domestic care), the majority of services are delivered by local authorities via private providers. According to the Office for National Statistics (ONS), the number of people receiving some level of informal care is approximately 2.1 million.¹²¹

However, a shortage of funds from government budget cuts pose the greatest challenge to long-term social care in England today.

Demographics

The population of the UK is getting older. In 2016, the ONS recorded that 18% of the population were aged 65 or over, whereas 2% were aged 85 and over.¹²² It is predicted that by 2046 almost 25% of the population will be over 65.¹²³ Unsurprisingly, this growing proportion of older people is expected to be matched by increased demand for long-term care. However, relative to the other five countries, the UK population is ageing at a slower rate.

Service Structures

¹²⁰ NHS Digital, [Community Care Statistics, Social Services Activity](#), England - 2015-16, 2016

¹²¹ Office for National Statistics, [Chapter 3: Home produced 'adultcare' services](#), 2016

¹²² Office for National Statistics, [Overview of the UK population: July 2017](#), 2017

¹²³ Office for National Statistics, [Overview of the UK population: July 2017](#), 2017

Long-term care provision in England is devolved to local authorities and private providers with the NHS taking responsibility for some aspects of nursing in residential care and the provision of continuing health care.

While government-funded care is available it is subject to strict means-testing. Currently, only people with savings or assets of £14,250 or less are entitled to have the local council pay for their care. For those with assets of up to £23,250 the council may contribute to care. However, people with more than £23,250 are not entitled to government-funded care and can expect to pay for their social care privately.¹²⁴ Income will also be taken into account through charging for services, with recipients expected to make a significant contribution towards the cost of their care. Local authorities set their own charging policy, guidance only states that individuals should not be left with less than the personal expenses allowance in a care home or see their income reduce below the level of the minimum income guarantee.

As a result, the overwhelming majority of long-term care in England is provided by informal carers such as friends or family. The number of unpaid carers in England appears to have increased from 4.9 million in 2001 to 5.4 million in 2011.¹²⁵

Relative funding and model

With 1.8% of GDP being spent on long-term care, government funding for long-term care in England is similar to that of Germany (1%), France (1.8%) and Japan (1.8%) and considerably healthier than Spain (0.84%) and Italy (0.91%). However, of the six nations considered, England struggles the most in limiting out-of-pocket payments and has very little risk pooling.

- Total funding of long-term care in England is 1.8% of GDP, slightly lower than Germany and Japan but much higher than the southern European countries
- Per capita spending (£518.10) is the third-highest behind Germany and Japan
- 33% of the long-term care spending comes from voluntary and out-of-pocket payments – the highest of any country in this report
- Informal carers are eligible for the carers allowance, a social security benefit. It amounts to £62.10 for a minimum of 35 hours which is equivalent to a maximum rate of £1.77 an hour

The long-term care system is funded through general and regional taxation as well as a large proportion of private payments. Crucially, funding cuts from central government level are straining the quality and scope of care at the point of delivery. These cuts translate into an 8% decrease in local spending on long-term care since 2010.¹²⁶

Outcomes

The most recent findings of the Care Quality Commission (CQC) indicate a decline in standards of long-term care, with one in five services declared in need of improvement.¹²⁷ Nonetheless, the ASCS continues to

¹²⁴ Department of Health & Social Care, [Care and support statutory guidance](#), 2018

¹²⁵ Full Fact, [Adult social care in England](#), 2017

¹²⁶ The Institute of Fiscal Studies, [Spending on Adult Social Care in England: Briefing note](#), 2017

¹²⁷ Care Quality Commission, [The state of adult social care services 2014 to 2017](#), 2018

register high levels of user satisfaction with 64.7% of those surveyed extremely or very satisfied with the care and support services they receive.

There has been a tightening of eligibility criteria for access to social care, given the budget cuts thereby reducing the number of older people accessing publicly funded social care by 400,000.¹²⁸

Moreover, the number of informal carers in England remains high. A recent estimate suggests that informal care hours increased by 9% from 2009 – 2014, as public provision decreased.¹²⁹ This amount of informal care is comparable to levels in Spain and Italy.

¹²⁸ The Nuffield Trust, The Health Foundation and The King's Fund, [The Autumn Budget, Joint statement on health and social care](#), 2017

¹²⁹ Institute for Government, [Performance Tracker Autumn 2017 – Adult social care](#), 2017

Annex 2: definitions

Crucial to any study of social care are effective, comparable definitions. The boundaries between 'social care', 'social-health care' and 'health care' are opaque. Unsurprisingly, different countries account for them in different ways according to the needs and structures of their own systems.

We have defined terms below where a potential for misdefinition exists.

To ensure comparability, unless otherwise stated, we have adopted the definitions used by the Organisation for Economic Development Council (OECD) in the 2011 A system of health accounts.¹³⁰ These definitions are widely used by other international bodies.

| Term | Definition |
|------------------------------------|--|
| Formal care | 'Formal care' refers to any professional service (whether medical or care based) which requires professional training. |
| Informal care | 'Informal care' refers to 'unqualified' care often, but not always, provided by family members. |
| Benefits in-kind | Refers to services received from the state, for example care services or telecare |
| Cash benefits | Refers to monetary benefits from the state, whether tied to specific payments for care or not. |
| Institutional care | Refers to care provided in an institutional setting whether medical or non-medical. |
| Home care | Refers to care provided in a domestic setting whether medical or non-medical. |
| Out-of-pocket / voluntary payments | Refers to payments for long-term care services made by individuals or their families. It excludes private insurance payments. |
| Dependent | Refers to a person with some form of "functional impairment", generally meaning the inability to perform daily tasks. ¹³¹ |

¹³⁰ OECD, [A system of health accounts](#), 2011.

¹³¹ European Commission, [Long-term care: need, use and expenditure in the EU-27](#), 2012