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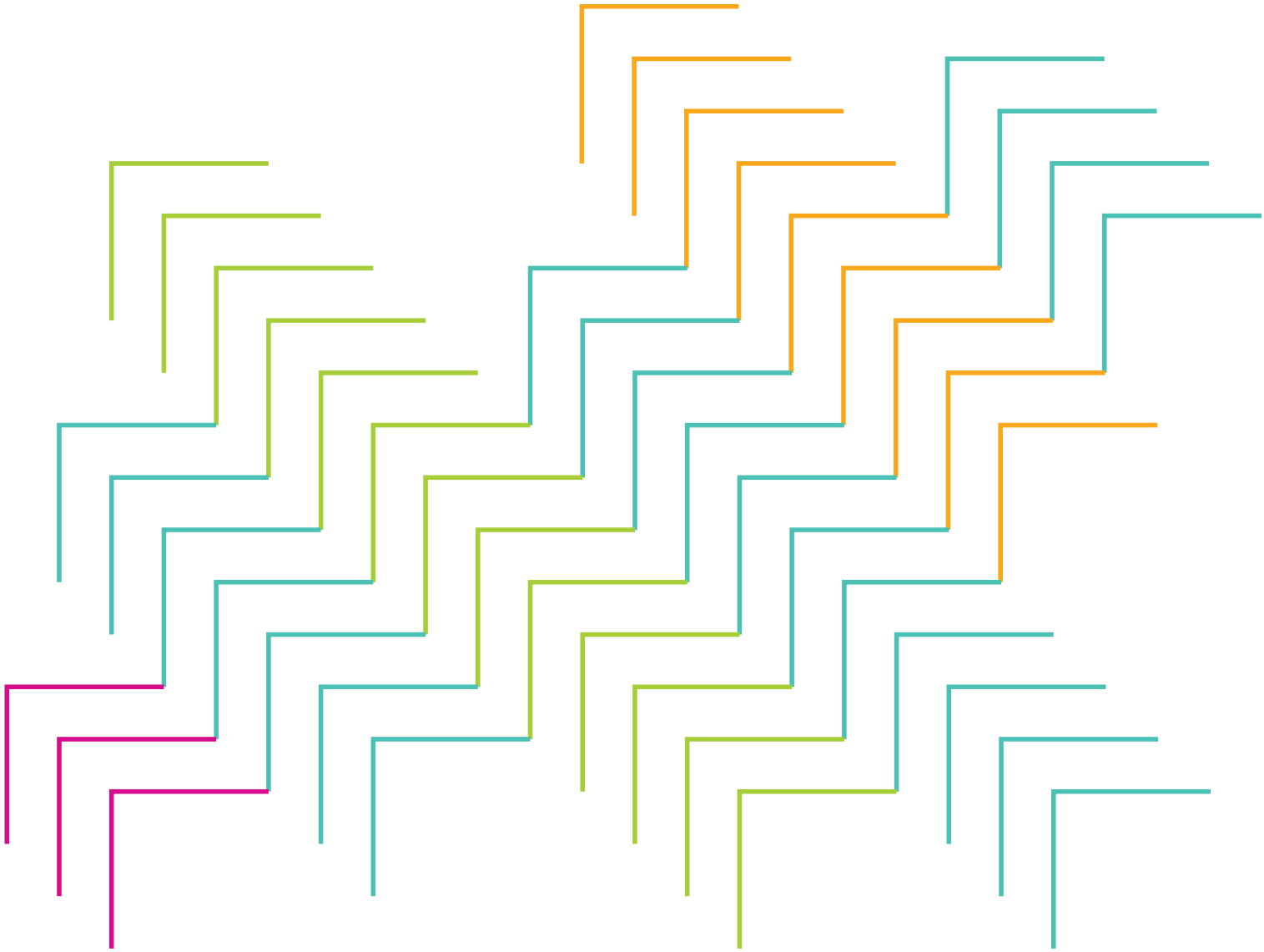
Terence C Cheng, Winnie Yip and Zhanlian Feng



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Abbreviations

ADL	activity of daily living
GDP	gross domestic product
HIC	high-income country
IADL	instrumental activity of daily living
LIC	low-income country
LMICs	low- and middle-income countries
LTC	long-term care
LTCI	long-term care insurance
MIC	middle-income country
NCMS	New Cooperative Medical Scheme
UEBMI	Urban Employee Basic Medical Insurance
URBMI	Urban Resident Basic Medical Insurance
URRBMI	Urban and Rural Resident Basic Medical Insurance
WHO	World Health Organization

Executive summary

As global populations age, governments around the world are investigating how to fund long-term care (LTC) in an equitable and sustainable manner. The research reported here has three objectives: (i) to identify and classify middle-income countries (MICs) and high-income countries (HICs) that have established LTC for older populations; (ii) to describe the financing features and undertake a detailed assessment of the public LTC programmes in these countries; and (iii) to identify and discuss the benefits, disadvantages and challenges of the different public LTC financing strategies, based on the experiences of high-income countries and on observations of the reviewed countries.

The public LTC financing system of 13 countries is reviewed: five HICs (Australia, Japan, Netherlands (Kingdom of the), Singapore and Uruguay), and eight MICs (China, Costa Rica, India, Indonesia, Malaysia, Serbia, South Africa and Thailand). Although information on LTC expenditure is not consistently reported or available for all countries, the 13 reviewed countries vary considerably in terms of their national income, total spending on health and public share of health care spending. Among the reviewed HICs, public spending on LTC reflects the financing strategies of each country; total public spending on LTC is highest in Japan and lowest in Singapore. Public LTC spending is very small in the studied MICs. For example, in Costa Rica and Thailand, public spending on LTC amounts to 0.05 and 0.01% of gross domestic product (GDP), respectively.

The eight MICs studied vary significantly in how they finance LTC, although these methods can be classified within two broad categories. China, Costa Rica, Serbia and Thailand use a mixture of limited or small-scale universal public LTC programmes that are combined with means-tested programmes. In India, Indonesia, Malaysia and South Africa, public LTC programmes are predominantly means tested and delivered by the social welfare system. Overall, while both universal and mean-tested programmes target older populations, many of the programmes operate within the social welfare system rather than as a separate LTC system.

There are three major types of public LTC programmes in the reviewed MICs: (i) the government either directly provides LTC services or else finances LTC through supply-side financing (e.g. operational grants) or demand-directed funding; (ii) cash allowance programmes that disburse monetary allowance to beneficiaries; and (iii) insurance-based models of public LTC financing (the approach China has taken in its ongoing long-term care insurance pilot programmes).

Approaches to publicly financing LTC services across these three types of programmes vary between countries, depending on how public funds are organized and allocated as well as the extent of coverage for people in need of LTC. In designing their public LTC

financing systems, countries need to take into account several important considerations, including whether governments should means-test eligibility or offer universal coverage, whether governments should provide services directly or instead act as an insurer or third-party payer, whether the financing should be structured nationally (centralized) or locally (decentralized), and the degree to which the financing of LTC should be separate from that of medical care services. How countries choose to finance LTC will have significant implications on equity and fairness, access, financial protection, affordability and sustainability. It is important that these factors are carefully considered when designing LTC financing systems to ensure that the well-being of individuals and their families are maximized.

This report concludes with some deliberations and lessons learned on financing options for LTC, specifically for low- and middle-income countries. Overall, the report offers valuable insights into how policy-makers can design effective and sustainable public LTC financing systems, ensuring that individuals and their families receive the necessary support and assistance to lead dignified lives as they age.

1

Background

There is a growing recognition of the need for formal mechanisms to finance LTC for older people (those aged either ≥ 60 or ≥ 65 years, depending on the specific policies of a particular country) *(1)* to complement the provision of informal care, which is becoming increasingly strained in many countries. The potentially high financial burden, resulting from uncertainties surrounding the duration and type of care required *(2)*, has prompted calls for public financing mechanisms for LTC *(3)*. Formal systems to publicly finance LTC have been established to meet this need in some HICs. Although these financing arrangements differ between countries in their exact design, they commonly comprise universal programmes through direct government financing and mandatory social health insurance, as well as means-tested programmes targeted at those with greater need *(3)*.

Low- and middle-income countries (LMICs) are confronted with specific challenges that limit their ability to publicly finance LTC services. Compared with HICs, LMICs generally have low tax revenues and therefore limited fiscal capacity to support public LTC programmes *(4)*. In addition, there are competing priorities *(5)* in areas such as infrastructure (e.g. building of roads), education, military and defence, and health. These competing priorities may further restrict the financial resources that can be allocated to LTC. Governments in LMICs often also have limited capacity for designing and operating public programmes *(6)*. For example, in the health care sector, many LMICs have limited health infrastructure, a low-skilled health care workforce, and poor capacity for management and governance. These challenges are similarly pertinent to the LTC sector, resulting in a lack of specialized infrastructure, facilities and equipment, and a lack of skilled care managers, workers and caregivers.

On a societal level *(7)*, these challenges are likely compounded by a lack of awareness of the function of and need for LTC, which in turn results in low political and public support for publicly financed LTC services. Cultural norms can further impede the acceptance of formal LTC and its place in society, as they are stigmatized or viewed as unnecessary. For example, placing an older parent in a residential LTC facility may be perceived as a dereliction of filial responsibility in some cultures *(8)*, leading to a reluctance to utilize such services.

It is within these broad contexts that this research seeks to contribute. The overarching objective of this project is to contribute to the development of policy recommendations on public LTC financing programmes for individuals from all socioeconomic backgrounds. This objective is achieved by compiling evidence of and information about how countries finance LTC, and analysing this evidence in terms of the implications of these financing choices for the coverage, quality, financial protection and financial sustainability of LTC.

This report is organized as follows. In Chapter 2, the objectives and methods of this study are described, and the MICs and HICs that have some established LTC programmes for older populations are identified and classified. In Chapters 3–5, the financing of these programmes is described and the three types of public LTC programmes are assessed in detail. In Chapter 3, programmes for which the government either directly provides, or finances, LTC services are reviewed. Cash allowance programmes are described in Chapter 4, which are a common form of social welfare payment in the reviewed countries. In Section 5, the financing of LTC using mandatory social insurance is discussed and the long-term care insurance (LTCI) pilots in China are reviewed. A discussion of the advantages, disadvantages and challenges of the surveyed public LTC financing strategies is provided in Chapter 6, and some lessons learned for LMICs are offered in Chapter 7.

2

Classifying LTC financing systems

2.1 Study objectives and methods

This work began by reviewing the published and grey literature to identify MICs and HICs that have, to varying degrees, established LTC programmes for their older populations. Substantial work already exists for HICs *(9,10)*, where publicly accessible and up-to-date information is readily available *(11)*. Many LMICs do not have an established LTC system (an important criterion determining inclusion in this assessment), have limited public financing and rely predominantly on private financing *(12)*. There is also much less information and systematic data collection on LTC programmes in LMICs *(12)*. Data from the WHO *Maternal, newborn, child and adolescent health and ageing* dataset *(13)* were used to identify countries that have an LTC policy, plan or strategy.

A key challenge in identifying countries among LMICs for inclusion was that publicly financed LTC programmes in many countries are either small and still developing, or are non-existent. For HICs, and especially MICs, reviewed countries are limited to those that have either well established LTC systems, or where some organized LTC programmes currently exist. In accordance with the classification of public LTC financing systems proposed by Colombo et al. *(3)*, MICs that have some form of universal and means-tested LTC systems that are financed by governments are focused on. Where universal public programmes for LTC exist in MICs, they are often of limited scope and small in scale; these definitions are described further in Chapters 3–5. Although both universal and means-tested programmes target the older population, many of the programmes operate within the social welfare system rather than as a distinct LTC system.

The public LTC financing systems of 13 countries that have some form of publicly financed LTC programme are reviewed in this document: five HICs covering four major geographical regions (Australia, Japan, Netherlands (Kingdom of the), Singapore and Uruguay), and eight upper- and lower-middle-income countries (China, Costa Rica, India, Indonesia, Malaysia, Serbia, South Africa and Thailand). Low-income countries (LICs) are excluded from the analysis because formal LTC programmes are absent from the policy agendas of nearly all LICs *(14)*; given their younger populations relative to MICs and HICs, population ageing is less of an issue. This selection provides a broad geographical coverage with an emphasis on countries within the WHO South-East Asia Region and Western Pacific Region, which contain more than one third of the world's older population *(15)*.

Colombo et al. *(3)* categorizes countries based on two main LTC financing criteria: (i) scope of entitlement, that is, whether publicly funded LTC benefits are universal or means tested; and (ii) whether LTC coverage is achieved through single or multiple programmes, benefits and services. Where applicable, countries can be further

classified based on sources of funding (earmarked tax, general revenue) for their LTC programme, and whether the programme is situated within or separately from their health system.

2.2 Overview of included countries

A summary of key indicators describing public spending on health and LTC, as well as relevant demographic data, for the 13 included countries is presented in Table 2.1 *(10,16–25)*. These countries vary considerably in terms of their national income, total spending on health and public share of health care spending. Although the emphasis of this report is on public financing of LTC, health expenditure is also discussed as it provides an indication of the availability of resources for, and also the priority placed on, health and social programmes. How countries choose to finance health expenditure provides useful contextual information; some reviewed countries adopt similar mechanisms to finance LTC and health care.

Among HICs, public expenditure on health reflects country fiscal capacity, financing strategies and public priorities on health. Public expenditure on health as a share of GDP is highest in Japan (9.2%), followed by Australia (8.0%), Netherlands (Kingdom of the) (7.7%), Uruguay (6.6%) and Singapore (3.2%) *(17)*. Japan and Uruguay have a social-insurance-style health financing system combined with government contributions, whereas Netherlands (Kingdom of the) has mandated universal private health insurance with voluntary complementary health insurance. Australia has a universal-tax-financed health insurance system combined with private insurance, whereas Singapore relies on direct government subsidies, medical savings accounts and risk-pooled funds for catastrophic health spending. These HICs have greater fiscal space for health and other public programmes as a result of the larger size of their economies and tax base. Government spending accounts for nearly half of the national income in Australia, Japan and Netherlands (Kingdom of the).

Government spending on health in included MICs is considerably lower compared with that in HICs. Public health expenditure as a share of GDP is highest in Costa Rica (5.6%), followed by Serbia (5.3%), South Africa (5.3%), China (3.1%), Thailand (3.1%), Malaysia (2.2%), Indonesia (1.9%) and India (1.1%) *(17)*. The large variations in public and total spending on health reflect the heterogeneity in the approach by countries to finance health care and the broader fiscal environment. China, Costa Rica and Serbia finance health care predominantly through social health insurance. In Malaysia, South Africa and Thailand, health care is funded mainly through general taxation. In Indonesia, health care is financed through general taxation and social health insurance contributions. In India, out-of-pocket user payments account for half of total spending on health.

Table 2.1. Summary of middle- and high-income countries reviewed for their financing of LTC

Country	GDP per capita (US$/PPP) *(16)*	Current health expenditure (% of GDP) *(17)*	General government expenditure (GGE) (% of GDP) *(17)*	Domestic general government health expenditure (% of GDP) *(17)*	Domestic general government health expenditure (% of GGE)[a] *(17)*	Total expenditure on LTC (% of GDP)	Public expenditure on LTC (% of GDP)	Population aged ≥ 65 years in 2021 (2040)[b] (%) *(18)*	Life expectancy at 65 years (women/men)
Australia	59 934	10.6	46.6	8.0	17.2	1.1 (2019) *(19)*	1.1 (2019) *(19)*	16.6 (21.9)	23.0/20.3 (2020) *(19)*
China	12 556	5.6	36.4	3.1	8.4	NR	< 0.1 (2010) *(20)*	13.1 (26.2)	NR
Costa Rica	12 509	7.9	22.4	5.6	25.2	0.05 (2020) *(17)*	0.05 (2020) *(17)*	10.5 (18.7)	21.5/18.9 *(21)*
India	2 277	3.0	32.7	1.1	3.3	< 0.001 (2018) *(17)*	< 0.001 (2018) *(17)*	6.8 (11.6)	NR
Indonesia	4 292	3.4	18.6	1.9	10.1	NR	NR	6.8 (12.0)	NR
Japan	39 285	10.9	44.5	9.2	20.6	2.0 (2020) *(19)*	< 1.0 (2020) *(10)*	29.8 (35.2)	24.9/20.1 *(21)*
Malaysia	11 371	4.1	25.3	2.2	8.6	< 0.001 (2019) *(17)*	< 0.001 (2019) *(17)*	7.3 (13.0)	NR
Netherlands (Kingdom of the)	58 061	11.1	47.6	7.7	16.1	3.2 (2020) *(19)*	3.0 (2020) *(19)*	20.0 (26.8)	20.8/18.4 (2021) *(19)*
Serbia	9 215	8.7	48.2	5.3	11.0	0.5 (2016) *(22)*	<1.0 (2015) *(22)*	20.7 (25.8)	NR

Country	GDP per capita (US$/PPP) *(16)*	Current health expenditure (% of GDP) *(17)*	General government expenditure (GGE) (% of GDP) *(17)*	Domestic general government health expenditure (% of GDP) *(17)*	Domestic general government health expenditure (% of GGE)[a] *(17)*	Total expenditure on LTC (% of GDP)	Public expenditure on LTC (% of GDP)	Population aged ≥ 65 years in 2021 (2040)[b] (%) *(18)*	Life expectancy at 65 years (women/men)
Singapore	72 794	6.1	23.9	3.2	13.3	NR	NR	14.1 (29.8)	19.3/23.0 (2021) *(23)*
South Africa	14 624	8.6	34.9	5.3	15.3	0.01 (2019) *(17)*	0.004 (2019) *(17)*	6.0 (8.9)	14.7/11.5 (2021) *(24)*
Thailand	7 233	4.4	23.2	3.1	13.2	0.01 (2020) *(17)*	0.01 (2020) *(17)*	14.5 (27.4)	NR
Uruguay	17 313	9.2	32.8	6.6	20.0	0.15 (2020) *(17)*	0.06 (2019) *(25)*	15.5 (20.2)	NR

GDP: gross domestic product; GGE: general government expenditure; LTC: long-term care; NR: not reported; PPP: purchasing power parity; US$: United States dollars.

[a] Calculated from the original data before rounding for inclusion in this table.

[b] 2021 statistics based on estimates; 2040 data according to medium fertility variants *(18)*.

In terms of population ageing and LTC expenditure, the populations of Japan (29.8%), Serbia (20.7%), Netherlands (Kingdom of the) (20.0%) and Australia (16.6%) have the highest concentration of people aged 65 years and older (in 2021) *(26)*. South Africa (6.0%), followed by India (6.8%), Indonesia (6.8%) and Malaysia (7.3%), has the lowest proportion of older people in their population. China and Singapore have among the fastest ageing populations: between 2021 and 2040 the fraction of their population aged 65 years and older is projected to grow from 13.1 to 26.2%, and from 14.1 to 29.8%, respectively *(18)*. Unlike health expenditure, information on LTC expenditure is not routinely reported or available for many of the included countries; information on public LTC spending was therefore compiled from a variety of sources. Overall, public LTC spending is very low in MICs (multiple sources; see Table 2.1). For example, in Costa Rica and Thailand, public spending amounts to 0.05% and 0.01% of GDP, respectively, compared with 1.1% in Australia and 3% in Netherlands (Kingdom of the) *(10,25,27)*.

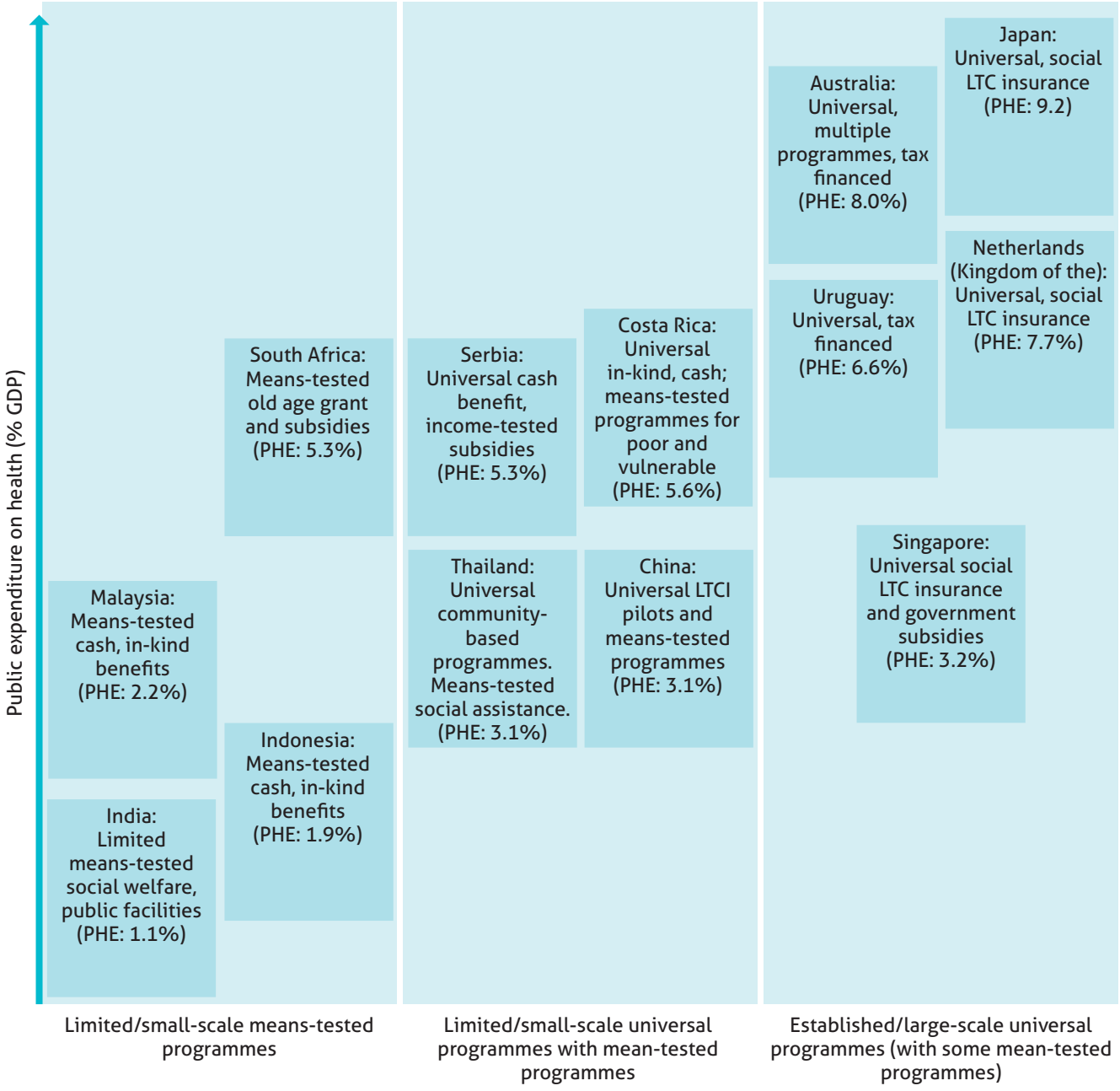
2.3 Classification of public LTC financing systems: an overview

According to Colombo et al. *(3)*, LTC financing systems can be classified within three broad groups. The first group comprises systems where LTC coverage is universal and provided within a single programme. The most common financing modes within this group are the tax-based model adopted in countries such as Norway and Sweden, and the social insurance model used in countries such as Germany and the Republic of Korea. The second group included a diverse range of systems where coverage is achieved through multiple universal schemes (e.g. Scotland) or where LTC benefits are universal, but the amount is contingent on recipients' incomes (e.g. Australia), or a combination of universal and means-tested programmes (e.g. Switzerland). The third group includes countries that use means-tested safety-net programmes as the primary means of funding LTC. The United States Medicaid programme, which funds long-term health, health-related and social services, as well as support for low-income Americans *(28)*, and the social care system in England, where access to financial support for home, nursing and residential care for adults requires both a needs test and a means test *(29)*, are two examples of these programmes in a high-income setting. The definitions of universality ("all those needing LTC because of their dependency status would receive it, including higher-income groups, although individuals may still be required to pay for a share of the cost") and means testing ("assessment of the financial means (income and assets) of a person to determine whether the person is eligible for LTC benefits") used by Colombo et al. *(3)* are adopted.

Fig. 2.1 summarizes how LTC is financed in the 13 surveyed countries. In the four countries included in the left-hand third (India,

Indonesia, Malaysia and South Africa), the public sector plays a small role in financing LTC; the limited public LTC programmes that are present exist predominately in the form of means-tested social welfare, providing both cash allowances and services targeting the older and disabled segments of their population (e.g. Indonesia and Malaysia). In India, there is no formal public delivery system for LTC *(27)*, and only a very small number of public LTC facilities exist. The majority of LTC facilities are funded and operated by private and not-for-profit organizations *(30)*. Although these are means-tested safety-net programmes, it is emphasized that they operate mainly within the social welfare system as opposed to being within a distinct LTC system.

Fig. 2.1. Categorization of public LTC financing systems. Data source: Global health expenditure database *(17)*.



LTC: long-term care; PHE: public expenditure on health.

China, Costa Rica, Serbia and Thailand are depicted in the centre of Fig. 2.1. These countries use a mixture of limited or small-scale universal public LTC programmes that are combined with means-tested programmes. For example, China has been piloting LTCI in 15 cities since 2016 (recently expanded to 49 cities in 2020). An LTC programme was introduced in Costa Rica in 2021. Serbia has a publicly funded universal cash benefit scheme for all eligible disabled people, and a means-tested programme providing residential and home care targeted at older people. Thailand's community-based LTC programme, partly funded through the Universal Coverage Scheme (the country's universal health care programme), provides community- and home-based care. Each of these four countries lie within the taxonomy outlined by Colombo et al. *(3)* in different ways. China's LTCI pilots, although small in scale by their nature, have the features of universal arrangements similar to those in HICs such as Germany, Japan and Netherlands (Kingdom of the) in that they provide access to a wide spectrum of LTC services. By contrast, in Serbia and Thailand, universal entitlement is limited to a specific benefit or service, namely cash benefits (Serbia) or community- and home-based programmes (Thailand). China adopts a social-insurance model (similar to Germany, Japan and Netherlands (Kingdom of the) to finance its LTC programme; Costa Rica's newly established universal programme, and the programmes in Serbia and Thailand, are financed through tax revenues.

The five reviewed HICs, with more established universal LTC programmes, feature in the right-hand third of Fig. 2.1. Australia's LTC system consists of three separate programmes (the Commonwealth home support, home care packages and residential care), in which users are required to pay a fee comprising a base rate and additional component depending on individual income. Japan's LTC programme provides a comprehensive package of services ranging from institutional care to community- and home-based care primarily for older people. The LTC system in Netherlands (Kingdom of the), which is funded by a social-insurance model as for Japan, is targeted at the disabled (young and old) assessed as needing LTC. Singapore has a mixed system that combines universal LTCI, providing cash payouts to those in need, with income-tested LTC subsidies for residential, community and home care. Uruguay's National Care System, financed through general taxes, provides home-based personal assistance, teleassistance and care at LTC centres.

Fig. 2.1 also highlights that countries with universal public LTC programmes tend to have health systems in which the government plays a larger role in financing health care. Public share of health spending is lowest in the three countries (India, Indonesia and Malaysia) that have only means-tested social welfare programmes, and is highest in the four countries that use a combination of limited or small-scale universal and means-tested programmes. The HICs with established universal LTC systems (Australia, Japan, Netherlands (Kingdom of the) and Uruguay) are also the settings in which the public sector plays the largest role in financing health care.

2.4 Public LTC financing classification and country summary

In this section, the public LTC systems of the reviewed countries are discussed in greater detail. The eight MICs for which published research is relatively scant are the focus although, where relevant, comparisons are made with the five HICs. To gauge the extent to which ageing is a national priority in these countries, the national LTC and ageing care plans in these countries are reviewed. It is also noted whether plans are in place and, if so, their implementation date. A summary of the public LTC coverage in the 13 studied countries is provided in Table 2.2.

2.4.1 Mixed system of universal and means-tested programmes

Four MICs (China, Costa Rica, Serbia and Thailand) have adopted a mixed system of LTC provision through limited or small-scale universal public LTC programmes combined with means-tested programmes. The features of universal programmes in these countries vary over several key dimensions, both between MICs and when compared with HICs. First, the types of benefits covered under the universal programmes vary. For example, China subsidizes LTC services (personal, community-based, home and residential care) as in HICs Australia, Japan and Netherlands (Kingdom of the), whereas Serbia provides cash benefits as in Singapore. Costa Rica and Thailand cover both services and cash benefits in the form of allowances to caregivers and care recipients.

There are often limits on benefits through explicit caps on the services or subsidies. In addition, subsidies vary by the types of services or by individuals' assessment of need. For example, the benefits package in Thailand differs by level of frailty. In China, LTCI funds typically reimburse a fraction of the cost of services subject to a reimbursement cap. To illustrate, in Anqing (one of the pilot cities) in the province of Anhui, LTCI pays 50% of the cost of nursing homes with a payment ceiling of 5.8 United States dollars (US$; 1 US$ = 6.90 Chinese yuan as of 1 January 2023 according to https://www.exchangerates.org.uk/) per person per day, which equates to 3% of local average income.

Despite all adopting a mixed system, these four countries vary in how their universal programmes and means-tested programmes coexist. Serbia has a system of universal cash benefits for all disabled individuals (young and old), combined with a means-tested programme (income-based) to provide services. The means-tested programmes in China, Costa Rica and Thailand are focused on providing assistance in the form of services for low-income and vulnerable members of the population (e.g. those without family support). Public LTC programmes in China, Costa Rica, Serbia and Thailand are briefly described in the following.

(a) China

China's LTC system mirrors its health system and social security system; it is a multi-tier system, in which the lower tier is an assistance programme for the poor, the middle tier is a basic universal programme and the upper tier is private. In 2016, China implemented a series of LTCI pilot programmes in 15 cities and expanded the programme to cover 49 cities in 2020. In 2019, 88.5 million individuals were covered by the LTCI pilots and 426 000 people had received benefits *(31)*. The public LTCI programme provides basic LTC services, with a focus on care for people aged 60 years and older and the disabled. Insured people are eligible to access benefits if they are deemed to be severely disabled for 6 months or longer *(32)*. The LTCI, financed through a social health insurance model, covers individuals that are enrolled in the basic medical insurance programmes, Urban Employee Basic Medical Insurance (UEBMI) and Urban Resident Basic Medical Insurance (URBMI). The exact financing mechanisms differ between pilot cities, and generally comprise contributions from the pooled funds of the basic medical insurance programme, direct contributions from individuals and/or through their medical savings accounts, and government subsidies. In some cities, the local government contributes to the LTCI funding pool only if basic medical insurance pooled funds are in deficit.

Services covered under LTCI include basic care, medical care (not already covered by health insurance), nursing care, home care and residential (or nursing home) care. LTCI reimburses 50–90% of the cost, subject to a benefit cap or payment ceiling, with beneficiaries responsible for the remainder. The caps on benefits vary between cities, but they are usually very low. For example, in Chengde city, the payment ceiling for residential care is US$ 8.7 per person per day, which equates to 4% of local average income *(33)*. Old-age allowances have been paid to people aged 80 years and older from 2016, with the allowance amount and eligibility rules varying between cities.

Means-tested programmes complement the universal coverage offered through LTCI. Low-income individuals requiring LTC can access home-based care that provides services including assistance with activities of daily living (ADLs), bathing, rehabilitation, meals and transportation. This programme is financed by the Public Welfare Lottery Fund, which is funded by the central government; programme eligibility rules are not explicit. Community-based programmes, such as community centres in urban areas and old-age ("happiness") homes in rural areas, provide services such as assistance with ADLs, meals and health education. The government also provides indirect support to the private sector through the provision of land, tax cuts and subsidies for building private LTC residential facilities.

(b) Costa Rica

Costa Rica is the second Latin American country to establish a national LTC system, through a presidential decree on the implementation of the National Care Policy (2021–2031) that began in 2021. Under the National Care Policy, the country will provide universal benefits in services and cash allowance to eligible disabled adults based on their need for help with performing ADLs. Caregivers can also be beneficiaries. The universal LTC programme is financed through general tax revenues combined with user co-payments (but the level of co-payment is yet to be determined) *(34)*. When implemented at scale, the programme is expected to cost US$ 253 million per year (0.48% of GDP). Three broad categories of services are covered under the programme: care services (home, residential, tele- or remote, and day care), cash for care (for home-based caregivers) and training for caregivers. The types of care services are to be defined and developed over the course of the programme's implementation.

Two means-tested programmes already exist alongside the planned universal LTC programme. The *Consejo National de la Persona Adulta Mayor* targets individuals aged 60 years and older and in poverty, and provides subsidies for care providers covering institutional (residential) care, home care and day care. The *Consejo National de las Personas con Discapacidad* covers disabled individuals younger than 65 years and in poverty via subsidies for institutional care. Both programmes are funded by the Social Development and Family Allowance Fund, financed through general payroll taxes and taxes on items such as alcohol and tobacco (referred to throughout as "sin taxes").

(c) Serbia

Serbia has a universal programme providing cash benefits to individuals with physical or mental impairments that affect their capacity to perform ADLs, and those with severe sight or hearing impairment. There are two levels of benefits: basic and increased, with the latter covering individuals with higher levels of disability (which applies to ≥ 70% of benefit claimants). In 2016, the monthly basic and increased benefits amounted to US$ 157–261 (approximately 20% of average wage) and US$ 265 (58% of average wage), respectively *(22)*. The cash benefit programme is delivered by the Ministry of Labour, Employment, Veteran and Social Policy, which is funded through general taxation.

In addition to the universal cash benefit programme, two means-tested programmes provide benefits in the form of services for individuals in need. The first programme covers institutional LTC in public residential homes targeting people aged 65 years and older. This programme is delivered and financed by the Ministry of Labour, Employment, Veteran and Social Policy, with user contributions in the form of co-payment. Beneficiaries with low or no income are

exempt from payment. In 2016, 24% of residents received some subsidies, 21% received a full subsidy and the remaining 55% paid for their care in full *(22)*. The second programme provides day care and home care services to a very small number of low-income individuals. Services covered include home care (support with personal hygiene, feeding and cleaning) and day care in community settings. The programme is also delivered by the ministry with additional funding from local governments and contributions from users and donors.

(d) Thailand

Thailand has a universal community-based LTC programme that provides community- and home-based care for frail individuals aged 60 years and older. The programme is partly funded through the country's tax-financed universal health care programme (Universal Coverage Scheme). The generosity of the benefits package depends on the level of frailty. Services include the provision of in-home visits by home caregivers, care management (e.g. care assessment and development of care plan), social care such as support for ADLs, improvement to home environment, assistive devices and medical care services. Complementing the community LTC programme are two universal allowance programmes targeting the older and disabled populations. All people aged 60 years and older are eligible for the allowance of US$ 20–33 per month *(35)*, and disabled individuals with disability identification are eligible for an additional allowance of US$ 26 per month *(35)*. A separate means-tested assistance programme for vulnerable older people provides financial assistance, secure accommodation and food. Thailand also runs a volunteer programme (the Village Health Volunteers), in which volunteers play an advocacy role connecting older people with health care personnel, organize community activities and undertake home visits.

2.4.2 Means-tested programmes

Public LTC financing programmes in India, Indonesia, Malaysia and South Africa exist predominantly through multiple means-tested programmes. Malaysia offers services and cash allowances for their older populations, whereas Indonesia primarily offers services. Assistance in both countries is targeted at low-income individuals and those who lack financial and caregiving support from family. Overall, family-based caregiving is still emphasized. LTC also remains largely the responsibility of the family in India; although public LTC facilities are available, they exist in very small numbers. Below, the LTC programmes in India, Indonesia, Malaysia and South Africa are briefly described.

(a) India

India's most recent national policy on ageing (the National Policy for Senior Citizens) was announced in 2011. The policy seeks to

prioritize the needs of the population aged 80 years and older while promoting ageing in place. The focus of the policy is on building formal and informal support systems for the older population through a mixture of public health services, health insurance and health services provided by civil society and the private sector *(27)*. Despite this policy, LTC still remains largely the responsibility of the family *(36)*. There is no formal or organized public service delivery system for LTC, although some programmes include components of LTC *(27,30)*. Only a very small number of public LTC residential facilities exist. The majority of LTC residential facilities are funded and operated by private and not-for-profit organizations *(30)*.

(b) Indonesia

Indonesia announced a new National Strategy on Ageing in 2021 with the target of implementing a national policy and funding strategy for LTC by 2024. This proposed national policy will involve a significant expansion of the LTC delivery system capacity, and the improved integration of LTC for older people into the country's public health care system at village-level health clinics (*Puskesmas*) through the *Posyandu Lansia* and *Puskesmas Santun Lansia* activities *(37)*. Currently, Indonesia's public LTC financing programme comprises multiple means-tested programmes supporting LTC services largely implemented by community-based organizations. Care programmes are prioritized for eligible older individuals based on status of neglect (in poverty with limited access to facilities or family support). The largest programme with public support is Elderly Family Care (*Bina Keluarga Lanjutusia*), operating with the support of the Family Planning Board within the Ministry of Health. Elderly Family Care comprises an estimated 31 000 nongovernment and volunteer groups, providing direct services as well as training to family caregivers and other informal workers, helping more than 625 000 older people annually across the country *(38)*. Slightly smaller in scale, social welfare groups for older people (*Lembaga Kesejahteraan Sosial Lansia*) are voluntary social organizations formed under the guidance of the Ministry of Social Affairs to support social rehabilitation and social functioning; the groups provide services such as meals and delivery of some supplies, while family members continue to provide direct daily care at home to their older members. Both programmes receive some grant support from their respective ministries.

An additional social assistance programme offers monthly cash allowances for older people (rebranded as *Bantu Lu* in 2019) that can be used for basic needs *(39)*. The current strategy for expanding LTC care by 2024 will rely on increased public support for Elderly Family Care (which in turn promotes family caregiving) as well as expanded direct provision of LTC and primary care services for older people coordinated at public *Puskesmas* health clinics *(37)*. System-wide reforms to pensions or non-contributory assistance to older people are being considered *(40)*.

(c) Malaysia

Through the National Health Policy for Older Persons announced in 2011, the government has made a commitment to ensure older people achieve optimal health through integrated and comprehensive health and health-related services. Malaysia's public LTC programme comprises a series of means-tested programmes providing cash benefits and LTC services for those aged 60 years and older, in poverty and unable to support themselves. Publicly funded services include government-funded residential homes (*Rumah Ehsan* and *Ruman Seri Kenangan*), community-based activity centres and transport services. Additionally, the *Bantuan Warga Emas* programme provides a cash living allowance to eligible people (aged 60 years and older, without financial means or family). A home-help service programme, *Khidmat Bantu di Rumah*, is supported by welfare volunteers and provides home assistance with ADLs for older people dependent on care.

(d) South Africa

South Africa has well developed policy frameworks around ageing and the rights of older people, having introduced the South African Policy for Older Persons in 2005, and both the South African Plan of Action on Ageing and South African Older Persons Act in 2006. Since the introduction of these policies, there has been little progress in the development of large-scale public programmes focusing on older people and on LTC because of a lack of funding and weak implementation *(41)*. The Department of Social Development manages residential-, community- and home-based care programmes. Public residential care is targeted at people aged 60 years and older who are frail and destitute. A total of 417 residential facilities are registered under this programme *(42)*, the majority of which are run by nongovernmental or religious organizations. Home-based care comprises assistance with household chores and personal care; day care is also provided for older people to assist working families. An old-age grant/pension is administered by the South African Social Security Agency; under this programme, beneficiaries aged 60 or 75 years and older receive a cash allowance of US$ 117 or 118 (1 US$ = 17 South African rand in 2022), respectively *(43)*.

Table 2.2. Summary of public LTC coverage in reviewed high- and middle-income countries

Country	LTC system classification	Coverage programmes	Name of programme(s)	Source of LTC financing	Target population	Types of benefits provided
Australia	Universal	Multiple programmes: income-related benefits	Commonwealth home support, home care packages, residential care	Tax-based subsidy and user fees	All	Home support, nursing and residential care (personal, clinical, social)
China	Mixed system: universal pilots and means tested	Public LTC social insurance model	(i) LTC insurance pilots; (ii) subsidies to private service providers	(i) Social health insurance funds, local government subsidies; for some cities, employer contributions and individual contributions from medical savings accounts; (ii) tax subsidy, in kind (e.g. provision of land)	(i) All (pilots in 49 cities since 2020); severely disabled for ≥ 6 months; (ii) NR	(i) Basic, medical and nursing care; caps on benefits with very low payment ceiling; (ii) government purchase of services, provision of land, tax breaks, subsidies
		Means tested	Social welfare for the vulnerable (e.g. those without family support)	Tax (central government program); Public Welfare Lottery Fund	Low-income or qualified for public social welfare	Home-based, residential, transport and medical care
Costa Rica	Mixed system: universal and means tested	Universal, tax based	National Care Policy (2021–2031)	Tax, user co-payment (to be defined)	Adults with disability	Home care, residential care, tele (remote) care, day care services; training for caregiver; cash benefit

Country	LTC system classification	Coverage programmes	Name of programme(s)	Source of LTC financing	Target population	Types of benefits provided
		Means tested for subsidies (subsidies to care provider)	Consejo National de la Persona Adulta Mayor; Consejo National de las Personas con Discapacidad	Social Development and Family Allowance Fund (general payroll taxes, sin taxes)	Aged ≥ 60 years, in poverty; aged < 65 years with disability and in poverty	Subsidies to care providers; institutional, home and day care (not implemented in 2019)
India	Means tested	Means-tested social care/ welfare (limited)	NR	NR	NR	Few public residential homes, day care centres, domiciliary care services (predominantly private, not-for-profit)
Indonesia	Means tested; government provides services; public funding to NGOs	Means-tested social care/ welfare	(i) Puskesmas primary care for older people; (ii) Puskesmas LTC for older people; (iii) Posyandu Lansia health posts for older people; (iv) Elderly Family Care (Bina Keluarga Lanjutusia) groups to support home-based LTC; (v) other cash benefits, social support programmes via social organizations (Lembaga Kesejahteraan Sosial)	(i)–(v) Tax revenue (Ministry of Health, Ministry of Social Affairs, National Insurance Agency)	(i)–(iv) Older people (not explicitly defined); (v) level of poverty or neglect	(i) Screening, noncommunicable disease management, rehabilitation; (ii) LTC/nursing at home; (iii) screening; (iv) training for home care (both ADLs and IADLs); (v) cash, meals, material support

Country	LTC system classification	Coverage programmes	Name of programme(s)	Source of LTC financing	Target population	Types of benefits provided
Japan	Universal	Public LTC social insurance model	LTC insurance system	Taxes (from national government, prefecture and municipality); premiums from those aged ≥ 40 years; user fees (10%)	Primary insured (≥ 65 years); secondary insured (40–64 years)	Institutional care, domiciliary home help, nursing and bathing services; day care and respite care for people living at home; home equipment and adaptations; residential care (e.g. for people with dementia)
Malaysia	Means tested; government provides services; public funding to NGOs	Means-tested social care/ welfare	(i) Activity centres (Pusat Aktiviti Warga Emas); (ii) government-run residential homes (Rumah Ehsan; Rumah Seri Kenangan); (iii) cash living allowances for older people (Bantuan Warga Emas); (iv) public support for private home help services (Khidmat Bantu di Rumah)	Tax revenue from central government via Department of Social Welfare, under Ministry of Women, Family and Community Development; private NGOs	Age ≥ 60 years; ill, homeless, poor or disabled	(i) Community workers help with ADLs and social activities; (ii) full nursing care; (iii) cash living allowance; (iv) home visits for IADL support

Country	LTC system classification	Coverage programmes	Name of programme(s)	Source of LTC financing	Target population	Types of benefits provided
Netherlands (Kingdom of the)	Multiple universal schemes	Public LTC social insurance model	(i) Long-term Care Act (residential care or intensive home care); (ii) Social Support Act (non-medical support); (iii) Health Insurance Act (medical care or nursing care)	(i) Payroll premiums and user fees; (ii) taxes from municipality and user fees; (iii) health insurance premiums (no user fees for district nursing)	All people assessed as needing care, regardless of age	Residential, home care, social and medical services
Serbia	Mixed system: universal and means tested	Universal, tax based	Cash benefit (for disabled people)	Tax revenue (from Ministry of Labor, Employment, Veterans and Social Policy)	All disabled	Cash benefit (basic; enhanced with higher impairment)
		Income-related benefits	Institutional care in public homes for older people; day care and home care services	(i) Tax revenue (from Ministry of Labor, Employment, Veterans and Social Policy); (ii) tax revenue (local government, national budget), donors, user co-payment	(i) Mainly those aged ≥ 65 years; (ii) all (in practice, older people or those in need)	(i) Institutional care; (ii) home and day care
Singapore	Mixed system: universal and means tested	Public LTC social insurance model	CareShield Life, Elder Shield	Premiums: private contributions (personal and family medical savings accounts or cash), tax revenue (means-tested subsidy on premiums)	Aged ≥ 30 years	Cash benefits
		Income-related benefits	Intermediate and LTC subsidies	Tax revenue, user co-payment	All	Home, community and residential care services

Country	LTC system classification	Coverage programmes	Name of programme(s)	Source of LTC financing	Target population	Types of benefits provided
South Africa	Means tested	Income-related benefit	(i) Old-age grant/ pension; (ii) grant-in-aid; (iii) disability grant	Tax revenue (general revenue)	(i) Aged ≥ 60 years; (ii) old-age grant recipients with degree of frailty; (iii) aged 19–59 years with disability	Cash benefit
		Means tested for subsidies (subsidies to care provider)	(i) Residential care; (ii) community-based care services	Tax revenue (general revenue)	(i) Aged ≥ 60 years; (ii) older people residing in the community	(i) Institutional care; (ii) home and day care
Thailand	Mixed system: universal and means tested	Universal tax based	Community-based LTC programme	Universal coverage scheme, public fund (Elder Fund, Treasury Department), user co-payment	Aged ≥ 60 years; with degree of frailty	Community- and home-based care (home visits, care management, social care, health care)
		Allowances	Disability allowance; old-age allowance	Ministry of Social Development and Human Security (National Office of Promotion and Development of Life Quality of Disabled Persons)	All with disability	Cash benefit
		Means-tested assistance	Various	(i) Elderly fund (through sin taxes); (ii) Ministry of Social Development and Human Security	(i) Aged ≥ 60 years; (ii) the vulnerable	(i) In kind (accommodation, food, funeral); (ii) cash benefit

Country	LTC system classification	Coverage programmes	Name of programme(s)	Source of LTC financing	Target population	Types of benefits provided
Uruguay	Universal	Universal tax based	(i) National Care System; (ii) Cupo Cama (Bed Quota)	(i) General taxation from central government, income-tested co-payment; (ii) social security fund, co-payment	(i) Age ≥ 60 years, all ages with disability, children aged < 12 years; (ii) low-income pensioners with severe dependency	(i) Allowance for home care (personal assistance), teleassistance (alarm service), day and night centres, training for caregivers; (ii) monetary subsidies for residency in care home

ADL: activity of daily living; GDP: gross domestic product; IADL: instrumental activity of daily living; LTC: long-term care; NGO: nongovernmental organization; NR: not reported.

3

Public provision of LTC services and subsidies

Many of the countries reviewed have programmes in which the government either directly provides, or finances, LTC services for older individuals. This chapter describes these services, as well as the most common forms of public funding for those services. Publicly funded LTC services can be classified as the provision of either: residential care in both public and private residential institutions; or care in home and community settings, which may be administered directly by government agencies and organizations, or by external organizations (e.g. private, non-profit) that receive public support through grants or subsidies.

3.1 Residential care homes

3.1.1 Availability

Several of the countries reviewed have public residential LTC institutions that provide round-the-clock care to a small fraction of the country's population (Table 3.1) *(41,42,44–47)*. Public residential homes, which often form part of the public social safety-net programme, cater to older people of high dependency and who have limited financial resources, either personally or within their supporting family.

In Malaysia, residential homes are managed by two public programmes – the *Rumah Seri Kenangan* and *Rumah Ehsan* – that are operated by the Department of Social Welfare and the Ministry of Women, Family and Community Development. There are 18 state and federal government-owned residential homes that serve 2400 older people without family support. By contrast, a significantly larger proportion of care-dependent older people in Malaysia are served by over 1000 private care homes that operate without public funding *(48,49)*. Similarly, Serbia provides public assistance to around 6780 older people through 43 state-run residential homes. The programme, managed by the Ministry of Labour, Employment, Veteran and Social Policy, has a considerable waiting list, highlighting the unmet demand for such facilities. In South Africa, there are only nine public institutions that are operated by local or national governments, while the private sector has hundreds of such institutions.

In other countries, the government provides subsidies to private residential institutions to subsidize the cost of residential LTC. For example, Uruguay's *Cupo Cama* (Bed Quota) programme, which is designed as one of three housing solution policies for vulnerable older people, subsidizes rents at registered old-age homes. These subsidy models enable public financing to increase coverage for LTC among fully institutionalized older people by taking advantage of the capacity offered by private providers. In South Africa, any registered residential facility, whether public or private, is eligible to apply for public support on a per capita basis.

Table 3.1. Public residential care home programmes

Country, programme	Financing	Eligibility	Benefits (in-kind services)	Service providers and provider payment	Governance arrangements
Malaysia, public residential homes	General tax revenue, at national or state level, depending on ownership; no user contributions	Restricted to older people without income or family support; voluntary application or referral; low- and high-dependency models of care	Residential, nursing care, food, support for ADLs	Public residential institutions (*Rumah Seri Kenangan* and *Rumah Ehsan*); 18 public institutions, owned by state and federal governments; public subsidies through supply-side operating budget	Department of Social Welfare under Ministry of Women, Family and Community Development
Serbia, public residential homes	General tax revenue with user contributions; government funding covers operational costs, including wages of the staff and maintenance of buildings; users are charged an accommodation fee which varies by location, occupancy and level of services needed (subsidies available)	No specific assessment for placement in public institution; 87% of residents aged ≥ 65 years *(44)*	Residential, nursing care, food, support for ADLs	43 public residential institutions with uneven geographic distribution; public subsidies through per-capita subsidy for low-income older individuals	Local centres for social work assess financial ability to pay and determine the cost-sharing; Ministry of Labour, Employment, Veteran and Social Policy provides the subsidy for those who cannot pay full cost

Country, programme	Financing	Eligibility	Benefits (in-kind services)	Service providers and provider payment	Governance arrangements
South Africa, residential care homes	All registered facilities (public or private) can apply for a subsidy (US$ 5.88 per resident per month); estimated total public spending on subsidies in 2014 was US$ 2.94 million *(42)*; additional public support may be directed to some institutional homes via NGO grants, but no data available	Restricted to people aged ≥ 60 years who are frail, destitute and needing full-time care; care dependency and financial need are evaluated by Department of Social Development through a screening test and home visit	Residential, nursing care, food, support for ADLs	Both public and private residential homes; of 417 formally registered residential facilities, nine operated by local or national government and remainder operated by NGOs including religious charities, and disproportionately available in wealthier regions of the country *(41,42,45)*; public subsidies through per capita subsidy for low-income older individuals	Department of Social Development registers facilities, although it has been criticized for assessing only a handful of them (as of 2012)
Uruguay, Cupo Cama (Bed Quota)	Social Security Fund, financed by payroll taxes and user co-payment; subsidies (30–70% of cost) account for 33% of total revenue; remaining 65% of revenue is out-of-pocket payments by beneficiaries or their families *(46)*	Restricted to older people who have a pension from the Social Security Fund, qualify for housing assistance, and with severe dependency or emotional/mental vulnerability	Payment of rent for older people at a qualified home; one of three housing solution policies for vulnerable older people	Private residential homes; most long-term establishments for the elderly registered by community organizations (65%) or faith-based agencies (20%) *(47)*; public subsidies through per capita subsidy with user cost-sharing	Policies around services and payments for residential care from Social Security Fund; quality of facilities regulated by National Care System, which also oversees early childhood and other social services

ADL: activity of daily living; IADL: instrumental activity of daily living; NGO: nongovernmental organization; US$: United States dollars.

In China, the government (mostly subnational and local government) provides financial incentives for the private-sector development of LTC facilities in the form of subsidies for new construction and ongoing operating subsidies for occupied beds *(50)*. These subsidies are used in conjunction with tax exemptions, land allotment or leasing for new construction, and reduced utility rates, and are aimed at encouraging private-sector investment in the development of LTC services.

3.1.2 Eligibility

Due to the limited availability of spaces in residential homes, eligibility for public support is restricted in all the reviewed countries. Malaysia restricts public residential homes to older people lacking income or family support. Individuals can apply voluntarily or through a referral process; those who are independent can be accommodated in *Rumah Seri Kenangan* and those who are care-dependent and/or have an infectious disease are placed in *Rumah Ehsan*. Less than 2000 older people are estimated to benefit from these programmes every year *(51)*.

In Serbia, in which approximately 87% of those residing in these facilities are aged 65 years and older, there is no specific assessment for placement in public homes. Although there has been a recent increase in capacity, the increasing waiting list highlights the unfulfilled demand. In 2018, publicly funded residents represented approximately 9000 of a total of 23 415 residents in private or public institutions (1.4% of the older population), an increase of 60% since 2015 *(44)*.

South Africa restricts eligibility for public subsidy and admission to a public institution to those aged 60 years and older, and who are frail, destitute and require full-time care. The South African Department of Social Development evaluates care dependency and financial need through a screening test and home visit. However, racial imbalances in the utilization of residential facilities persist, with Black South Africans comprising less than 4% of all residents in institutions; strong racial disparities in care dependency and demographic ageing highlight the greater need for this population group *(42)*. An estimated 42 000 residents receive public subsidies, but information on distribution by race and facility ownership is not available. Private facilities manage their own admissions processes, which have been criticized for perpetuating these imbalances *(42)*.

3.1.3 Benefits

Residential homes offer a range of services that include nursing care such as medication administration, specialized dementia care, occupational and physical therapy, and assistance with ADLs. The specific services provided may vary depending on regulation, workforce availability and preferences of residents. In Serbia and Malaysia, some public residential homes offer only social care and

support for ADLs, while others provide nursing care. Serbia's care homes provide rooms, meals and housekeeping, similar to Malaysia's *Rumah Seri Kenangan*, which offer a safe living environment, religious guidance, counselling, physiotherapy, recreational activities and some medical treatment.

A smaller number of public residential homes offer nursing care. Malaysia's *Rumah Ehsan* provides the same services as *Rumah Seri Kenangan* but can also provide medical treatment for infectious diseases (Box 3.1).

Box 3.1. Malaysia's long legacy of public homes

Before independence, Malaysia had a long history of charitable, private "old folks' homes" that mostly supported unmarried male laborers from India and China who did not have a next of kin. By the 1960s, the Malaysian government took over several of these homes and positioned the public institutionalization of a small subset of elders who lacked family support as a component of its social welfare strategy. Today's public institutions that represent this legacy – *Rumah Ehsan* and *Rumah Seri Kenangan* – serve at most 2400 older people, which is a fraction of the country's total older population. Over 1000 private care homes operated by nongovernmental, religious and private/commercial entities, of which perhaps one third are registered and licensed, now serve a much greater share of the care-dependent older population.

3.1.4 Financing mechanisms and cost-sharing

Most of the residential programmes are funded through general taxation, and cost-sharing arrangements vary. In Malaysia, public residential homes are funded by national or state government, depending on ownership. The Malaysian national or state governments bear the full costs of operating public residential homes, and there are no charges levied on residents.

This is different from Serbia, where cost-sharing is used to reduce the financial commitment of the government (Box 3.2). Government funding covers operational costs, including wages of the staff and maintenance of residential buildings. Users are charged an accommodation fee that varies by location, occupancy of the accommodation and level of services needed. Beneficiaries with low or no income receive some subsidies, while those with moderate to severe functional restrictions are fully subsidized.

Box 3.2. Cost-sharing in Serbia's residential homes

Serbia's residential homes cost approximately US$ 247–553 (US$ 1 = 0.93 euros as of 1 January 2023) per person per month *(44)*. Approximately 65% of the total cost is borne by the national government, including paying providers and maintaining buildings. An older person or their family is expected to pay the remaining 35% (the accommodation cost, which varies significantly by location and level of services provided), unless the local centre for social work determines the older person is eligible for a subsidy. In 2016, 55% of residents in public institutions paid the full user fee, 24% received co-financing and 21% were fully subsidized by the budget of the institution. This public funding model in Serbia depends on national and local sources, and the level of resources provided by local governments varies between regions.

Uruguay's *Cupo Cama* programme is subsidized through the Social Security Fund and user co-payment. The subsidy accounts for around one third of the total revenue of residential centres, with the remaining two thirds of the revenue from (out-of-pocket) payments by residents or their families *(52)*.

3.2 Home- and community-based LTC care programmes

A number of reviewed countries have public programmes that offer support for LTC services in home or community settings (Table 3.2) *(37,39,44,46,53–58)*. These programmes come in different forms, including supply-side financing (supply-side subsidies) through public payments in the form of operational grants to LTC-providing organizations who may engage formal or informal LTC caregivers, or demand-directed funding through public payments that follow an individual's choice of provider.

3.2.1 Governance arrangements and service providers

Government-funded home-visit programmes are common in many of the reviewed countries, although the nature of caregiving (and caregivers) varies depending on the priorities and ideologies of the country. For example, Uruguay emphasizes formal caregiving, where an older person selects a registered care assistant from a list and their wages are paid directly by the national Social Security Fund. Care assistants must meet certain qualifications, including training and registration, and be without a close relationship (e.g. familial) to the beneficiary. By contrast, Thailand relies on community-based health services and prioritizes caregiving by family members. Their programme trains volunteer caregivers from the community, who may be paid or unpaid, and their primary role is to strengthen the capabilities of family members to provide care. Each caregiver is responsible for a group (7–15) of older people and is supervised by

care managers who have received special training. Care managers are often nurses, physiotherapists or social workers *(12,42)*.

Publicly funded home-visit programmes in Indonesia, Malaysia and Serbia do not directly engage individual caregivers but instead fund private and community organizations who identify and mobilize informal volunteer workers to provide home-based care. In Indonesia for example, the Elderly Family Care group (*Bina Keluarga Lanjutusia*) is not a legal entity but can be formed as an activity associated with an existing local health centre or community organization. Volunteers are compensated for their time through the use of stipends or allowances for transportation costs. In Serbia, provider organizations must be licensed in social care. These organizations can engage LTC caregivers, who may be paid or unpaid volunteers from the community, or para-professionals with some LTC training, such as Serbia's Gerontology Housewives. Of all the publicly funded interventions examined, these community-based mechanisms provide the broadest coverage; by relying on thousands of LTC caregivers, many of whom are from the communities they serve, tens or hundreds of thousands of beneficiaries can be reached.

The home- and community-based LTC programmes vary according to the overall rationale for public intervention. These may be from the perspective of the health care system, social welfare, social protection, or pension and labour, or a combination of these. Although the country examples discussed in this report are not exhaustive, they show these different perspectives. In the case of Thailand's community-based LTC services and Indonesia's *Posyandu Lansia*, these programmes fall under the health care system and are governed by the same entities that provide health services, such as the Ministry of Health and the relative health insurance agencies. In contrast, some countries organize home-based care under their social care systems. For example, Malaysia's Home Help Services (*Khidmat Bantu di Rumah*) programme is operated by the Department of Social Welfare in collaboration with the Ministry of Health, while Serbia's day care and home care services are provided by the Ministry of Labour, Employment, Veteran and Social Policy. Uruguay's *Programa de Asistentes Personales* is provided by the Ministry of Social Development, which also determines the level of care needed and makes payments through the Social Security Fund.

3.2.2 Eligibility

The community- and home-based services that are publicly funded and targeted at those aged 60 or 65 years and older are usually only available to those with some level of care dependency. Uruguay's *Programa de Asistentes Personales* is even more tightly rationed, and is only available to those aged 80 years and older with high care dependency and low household income. The level of dependency is determined by the Ministry of Social Development based on a questionnaire and home visit using a national standard for

evaluation of four aspects of ADLs: level of functional performance, types of problems (physical and/or mental), type of help needed and frequency of help required. In contrast, LTC programmes within Indonesia and Thailand involve caregivers who assess dependency needs and coordinate care with the primary health system, and have no income-based restrictions.

LTC programmes have varying target criteria between countries according to family structure. For example, Malaysia's *Khidmat Bantu di Rumah* programme is aimed at older individuals who live alone and have no income or family support, whereas Thailand's community LTC programme and Indonesia's Elderly Family Group provide training, support and respite to family members who provide the bulk of direct care at home.

Estimating the overall coverage of publicly funded community- and home-based care is challenging, particularly in LMICs. In Serbia and Uruguay, where governments pay individual caregivers, the total coverage is roughly 1.25% of the older population. Although community-based interventions have the broadest coverage in potentially serving tens or even hundreds of thousands of beneficiaries, assessing and maintaining the quality of these interventions can be challenging. In Thailand for example, when the Home Care Service Volunteers programme was reviewed in 2016, concerns were raised about the inconsistent and/or low quality of services provided by volunteers. This programme was updated and upgraded as the Community-Based Long-Term Care programme with para-professional care managers, and extensively piloted to improve professional LTC and health support, particularly for older people with high dependency.

3.2.3 Services and benefits

The overarching goal of home-based care programmes is to improve the quality of life and health of older individuals who live either independently or with others, with the aim of reducing their need for more intensive care or institutionalization. There is considerable variability in the definitions and scope of home care services provided between countries. Examples of care services provided in the reviewed countries include: (i) ADLs (e.g. eating; bathing, hygiene and toileting; dressing and laundry; and walking and transferring positions and locations); (ii) instrumental activities of daily living (IADLs) (e.g. medication, communication, house cleaning, shopping and meal preparation, transportation and paying bills); (iii) health-related tasks (partial overlap with IADLs, e.g. transportation to medical appointments or to purchase medication, administration of medication at home; screening and early detection of conditions; coordination of health care services provided by other professionals, including occupational and physical therapy; and provision of/assistance with medical devices and equipment); and (iv) other services (e.g. social interaction; training of family caregivers on

providing direct care; development of care plan; physical improvements to living space to reduce risk of falls; respite and/or day care for the benefit of other family members; and palliative care).

3.2.4 Financing mechanisms and user contributions

Most of the community and home-based programmes reviewed here are funded through general taxation, either through funding mechanisms for health care and health insurance (Indonesia and Thailand) or for social care systems (Malaysia, Serbia and Uruguay). For example, Thailand's community-based LTC programme is jointly funded by national and local governments following the funding mechanisms of the health care system. A local health fund receives funding from both the national universal care scheme (funded by general taxation through the National Health Security Office) and the local government (through a local administration organization). Serbia's day care and home-based care are funded by local governments using the funding mechanisms of the social care system through the Ministry of Labour, Employment, Veteran and Social Policy. Financing mechanisms also vary by the level of government: programmes in Malaysia and Uruguay are funded by the national government, while the budgets for the programmes in Indonesia, Serbia and Thailand are shared between the national and local governments. Some programmes rely on user cost-sharing, although this information is not widely available.

Table 3.2. Home-based and community-based programmes

Country, programme	Financing	Beneficiaries	Benefits	Service providers
Indonesia, voluntary community groups supporting families (*Bina Keluarga Lanjutusia*)	Can apply for operational funding from their local government; some grant support from national social or health ministries, including transport costs for informal workers	Benefitting > 625 000 older people annually (in 2017) *(37)*	Leaders of groups: directly provide LTC care (ADLs and IADLs) to their members via home visits; provide counselling to associated families, including training on how to provide direct LTC care to the older people at home; and serve as part of the safety-net and primary care referral system (e.g. check on members who miss regular meetings)	Voluntary groups across the country of informal community-based workers, operating under the guidance of the Family Planning Board, Ministry of Health; services implemented in coordination with health care centres and district-level health officers and social affairs officers; groups (minimum 20 members and two volunteers) formed or hosted by community organizations or clinics *(53)*; payment through grants
Indonesia, publicly funded LTC (*Posyandu Lansia*)	General tax revenue through the funding mechanisms of the national health insurance system; Ministry of Health transfers to local governments and the operating budgets of *Puskesmas*; actual allocation relies on prioritization by local authorities	Any older person can participate, although it is targeted at older people with low or moderate dependency	Public, community-based activities providing health promotion and screening activities for older people in the catchment area of a public health clinic; services include health outreach and referral services, identifying problems with ADLs and IADLs, mental health, body weight, blood pressure, glucose and haemoglobin levels, and health counselling *(39)*	Public health clinics

Country, programme	Financing	Beneficiaries	Benefits	Service providers
Malaysia, home help services programme (*Khidmat Bantu di Rumah*)	General tax revenue through the funding mechanisms of the social welfare system; no user contributions	Targeted at people aged ≥ 60 years who live alone without an income or family support *(54)*; can include bedridden older people	Home visits for ADLs and IADLs, including accompanying people to medical appointments or when buying groceries	3178 paid volunteers from private and community organizations (as of 2022) *(54)*
Serbia, day care and home-based care	Primarily funded by local government through the funding mechanisms of the social care system; source: 83% local government, 7% national budget, 3% donors, 7% users in form of token co-payment	15 064 older people (2015) in ~ 84% of local communities; estimated to reach 1.2% of the older population *(55,56)*	Home-based care, 2–3 hours per day for IADLs	Social care organizations licensed by Ministry of Labour, Employment, Veteran and Social Policy (e.g. centres for social work within system of social security delivery, local communities, organizations of civil society, NGOs), few are commercial/ private; in 2018, 29 cities and municipalities had service providers *(44)*
Thailand, community-based LTC	A local health fund receives funding from both the national universal care scheme (funded by general taxation) and the local government through the health care system funding mechanisms	People aged ≥ 60 years with dependency; care managers assess level of dependency and family support, and develop care plans *(57,58)*	Home visits of 2–8 hours a week by volunteer caregivers and case managers to support care management; care with ADLs and IADLs; conduct health promotion and detection and coordinate with health services; training for family caregivers	Paid or volunteer caregivers for direct provision of LTC home care for 7–15 older people, although most care is intended to be provided by families; community caregivers are supervised by care managers who are nurses, physiotherapists or social workers, who also receive special training

Country, programme	Financing	Beneficiaries	Benefits	Service providers
Uruguay, home care assistants (*Programa de Asistentes Personales*)	General taxation and co-payments, through the funding mechanisms of the National Care System (which includes older population care, child care, early child development and disability care)	Limited to those aged ≥ 80 years with severe dependency residing in their home; must have citizenship or 10 years of residence in the country	Help with basic needs of daily life (eating, cleaning, dressing, getting around, work, study and recreation); maximum of 80 hours/ month	Formal home care assistance; beneficiaries select a registered qualified care assistant (without close relationship to beneficiary) from official list, and wages are paid directly by the national Social Security Fund *(46)*

ADL: activity of daily living; IADL: instrumental activity of daily living; LTC: long-term care; NGO: nongovernmental organization.

4

Cash allowance programmes

Cash allowances are a common component of social welfare payment in many countries. These programmes offer monetary assistance to vulnerable individuals and families experiencing financial hardship or difficulty in accessing necessities such as food, housing and health care services. Cash allowances are also common in LTC systems; these are monetary allowances disbursed to LTC care recipients on a regular basis to help with access to necessary LTC services and reduce the LTC-associated financial burden.

Cash-for-care schemes have become increasingly popular in HICs since the 1990s, particularly in European nations. For instance, in Netherlands (Kingdom of the) and Sweden (*Hemvårdsbidrag*), cash-for-care schemes were introduced to make the existing supply-oriented and expensive LTC systems more flexible. These schemes feature prominently in the new LTC systems in Austria and France. In Italy, the cash-for-care schemes reflect the traditional approach (cash transfers) to social protection principles. These schemes can be tax-based as in Austria, France and Italy, or insurance-based as in Netherlands (Kingdom of the), with the primary goal of providing free choice and autonomy to choose among various care options and providers. The schemes also recognize the significance of informal care and family responsibility by allowing beneficiaries to compensate or employ family members. Finally, cash-for-care schemes are often less expensive than traditional services, making them an attractive alternative for cost containment.

In contrast to the practices in many European countries, Uruguay's cash-for-care scheme focuses on providing LTC in a formal setting (Table 4.1) *(22,44,46,54,55,59,60)*. The National Care System was initially established in 2015 to provide childcare and was later expanded in 2017 to include LTC services for older people. The programme is financed through general taxes from the central government, as well as an income-based co-payment. Under the National Care System, beneficiaries receive a monthly allowance for up to 80 hours of personal assistance in the form of home care services. These services must be provided by trained and certified care workers who have no family relationship to the beneficiary. Formal home care is provided through contracting and registration with formal care providers, necessary because of the decreasing availability of informal care from family members. This is particularly true for female family caregivers driven by changes in family structure, greater female participation in the labour market, and shifting social norms that no longer place the sole responsibility for caregiving on women *(61)*. The National Care System primarily supports home care as opposed to residential care, which is more expensive. Although the system is intended to be universal and available to those aged 65 years and older, benefits are currently limited to individuals aged 80 years and older because of financial constraints *(46)*.

Table 4.1. Cash allowances in LTC and social welfare targeting older population

Country, programme	Universal or means-tested	Eligibility	Financing sources	Governance arrangements	Use of allowance	Principles	Population coverage	Amount
China, old-age allowance	Mostly means-tested (income and assets), targeted at low-income population	Aged ≥ 80 years; no requirement on dependency; enrolment by voluntary application and government identification	General tax revenue	Ministry of Civil Affairs; local level	Free to use	Social protection	NR	Varies by province/city, typically US$ 14–44/month, increasing with age (7–22% of global poverty line)
Malaysia, *Bantuan Warga Emas* (Senior Citizen Assistance)	Means-tested, targeting the poorest 40% of the population	Aged ≥ 60 years; no requirement on dependency; either living alone or without financial support from family; enrolment by voluntary application	General tax revenue	Branch offices of Ministry of Women, Family and Community Development, Department of Social Welfare	Free to use	Social protection (safety nets)	~ 140 000 older people annually in 2022 *(54,59)*	A living allowance of US$ 108/month (60% of global poverty line)
Serbia, cash allowance	Universal	No age requirement; dependent individuals with physical and/or mental impairments	Dependent on employment status: (i) pension and invalidity fund for the employed and pensioned; or (ii) national budget for unemployed	Ministry of Labour, Employment, Veteran and Social Affairs; Old-Age and Disability Insurance Fund; national level	Recipients have no obligation to report on how it is spent; described as an allowance to support informal caregivers *(55)*	Social protection	96 635 older people (estimated coverage of 7.14% of the older population) in 2016 *(22)*	Average basic allowance (2019) US$ 150 for employed (50–75% of global poverty line) or pensioned and US$ 96 for the unemployed; increased allowance US$ 260 *(44)*

Country, programme	Universal or means-tested	Eligibility	Financing sources	Governance arrangements	Use of allowance	Principles	Population coverage	Amount
South Africa, old-age pension	Means-tested for income and asset	Aged ≥ 60 years	General revenue	South African Social Security Agency; national level	Free to use	Social protection (social pension)	73% of the population aged ≥ 60 years	Approximately US$ 110/month (50% of global poverty line)
Thailand, old-age allowance	Universal (expanded to universal scheme from 2009)	Older people aged ≥ 60 years (excluding government and private employees)	Elderly Fund (from 2% of sin taxes capped at US$ 115.6 million and payment from donors); budget in 2017 was US$ 1870 million	Not available	Free to use	Social protection (social pension)	8.2 million recipients in 2017	US$ 17–29/ month, increasing with age (< 4% of average household income; 8–15% of global poverty line)
Uruguay, National Care System	Universal	Aged ≥ 65 years with dependency (physically and mentally); care dependency assessed using a standardized instrument (13 groups of ADLs and four variables)	General taxation from central government; 95% income-tested and 5% co-payment	National Care Council (an inter-institutional body), although political responsibility lies with Ministry of Social Development	Monthly allowance for up to 80 hours of home care (personal assistance)	LTC support	6125 recipients (~ 1.2% of those aged ≥ 65 years) in 2020, 86% of whom received full subsidy (household income of < US$ 343/ month) *(46)*	NR

ADL: activity of daily living; LTC: long-term care; NR: not reported; US$: United States dollars.

The amount of freedom that recipients have in determining how their care allowance is utilized varies between countries; for example, care allowance in France can only be spent on a particular care package identified by a team of professionals based on the recipient's needs, and care allowance in Uruguay is restricted to certified home care assistants. In contrast, in countries such as Austria, Italy and Netherlands (Kingdom of the), recipients have greater flexibility. In Netherlands (Kingdom of the), the personal budget can be utilized for all three types of care (i.e. residential, community nursing and home care). Budget holders have the option to pay informal caregivers, such as family members and acquaintances, at a lower rate than formal caregivers.

Cash-for-care schemes are rare in LMICs (with the exception of the LTCI pilot in Shanghai, China). Instead, many cash allowance programmes fall within the broader category of social protection and are not specifically targeted at LTC. For example, some countries offer old-age allowance programmes that serve as supplementary social pensions in places where formal pensions are limited (e.g. Thailand's old-age allowance programme). Other programmes are means tested and aimed at alleviating poverty among low-income older people, such as China's old-age allowance, Malaysia's *Bantuan Warga Emas* and South Africa's old-age pension (see Table 4.1 for programme features). Beneficiaries are free to use their cash allowance at their discretion for, for example, LTC services, food, transportation or other needs.

The criteria for entitlement and eligibility differ between cash allowance programmes and vary by income, age and level of dependency. Thailand extended its old-age allowance programme in 2009 from means tested to a universal scheme that covers all citizens, and Serbia has a cash allowance programme for individuals of all ages with dependency needs. Most programmes grant benefits to those aged 60 or 65 years and older; China is the exception, where cash allowances are only available to those aged 80 years and older. Certain programmes require a specific degree of dependency to qualify for the cash allowance. Additionally, Malaysia only offers cash allowance to older individuals who live alone or lack financial assistance from their family.

Tax-based financing is the most common method of financing cash allowance programmes offered under social protection principles (e.g. Malaysia and South Africa). In most cases, programmes are funded through general taxation. However, Thailand's old-age allowance is funded through an Elderly Fund, which receives funding from sin taxes and donor contributions. The responsibility for funding the programme can either fall on local or central governments. Typically, the amount of cash allowance offered by unconditional programmes – where recipients have full discretion in deciding how their funds are used – is modest and insufficient to cover LTC. Assessments of South Africa's old-age pension scheme

(60) have revealed that the programme may not provide the intended benefit for the older population as recipients often use the allowance to support unemployed children, grandchildren and other relatives.

To summarize, cash allowance programmes can be divided into two types: cash-for-care schemes that explicitly support LTC, and cash allowances that are provided as welfare payments. HICs have mostly adopted cash-for-care schemes to allow beneficiaries to access LTC services that are cost-effective and responsive to individuals' needs, while recognizing the role of informal caregivers. These schemes are effective in financing LTC, while promoting ageing in place, leveraging informal care and containing costs. In LMICs, cash allowance programmes are mostly used for poverty alleviation and as social pensions. However, the benefits provided are usually insufficient to cover the cost of LTC services.

5

LTCI programmes

5.1 LTCI in Japan, Netherlands (Kingdom of the) and Singapore

LTC services in some HICs are financed through mandatory LTCI, which bears many similarities in its design features to social health insurance *(1,62)*. LTCI plays a primary role in financing LTC in Japan and Netherlands (Kingdom of the), while in Singapore a hybrid approach of combining LTC (through CareShield Life) and means-tested public subsidies for services has been adopted. Despite varying types of benefits, the LTCI programmes in these three countries have similar features in terms of financing, pooling and eligibility rules.

All three programmes are financed through a combination of individual and government contributions. In Japan, individual contributions collected through payroll taxes make up 50% of LTCI premiums, with the government contributing another 50% between national (25%), prefecture (12.5%) and municipal (12.5%) jurisdictions *(63)*. In Netherlands (Kingdom of the), LTCI is financed through a combination of premiums collected through payroll tax (9.7% of income), income- and asset-related user fees, and government subsidies. Singapore's CareShield premiums are paid by individuals using funds from their medical savings accounts (Medisave); the government subsidizes premiums for low-income individuals.

Eligibility criteria for LTC benefits are similar for all three countries: eligibility is based on assessed need and is not restricted to older people, and the generosity of benefits depends on the assessed level of care needs. However, the benefit packages differ between the countries. In Japan, LTCI only covers in-kind services; in Netherlands (Kingdom of the), beneficiaries can choose between receiving LTC services or a cash allowance (known as cash-for-care) that can be used to pay informal caregivers such as family members; and Singapore's CareShield provides a monthly cash payout to beneficiaries for the duration of an individuals' disability.

5.2 LTCI pilots in China

Among the MICs reviewed here, China is the only country that has adopted an LTCI programme. To address the challenges posed by a rapidly ageing population and the weakening of family-based elderly care, China formally rolled out public LTCI pilot programmes in 15 cities across the country in 2016. As of 2019, these 15 pilot programmes have enrolled over 88.5 million people, with approximately 426 000 individuals receiving benefits *(64)*. In 2020, the LTCI pilots were expanded to include an additional 34 cities. China opted to finance LTC services in the same way that pension and social health insurance are funded, namely from pooled (insurance) funds and individual accounts. All three social insurance programmes – health, pension and LTC – are overseen by the

Ministry of Human Resources and Social Security, and the National Healthcare Security Administration. The country's approach to financing LTC is affected by previous decisions made with regards to the financing of health care.

Below, key features of the LTCI systems in four cities are described and compared, namely: Anqing in Anhui province located in east China; Changchun of Jilin province in north-east China; Guangzhou in the southern province of Guangdong, and Shanghai in east China. These cities were chosen to provide a representation of the ageing demographic and economic development of different regions in China. Our discussion on LTCI programme features references the study by Feng et al. *(32)*, which provides an in-depth discussion of China's LTCI pilots.

Table 5.1 summarizes the programme features of the LTCI schemes in the four cities. The programmes vary in terms of the insured population. At the start of the pilots, most of the 15 pilot programmes begin with providing social health insurance to urban employees in the UEBMI scheme. As the programmes have evolved, some pilot cities have expanded the target population to include residents enrolled in the URBMI scheme as well as rural residents in the New Cooperative Medical Insurance (NCMS) scheme. The URBMI and NCMS subsequently merged in 2009 to form the Urban and Rural Resident Basic Medical Insurance (URRBMI) scheme. In the four cities reviewed, Anqing and Guangzhou provide insurance coverage only to enrolees in the UEBMI. Changchun covers residents enrolled in the URBMI in addition to UEBMI. In Shanghai, an economically prosperous city but one in which one quarter of its population is aged 60 years and older, LTCI covers both urban and rural residents.

5.2.1 Financing mechanism and revenue raising

The sustainability of a social insurance system depends crucially on sustainable financing. Accordingly, the central government recommended that pilot cities explore a multichannel financing mechanism for LTCI, and fundraising should be based on local conditions and needs. It advised pilots to follow the general principle of "balancing revenues and expenses, with a small surplus maintained" *(65)* to ensure financial stability. The pilot cities designed a financing mechanism that combines funds from multiple sources: premiums, payroll taxes, individual/employer contributions and government subsidies. However, individual and employer contributions are generally very low in practice, and LTCI programmes rely heavily on contributions collected through the medical insurance funding pool. For example, all of the LTCI funding in Changchun and Guangzhou, and two thirds of the funding in Anqing, is derived from the UEBMI. If the basic medical insurance funds are in deficit, local governments can provide subsidies to the LTCI fund.

Table 5.1. Population characteristics and LTCI design features in four Chinese pilot cities

City (province)	Average GDP per capita (US$)	Population aged ≥ 60 years (%)	Financing mechanism	Eligibility	Benefit package and cost-sharing [provider payment mode] *(33)*		
					Health care facility	Residential facility	Community or home
Anqing (Anhui)	9 232	21	US$ 3 per person per year (UEBMI); US$ 1.5 per person per year (from individual)	Severely disabled	*Nursing:* 40% co-payment, cap US$ 7/day (3% of local average income) [contracted, per diem] *Daily living:* NA	*Nursing:* 50% co-payment, cap US$ 5.8/day (3% of local average income) [contracted, per diem] *Daily living:* NA	*Nursing:* (i) contracted: cap US$ 109/ month (2% of average income) [per diem]; (ii) non-contracted: US$ 2/day (1% of average income) [not directly paid] *Daily living:* NA
Changchun (Jilin)	11 348	21	0.5% payroll (UEBMI); US$ 4 per person per year (URBMI)	Severely disabled	*Nursing:* 10% co-payment (UEBMI); 20% co-payment (URBMI) [per admission, based on disease] *Daily living:* NA	*Nursing:* 10% co-payment (UEBMI); 20% co-payment (URBMI) [per diem] *Daily living:* NA	*Nursing:* NA *Daily living:* NA

City (province)	Average GDP per capita (US$)	Population aged ≥ 60 years (%)	Financing mechanism	Eligibility	Benefit package and cost-sharing [provider payment mode] *(33)*		
					Health care facility	Residential facility	Community or home
Guangzhou (Guangdong)	21 979	16	US$ 19 per person per year (UEBMI)	Severely disabled; dementia plus moderate disability	*Nursing:* 25% co-payment, cap US$ 145/month (2% of local average income) [FFS] *Daily living:* 25% co-payment, cap US$ 17/day [FFS]	*Nursing:* 25% co-payment, cap US$ 145/month (2% of local average income) [FFS] *Daily living:* 25% co-payment, cap US$ 17.4/day [FFS]	*Nursing:* 10% co-payment, cap US$ 145/month (2% of local average income) [FFS] *Daily living:* 10% co-payment, cap US$ 16.7/day [FFS]
Shanghai (NA)	25 160	25	UEBMI enrolees: 1% of payroll (UEBMI); URRBMI enrolees: from URRBMI	Aged ≥ 60 years, assessed and certified for level 2–6 disability	*Nursing:* 20% co-payment [FFS] *Daily living:* NA	*Nursing:* 15% co-payment [FFS] *Daily living:* 15% co-payment [per diem]	*Nursing:* 10% co-payment; 3, 5 and 7 hours/week for levels 2–3, 4 and 5–6, respectively; cash alternative to services for those eligible for > 6 months of care *Daily living:* NA

FFS: fee-for-service; GDP: gross domestic product; LTCI: long-term care insurance; NA: not applicable; UEBMI: Urban Employee Basic Medical Insurance; URBMI: Urban Resident Basic Medical Insurance; URRMBI: Urban and Rural Resident Basic Medical Insurance; US$: United States dollars.

The levels of premiums also vary considerably between cities, partly because of differences in income levels and population age structure. Premiums also differ in how they are structured: in some cities, premiums are stipulated in dollar amounts; in other cities they are calculated as a percentage of payroll income. The level of premiums in Guangzhou amounts to US$ 19 per person per year; in the less economically prosperous city of Anqing, premiums are significantly lower at US$ 4.5 *(33)*. Premiums are calculated as a percentage of payroll income in Changchun and Shanghai at 0.5% and 1%, respectively.

5.2.2 Eligibility

The conditions for eligibility for receipt of LTCI benefits vary between LTCI pilot cities. In Anqing and Changchun, individuals must have a severe disability (e.g. caused by age, illness or injury) and must have been in their state of disability for at least 6 months to be eligible for LTCI benefits. Shanghai stipulates an age requirement of 60 years and older to be eligible; in Guangzhou, people with moderate disability are eligible for benefits. Some pilot cities do not consider dementia and psychological conditions to be eligible, excluding many individuals from the LTCI system and resulting in significant levels of unmet need for LTC.

There is no uniform or standardized assessment tool. All pilot cities either designate a government agency or hire a third-party evaluator to assess physical impairment based on limitations in performing various ADLs. Of the 15 cities, six cities (Anqing, Changchun, Chengde, Jingmen, Nantong and Shihezi) use the Barthel scale *(33)*; a score of lower than 40 (on a 100-point scale) indicates severe disability, meaning that the person is eligible to receive LTCI benefit.

5.2.3 Benefits and cost-sharing

All LTCI pilot programmes provide in-kind benefits. As shown in Table 5.1, the programmes generally cover three types of service: (i) those provided at designated health care facilities; (ii) those provided at designated residential facilities; and (iii) home care. Features such as service benefit, payment cap, co-payment and type of service vary considerably between cities and for different levels of assessed disability. In Changchun, the co-payment is higher for URBMI enrolees compared with UEBMI enrolees (20% versus 10%). In Shanghai, beneficiaries are eligible for more hours of care if they have a higher level of disability (for which six levels exist).

The generosity of the benefits can also vary between different service providers, as well as the types of services. For example, the LTCI in Guangzhou covers 75% of the cost of nursing care received at health care facilities, and 90% of the cost for nursing care provided at the community level. The payment cap for nursing care is US$ 145/month, whereas the payment cap for assistance with daily living is US$ 17/day *(33)*. In theory, LTCI covers 70% of the

costs. However, in many pilot programmes, the co-payment is high and the payment cap is low. In Anqing, the co-payments for nursing care in health care facilities and residential facilities are 40% and 50%, respectively. There is also a per diem payment cap of less than US$ 8.

Some pilot cities such as Qingdao (not included in Table 5.1) offer a more comprehensive range of services. These services include basic life care and medical care for people with complete disability and severe dementia, as well as training to maintain body functions for those with mild to moderate dementia and semi-disabled individuals.

Cash benefits are included in the Shanghai pilot programme, the only city to do so. Beneficiaries receive cash payments directly, which they can use to purchase LTC or to pay informal caregivers or family members. Cash-for-care schemes are found in a number of HICs including Belgium, Netherlands (Kingdom of the), Spain and the United Kingdom of Great Britain and Northern Ireland *(62,66)* (Chapter 4).

5.2.4 Service provision

In terms of service providers, LTCIs are responsible for the management of service providers ranging from contracts and finance, service provision, standards and quality, and supervision and audit. Designated LTCI service providers comprise health care facilities, residential facilities and, in some cities, community senior care service institutions, health care centres, and other community- and home-based LTC facilities. There is an increasing reliance on private-sector service providers as demand for LTC services has risen sharply, especially in highly specialized functions such as disability and needs assessment. Payment modalities differ between pilot cities and type of service providers. In Guangzhou and Shanghai the majority of the nursing care services are paid on a fee-for-service basis; in contrast, in Anqing and Changchun nursing care providers are paid a per diem rate (Table 5.1).

6

Assessing advantages and disadvantages

Approaches to publicly financing LTC services vary between countries, in terms of how public funds are organized and allocated as well as the extent of coverage for people in need of LTC *(67)*. When designing their public LTC financing systems, countries need to take into account several important considerations, including: whether the government should means-test eligibility or offer universal coverage; whether the government should provide services directly or instead act as an insurer or third-party payer; whether the financing should be structured nationally (centralized) or locally (decentralized); and the degree to which the financing of LTC is separate from that of medical care services *(68)*. In this chapter, the advantages and disadvantages of these various design features of public financing for LTC are discussed, drawing on the experiences of HICs with established LTC systems. How countries choose to finance LTC will have significant implications on equity and fairness, access, financial protection, affordability and sustainability. It is important that these factors are carefully considered when designing LTC financing systems, to ensure that the well-being of individuals and their families are maximized while promoting affordability, fairness and efficiency.

6.1 Means-tested versus universal coverage

6.1.1 Advantages and disadvantages

In LTC systems that primarily use means testing to determine eligibility for publicly funded LTC benefits, coverage is limited to a small number of individuals who meet certain income and/or asset thresholds; the majority of individuals who require LTC services pay privately for the care and services they need. In means-tested LTC systems, the dominant source of public financing is typically taxation. In comparison, in LTC systems with universal coverage (i.e. LTC for all individuals with demonstrated needs) the dominant source of public financing can be either social insurance (as in Germany, Japan and the Republic of Korea) or taxation (as in Denmark, Finland, Norway and Sweden).

In countries that primarily operate means-tested LTC financing programmes (e.g. England and the United States of America (USA)), public benefits are limited to low-income members of the population who meet certain eligibility requirements determined by incomes and assets *(67)*. The underlying premise is that the primary responsibility for LTC of people with disabilities is with individuals and their families, and that government support should only be viewed as a last resort for those who are unable to provide for themselves *(68)*. As such, means-tested LTC financing systems serve as public welfare safety-net programmes providing social protection for the most vulnerable members of society.

Means-tested LTC programmes have some advantages. These types of programmes target individuals who are most in need of

assistance; prioritizing and directing resources to individuals with limited means can assist with controlling costs, an important consideration for countries faced with limited fiscal capacity and constrained budgets for financing LTC programmes. Means-tested programmes can also reduce disparities in access to LTC services by directing assistance to individuals who fall below specific incomes or asset thresholds. Means testing helps to bridge the gap in access arising from socioeconomic inequalities, promoting more equitable access to LTC services.

However, means-tested programmes also have many shortcomings and disadvantages. First, the use of a means-tested, and often stringent, threshold for determining eligibility always creates a group of individuals whose income is not low enough to qualify for public funding but who are not wealthy enough to afford the costs of needed care, raising concerns about fairness and equity in LTC access. Second, the receipt of means-tested welfare benefits often comes with a sense of stigma rather than entitlement. Third, means testing carries a high administrative burden associated with monitoring eligibility and benefits *(68)*. Fourth, a means-tested approach cannot prevent catastrophic out-of-pocket costs for medical and LTC services, as individuals often have to spend significant amounts of their incomes and/or deplete their assets before qualifying for the means-tested eligibility and benefits *(68)*. Furthermore, public funds for means-tested LTC programmes are usually allocated from the general government budgets, which are subject to fiscal pressures and shortfalls and can be unstable or unpredictable. The limitations of means-tested LTC financing programmes are therefore substantial, leaving large gaps in coverage for the vast majority of the middle-class population *(67)*.

The alternative to means testing is for governments to design financing systems aimed at achieving universal LTC coverage. In such systems, LTC services are financed primarily through either public social insurance (as in Germany, Japan, Luxembourg, Netherlands (Kingdom of the) and the Republic of Korea) or general taxation (as in Denmark, Finland, Norway and Sweden). Underpinning this approach is the premise that the government should take the lead in mobilizing resources to ensure that all people with disabilities are eligible for the LTC services they need, regardless of financial status *(68)*. This approach recognizes that the financial risks associated with LTC use are so great for the vast majority of older people and their families that a collective arrangement for social protection against these risks is imperative. As such, social solidarity is highly valued, and universal access to LTC is viewed in the same way as an entitlement to basic medical care. Since everyone pays into the system and receives benefits once meeting certain disability criteria, it essentially creates an entitlement, ensures equitable access and eliminates the stigma associated with means-tested LTC support *(67)*.

6.1.2 Public social insurance approach to financing universal LTC

The main advantages of a public social insurance LTC financing system include broad-based social contributions, typically through a combination of employee payroll taxes, employer contributions and government subsidies. Because this financing approach requires mandatory participation and is built on, and linked to, the payroll system that covers the formal sector of the economy, it ensures a broad risk pool and stable revenue stream for LTC financing.

Among the potential issues and challenges, the ongoing costs and administrative burden of a government-managed public social insurance programme for LTC financing can be a concern, as is the long-term sustainability of this financing mechanism. Public social insurance is essentially a pay-as-you-go system. With population ageing the ratio of the working-age population to retirees is forecast to decrease in many countries in the future, weakening the payroll tax base and the risk pool. In addition, the payroll-based contribution system tends to exclude workers who are employed in informal sectors of the economy, prevalent in many developing settings. The changing employment structure in many countries, such as a labour market characterized by increasing short-term and freelance contracts (i.e. a gig economy), poses additional challenges for payroll-based contributions *(67)*.

6.1.3 Tax-based financing for universal LTC coverage

Tax-based LTC financing models have the advantage of a broader revenue base relative to the payroll-based social insurance financing model discussed in the previous section: taxes are ubiquitous in all countries and levied in many forms such as those on individual incomes, properties and consumption, and business corporate taxes.

However, the disadvantages and limitations of tax-based financing for LTC are also considerable. First, there are limits to the willingness of taxpayers to contribute to the costs of LTC through tax increases, which are often politically unpopular. Second, there is no guarantee that a stable and sufficient share of tax revenues will be allocated for LTC financing, unless mandated by strong and long-lasting legislations that can be practically difficult to establish. Moreover, because most often taxation is locally based, tax revenues – and the portion of them dedicated to LTC financing – will vary greatly between administrative jurisdictions and localities as a result of uneven socioeconomic development and resources, creating or exacerbating regional disparities in LTC access.

6.2 Direct provision versus purchasing

Although LTC services are predominantly financed by public resources in HICs with established LTC systems, actual services can be provided directly by government agencies (e.g. in Denmark,

Finland, Norway and Sweden) or nongovernmental organizations (as in the USA, where private for-profit service providers dominate the LTC landscape). The goal of government ownership is to focus more on care provision rather than considering whether an activity is profitable, which can be taken as an advantage but not without drawbacks. Where government agencies provide the services, the fact that the government is both the service provider and the payer can lead to inefficiencies in spending and operations *(68)*.

In countries such as Germany, Japan and the USA, where government ownership of LTC providers is uncommon, the government functions as a third-party payer or insurer to reimburse private-sector service providers for publicly covered services *(68)*. In financing systems that operate as third-party payers, the government are responsible for (and burdened with) developing systems of enrolling eligible providers; determining eligible beneficiaries; setting reimbursement rates; monitoring compliance with quality, administrative and fiscal standards; and paying providers for services *(68)*.

Nongovernmental entities providing LTC services include both non-profit organizations and for-profit companies. The theory motivating privatization is that competing providers will provide more choices and care options to consumers at a lower cost, with more flexibility and with greater consideration of the needs of consumers *(68)*. However, the quality of care by for-profit providers has frequently been a concern given the tendency of these providers to focus on profit-seeking rather than the needs of their clients.

In practice, most countries (including HICs and LMICs) have opted to contract out LTC services fully or partially to private non-profit or for-profit organizations, and the global trend is to move away from direct public provision of services *(69)*. Where public funding is involved, various forms of public–private partnership are commonly used to engage private-sector service providers in the LTC system. As contracting out for LTC services through public–private partnerships is increasingly the norm in many countries, the related transaction costs – such as those incurred in setting up contractual arrangements and quality standards, monitoring provider performance and ensuring regulatory compliance – will also inevitably increase, which could offset efficiency gains from the marketization and privatization of LTC provision *(70)*.

6.3 Centralized (national) versus decentralized (subnational)

A key consideration in the design of LTC systems is the level of government responsible for financing and delivery. Some HICs, such as Germany and Japan, operate more centralized and nationalized LTC systems in terms of financing and determination of eligibility, benefits and reimbursement rates, although subnational and local governments are also involved to a lesser degree *(68)*. This

centralized approach can be justified on two grounds. First, a uniform national programme helps achieve horizontal equity between geographical areas, that is, national rules help ensure that similarly situated individuals in different geographical areas receive the same benefits. Second, developing a single LTC system nationally may involve lower administrative costs because programme rules and systems need to be developed only once, and subnational and local governments do not need to reinvent procedures and systems *(68)*. However, a centralized system can be bureaucratic and unresponsive to local conditions, needs and preferences.

Other HICs, such as Canada, Netherlands (Kingdom of the), Sweden, the United Kingdom and the USA, rely primarily on subnational governments to design and administer their LTC systems, often with substantial policy guidance from the national government *(68)*. There are good reasons to justify this decentralized approach. First, local authorities and jurisdictions (states, provinces and municipalities) are directly and heavily involved in the development of various social services in many countries. A localized approach can establish necessary links between LTC and other services often needed by people with disabilities. Second, LTC is an intensely personal service involving decisions about how individuals want to live their lives. The planning and delivery of services can therefore be influenced by local circumstances, norms and values as well as by local preferences of the disabled people, their caregivers and providers. Finally, because subnational and local governments are less driven to routinize their decision-making process, and because individual cases loom larger in the policy process, locally designed and administered programmes are arguably less rigid and bureaucratic than centrally run programmes. However, a decentralized approach runs the risk of creating or institutionalizing disparities between regions and individuals, and may result in inefficiencies as each local government must decide how to design and manage its system *(68)*.

6.4 Financing for medical care versus LTC

In virtually all countries, individuals with disabilities have to navigate fragmented financing and delivery systems that separate medical care from LTC services *(68)*. This fragmentation creates difficulties because people with disabilities typically have a combination of medical and LTC needs. Although a separate LTC programme helps to protect funding for LTC services and militates against the risk of unnecessary medicalization of LTC services, financing fragmentation and misalignment certainly pose challenges in efforts towards integrating acute, post-acute and LTC services.

The degree of separation between medical care and LTC services varies between countries. In many countries (e.g. Germany, Japan, Netherlands (Kingdom of the), Sweden and the USA) LTC is financed and organized separately from medical care. In other countries (e.g.

Belgium, France, Italy, Portugal, Spain and the United Kingdom) the skilled nursing or medical component of home care, and sometimes nursing home care, is part of the health care system, while the social component is part of the social service system *(68)*.

6.5 Leveraging government subsidies to incentivize LTC provision and access

Few (if any) LMICs currently have comprehensive LTC financing systems to ensure universal coverage for people with disabilities in need of LTC services. Establishment of such systems, whether built on the public social insurance framework or primarily taxation based, will take time and resources. Until this stage is reached, policy-makers in LMICs may consider using their limited resources in various forms of government subsidies to incentivize the development of LTCs on the supply side, and to mitigate the lack of affordability for LTC services on the demand side.

6.5.1 Supply-side subsidies to service providers

In some LMICs (e.g. China) the government (mostly subnational and local governments) provides financial inducements for the development of LTC facilities by the private sector in the form of subsidies for new construction, and ongoing operating subsidies for occupied beds *(50)*. In conjunction with other preferential policy treatments such as tax exemptions, land allotment or leasing for new construction, and reduced utility rates, these subsidies are intended to encourage private-sector investment in the development of LTC services. These subsidies vary between provinces and are typically low relative to facility operating costs. Most of these subsidies are aimed at residential care facilities, but in recent years more subsidies have been targeted at the development of home- and community-based services. In general, these subsidies are not linked explicitly to quality of care or other performance standards.

It is important to note that, although these supply-side financial inducements may be necessary to stimulate the development of LTC services in the early stage, their contribution towards financing the recurrent costs of those services is small. These inducements also have no influence on the monitoring and enforcement of quality standards, and no impact on enabling the government to achieve a balance between institutional care and home- and community-based services *(50)*.

6.5.2 Demand-side subsidies to service users

In LMIC settings, demand-side subsidies (e.g. vouchers and cash allowances) can be effective instruments to increase the purchasing power of low-income members of the population and those in need of LTC who wish to live in their homes for as long as possible *(44)*. These types of subsidies can help promote ageing in place if

vouchers can be redeemed for home- and community-based services. Similar financial incentives can also be provided to support informal care provision, for example through cash allowances for family caregivers or vouchers that caregivers can redeem for services such as respite care.

In China, some local governments provide limited cash allowances or service vouchers to all people aged 80 (or 60) years and older or other frail older adults in financial hardship without children living with them. Although these allowances or vouchers are rarely enough (in cash value) to purchase significant amounts of LTC services, they do to some degree improve the financial position of older adults at high risk of LTC service needs. One appeal of these subsidies is their low administrative costs, because individuals do not need to go through complicated assessments of their functional capacities and needs *(68)*.

There are potential pitfalls associated with cash benefits, such as the moral hazard effects of cash payments, particularly in contexts where recipients are not required to justify the use of funds *(62)*. In these contexts, individuals face few constraints when spending their cash allowances on items that the allowances are not intended for (e.g. food or other necessities) instead of on LTC services. This problem can be mitigated by designing cash benefits that are conditional on care budgets or receipts justifying the use of allowances *(62)*. However, it should be noted that cash benefits for family caregivers may have the unintended consequence of perpetuating the traditional inequitable sex and gender roles by financially incentivizing women to continue to provide informal care *(71)*. Lastly, unregulated cash benefits or vouchers provided to users are more likely to boost informal care and the grey markets of care mostly provided by domestic helpers (as in countries such as Austria, Germany and Italy) rather than generating demand for formal services and fostering professionalism in the provision of those services *(72)*.

In summary, both supply-side and demand-side financing incentives in the form of government subsidies are needed to bolster the development of an LTC system, especially in the early stage of development. However, these subsidies alone are not sufficient. Policy-makers in LMICs should take steps towards establishing more comprehensive approaches to public LTC financing, ideally following a broad-based social insurance model providing universal coverage for all individuals in need of LTC.

7

Summary and lessons learned for LMICs

The potentially high financial burden of LTC, resulting from uncertainties surrounding the duration, volume and type of care required, has prompted calls for public financing mechanisms to complement informal care provision. In HICs, formal systems of public LTC financing have been introduced for this purpose, with LTC programmes in these countries comprising universal programmes financed through taxation and mandatory social health insurance, as well as means-tested programmes. This review of publicly funded LTC programmes has focused on MICs, for which the current evidence is relatively sparse. For the reviewed MICs, countries such as China and Thailand have some universal LTC programmes that are of limited scope and scale; other countries, including India and Malaysia, have limited public programmes predominantly in the form of means-tested social welfare.

Three major types of public LTC programmes commonly exist in the reviewed MICs: those in which the government either directly provides LTC services or finances LTC programmes through supply-side or demand-side financing mechanisms; cash allowance programmes, which disburse monetary allowances to beneficiaries; and insurance-based models of public LTC financing. These different approaches to financing LTC services vary by how public funds are organized and allocated, as well as the extent of coverage for people in need of LTC. There are important considerations when designing LTC systems: whether eligibility to publicly funded services should be means tested or universal; whether the government provide services directly or through the role of a third-party payer, that is, via contracts with nongovernmental service providers; and whether the finance structure should be centralized or decentralized. Each of these design features has both advantages and disadvantages.

This report concludes with some deliberations on financing options for LTC, specifically for LMICs. Of the two most common approaches to financing LTC, tax-based financing is preferred over a social-insurance-based model, as the former has two key advantages over the latter. Tax financing is more efficient as it pools LTC risks (likewise for health risk) across a larger population. Tax financing is also more equitable as it ensures that LTC services are accessible to individuals who are either not employed or who are employed in the informal sector, as well as to formal sector workers covered under social insurance. LMICs, and especially LICs, often face constraints in raising revenue to finance public programmes and have many competing priorities in other areas (e.g. infrastructure and defence). The presence of a large informal labour sector, which is common in many LICs and in some MICs, would render a social insurance model of LTC financing unfeasible.

The financing of LTC involves complex and multidimensional challenges that countries globally will need to confront. In this report, the financing models and approaches adopted by different countries have been explored, country case studies examined and

the implications of these financing choices discussed. This report therefore offers valuable insights into how policy-makers can design effective and sustainable public LTC financing systems, ensuring that individuals and their families receive the necessary support and assistance to lead dignified lives as they age.

References

1. Colombo F, Llena-Nozal A, Mercier J, Tjadens F. Help wanted? Providing and paying for long-term care. Paris: Organisation for Economic Co-operation and Development. OECD Health Policy Studies OECD; 2011 (https://www.oecd-ilibrary.org/social-issues-migration-health/help-wanted_9789264097759-en; accessed 9 October 2023).

2. Barr N. Long-term care: a suitable case for social insurance. Soc Policy Adm. 2010;44(4):359–74. doi:10.1111/j.1467-9515.2010.00718.x.

3. Colombo F, Llena-Nozal A, Mercier J, Tjadens F. Public long-term care financing arrangements in OECD countries. In: Help wanted? Providing and paying for long-term care [Internet]. Paris: Organisation for Economic Co-operation and Development. OECD Health Policy Studies OECD; 2011 (https://www.oecd-ilibrary.org/social-issues-migration-health/help-wanted/public-long-term-care-financing-arrangements-in-oecd-countries_9789264097759-12-en; accessed 9 October 2023).

4. Kutzin J, Yip W, Cashin C. Alternative financing strategies for universal health coverage. In: Scheffler RM, editor. World scientific handbook of global health economics and public policy. Volume 1: The economics of health and health systems. Singapore: World Scientific; 2016; 267–309.

5. Bennett S, Glandon D, Rasanathan K. Governing multisectoral action for health in low-income and middle-income countries: unpacking the problem and rising to the challenge. BMJ Glob Health. 2018;3(Suppl 4):e000880. doi:10.1136/bmjgh-2018-000880.

6. Hsiao WC. Why is a systemic view of health financing necessary? Health Aff (Millwood). 2007;26(4):950–61. doi:10.1377/hlthaff.26.4.950.

7. The road to better long-term care in Asia and the Pacific: building systems of care and support for older persons. Manila, Philippines: Asian Development Bank; 2022 (https://www.adb.org/publications/better-long-term-care-asia-pacific, accessed 9 October 2023).

8. Feng Z. Filial piety and old-age support in China: tradition, continuity, and change. In: Zang X, Zhao L, editors. Handbook on the family and marriage in China. London: Edward Elgar Publishing; 2017:266.

9. Hashiguchi TCO, Llena-Nozal A. The effectiveness of social protection for long-term care in old age: is social protection reducing the risk of poverty associated with care needs? Paris: Organisation for Economic Co-operation and Development. OECD Health Working Paper no. 117; 2020 (protection-for-long-term-care-in-old-age_2592f06e-en, accessed 9 October 2023).

10. Long-term care and health care insurance in OECD and other countries. Paris: Organisation for Economic Co-operation and Development; 2020 (https://www.oecd.org/daf/fin/insurance/Long-Term-Care-Health-Care-Insurance-in-OECD-and-Other-Countries.pdf, accessed 9 October 2023).

11. OECD health statistics. Long-term care resources and utilisation. Paris: Organisation for Economic Co-operation and Development; 2023 (https://www.oecd-ilibrary.org/social-issues-migration-health/data/oecd-health-statistics/oecd-health-data-long-term-care-resources-and-utilisation_data-00543-en, accessed 9 October 2023).

12. Wyse M, Walker W. Financing long-term care in Asia and the Pacific. Manila, Philippines: Asian Development Bank; 2021 (https://www.adb.org/publications/financing-long-term-care-asia-pacific, accessed 9 October 2023).

13. Maternal, newborn, child and adolescent health and ageing. Geneva: World Health Organization; 2023 (https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/static-visualizations, accessed 9 October 2023).

14. Live long and prosper: aging in East Asia and Pacific. New York: World Bank; 2015 (https://elibrary.worldbank.org/doi/abs/10.1596/978-1-4648-0469-4, accessed 9 October 2023).

15. United Nations. World population ageing 2019 highlights. San Fransisco: United Nations; 2019 (https://www.un-ilibrary.org/content/books/9789210045537, accessed 9 October 2023).

16. World development indicators [database]. Washington (DC): World Bank Group; 2023 (https://databank.worldbank.org/source/world-development-indicators, accessed 20 October 2023).

17. WHO. Global health expenditure database [database]. Geneva: World Health Organization; 2023 (https://apps.who.int/nha/database/Select/Indicators/en, accessed 9 October 2023).

18. World population prospects. New York: United Nations Department of Social and Economic Affairs, Population Division; 2023 (https://population.un.org/wpp/Download/, accessed 9 October 2023).

19. OECD.stat [database]. Paris: Organisation for Economic Co-operation and Development; 2023 (https://stats.oecd.org/, accessed 20 October 2023).

20. de la Maisonneuve C, Martins JO. The future of health and long-term care spending. OECD J Econ Stud. 2015;2014:61–96.

21. Life expectancy at 65. Paris: Organisation for Economic Co-operation and Development; 2022 (https://doi.org/10.1787/0e9a3f00-en, accessed 9 October 2023).

22. Stokic LP, Bajec J. Thematic report on challenges in long-term care - Serbia. Brussels: European Commission, European Social Policy Network (ESPN); 2018.

23. Death and life expectancy. Department of Statistics, Singapore; 2021 (https://www.singstat.gov.sg/find-data/search-by-theme/population/death-and-life-expectancy/latest-data, accessed 9 October 2023).

24. Life expectancy. Paris: Organisation for Economic Co-operation and Development; 2023 (https://www.oecd-ilibrary.org/sites/a957e891-en/index.html?itemId=/content/component/a957e891-en, accessed 26 October 2023).

25. Matus-Lopez MA, Chaverri-Carvajal A, Jara-Males PC. The challenge of ageing in Latin America: Long-term care in Costa Rica. Saúde E Soc. 2022;31(1):e201078–e201078. doi:10.1590/S0104-12902022201078.

26. Population ages 65 and above (% of total population). New York: United Nations Department of Social and Economic Affairs, Population Division; 2023 (https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS, accessed 9 October 2023).

27. Agarwal A, Bloom DE. Long-term care in India: capacity, need and future. Int Soc Secur Rev. 2022;75(3–4):167–86. doi:10.1111/issr.12312.

28. Thach NT, Wiener JM. An overview of long-term services and supports and Medicaid. Final report. Washington, DC: RTI International; 2018 (https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//182846/LTSSMedicaid.pdf, accessed 9 October 2023).

29. Foster D. Adult social care funding (England). London: Government of United Kingdom, Great Britain and Northern Ireland, Report no. 7903; 2023 (https://researchbriefings.files.parliament.uk/documents/CBP-7903/CBP-7903.pdf, accessed 9 October 2023).

30. Rajagopalan J, Hurzuk S, Arshad F, Raja P, Alladi S. New country report: the COVID-19 long-term care situation in India. International Long-Term Care Policy Network; 2020 (https://ltccovid.org/2020/05/29/new-country-report-the-covid-19-long-term-care-situation-in-india/, accessed 9 October 2023).

31. Chen S, Li L, Yang J, Jiao L, Golden T, Wang Z et al. The impact of long-term care insurance in China on beneficiaries and caregivers: A systematic review. J Glob Health Econ Policy. 2021;1:e2021014. doi:10.52872/001c.29559.

32. Feng Z, Lin Y, Wu B, Zhuang X, Glinskaya E. China's ambitious policy experiment with social long-term care insurance: promises, challenges, and prospects. J Aging Soc Policy. 2023;Feb 24:1–17. doi:10.1080/08959420.2023.2182574.

33. Feng Z, Zhuang X, Glinskaya E. Understanding China's long-term care insurance pilots: key features, challenges and prospects. China Int J. 2021;19(3):168–87. doi:10.1353/chn.2021.0034.

34. Matus-López M, Chaverri-Carvajal A. Progress toward long-term care protection in Latin America: a national long-term care system in Costa Rica. J Am Med Dir Assoc. 2022;23(2):266–71. doi:10.1016/j.jamda.2021.06.021.

35. Country diagnostic study on long-term care in Thailand. Manila, Philippines: Asian Development Bank; 2020 (https://www.adb.org/publications/thailand-country-diagnostic-study-long-term-care, accessed 9 October 2023).

36. Ponnuswami I, Rajasekaran R. Long-term care of older persons in India: Learning to deal with challenges. Int J Ageing Dev Countries. 2017;2(1):59–71.

37. Peraturan Presiden (Presidential Decree). Strategi Nasional Kelanjutusiaan (National Ageing Strategy); 2021 (https://jdih.bappenas.go.id/peraturan/detailperaturan/2700, accessed 20 October 2023).

38. Rahardjo TB, Dinni A, Guritno DE. Service delivery for older persons by young generation in Indonesia. In: Amorim A, Tzvetkova Y, Tran H-V, editors. South-south and triangular cooperation and the care economy: a compilation of short south-south cooperation articles for the Expert Meeting on Future of Work in Asia; 2018 (https://www.itcilo.org/sites/default/files/inline-files/Compendium%20SSTC%20CARE%20ASEAN%2015-11.pdf, accessed 20 October 2023).

39. Country diagnostic study on long-term care in Indonesia. Manila, Philippines: Asian Development Bank; 2021:96 (http://dx.doi.org/10.22617/TCS210416-2, accessed 9 October 2023).

40. Burke PJ, Siyaranamual MD. No one left behind in Indonesia? Bull Indones Econ Stud. 2019;55(3):269–93.

41. Rapid review of healthy ageing and long-term care systems in East and Southern Africa: country summary report – South Africa. Geneva: United Nations Office for the Coordination of Humanitarian Affairs; 2022 (https://reliefweb.int/report/south-africa/rapid-review-healthy-ageing-and-long-term-care-systems-east-and-southern-africa-country-summary-report-south-africa, accessed 9 October 2023).

42. Lloyd-Sherlock P. Long-term care for older people in South Africa: the enduring legacies of apartheid and HIV/AIDS. J Soc Policy. 2019;48(1):147–67. doi:10.1017/S0047279418000326.

43. Old age pension. Cape Town: South African Government; 2023 (https://www.gov.za/services/social-benefits-retirement-and-old-age/old-age-pension, accessed 9 October 2023).

44. Stokic LP, Bajec J. Thematic report on long-term care for older people – Serbia. Brussels: European Commission, European Social Policy Network (ESPN); 2021.

45. Makiwane M, Alubafi MF, Gumede NA. Understanding and evaluating older persons services: the case of the Gauteng Province, South Africa. J Popul Ageing. 2022;15(4):999–1015.

46. Matus-López M, Terra F. The long-term care system in Uruguay. Bremen: University of Bremen, Collaborative Research Centre, Social Policy Country Brief 1342, Report No. No. 6; 2021 (https://media.suub.uni-bremen.de/bitstream/elib/4842/4/2021_Country%20Brief_LTC_Uruguay.pdf, accessed 9 October 2023).

47. Llamado a establecimientos de larga estadía; controles del Mides y MSP. El Telégrafo; 2022 (https://www.eltelegrafo.com/2022/02/llamado-a-establecimientos-de-larga-estadia-controles-del-mides-y-msp/, accessed 20 October 2023) (in Spanish).

48. Hoe CS, Kamarulzaman WB, Heang LT. Elderly people in old age homes: Engaging factors leading to institutionalization. Int Acad Res J Soc Sci. 2018;4(1):28–41.

49. Batumalai K. What Malaysia needs for healthy ageing and care. Kuala Lumpur: CodeBlue; 2020 (https://codeblue.galencentre.org/2020/11/17/what-malaysia-needs-for-healthy-ageing-and-care/, accessed 9 October 2023).

50. Glinskaya E, Feng Z. Options for aged care in China: building an efficient and sustainable aged care system. Washington (DC): World Bank Publications; 2018 (https://elibrary.worldbank.org/doi/abs/10.1596/978-1-4648-1075-6, accessed 9 October 2023).

51. Tengku Aizan H, Sulaiman WAW, Bagat MF, Chai ST. Policy development on ageing in Malaysia: issues and challenges. In: Soon GC, Bodeker G, Kariippanon K, editors. Healthy ageing in Asia: culture, prevention and wellness. Boca Raton: CRC Press, Taylor & Francis Group; 2022.

52. Matus-Lopez M, Pedraza CC. New long-term care policies in Latin America: the national system of care in Uruguay. J Am Med Dir Assoc. 2016;17(7):663–5. doi:10.1016/j.jamda.2016.04.001.

53. Direktorat Bina Ketahanan Keluarga Lansia dan Rentan. Panduan Bina Keluarga Lansia Integrasi. Badan Kependudukan dan Keluarga Berencana Nasional; 2020 (https://golantang.bkkbn.go.id/publikasi_golantang/9/download, accessed 20 October 2023) (in Indonesian).

54. Jumri N. Perkasa Sistem Sokongan Demi Kesejahteraan Warga Emas. BERNAMA; 2022 (https://www.bernama.com/bm/rencana/news.php?id=2129986, accessed 20 October 2023) (in Malaysian).

55. Perišić N. Long-term care in the Republic of Serbia. Bremen: University of Bremen, Collaborative Research Centre, Social Policy Country Brief 1342, Report No. No. 14; 2021. (https://media.suub.uni-bremen.de/bitstream/elib/5895/3/2021_Country%20Brief_LTC_Serbia.pdf, accessed 9 October 2023).

56. Sevo G, Davidovic M, Erceg P, Despotovic N, Milosevic DP, Tasic M. On aging and aged care in Serbia. J Cross Cult Gerontol. 2015;30(2):217–31. doi:10.1007/s10823-015-9261-1.

57. Lessons from Thailand's national community-based long-term care program for older persons. Manila, Philippines: Asian Development Bank; 2020 (https://www.adb.org/publications/thailand-long-term-care-older-persons, accessed 9 October 2023).

58. Lloyd-Sherlock P, Pot AM, Sasat S, Morales-Martinez F. Volunteer provision of long-term care for older people in Thailand and Costa Rica. Bull World Health Organ. 2017;95(11):774–8. doi:10.2471/BLT.16.187526.

59. RM635m for elderly care. DailyExpress.com [internet]; 2022 (http://www.dailyexpress.com.my/news/185536/rm635m-for-elderly-care/, accessed 9 October 2023).

60. Lloyd-Sherlock P, Agrawal S. Pensions and the health of older people in South Africa: is there an effect? J Dev Stud. 2014;50(11):1570–86. doi:10.1080/00220388.2014.936399.

61. Aranco N. Panorama of aging and long-term care: summary uruguay. Washington (DC): Inter-American Development Bank; 2019 (file:///C:/Users/Elaine%20Rowan/Downloads/Panorama_of_Aging_and_Long-term_Care_Summary_Uruguay.pdf, accessed 20 October 2023).

62. Costa-Font J, Raut N. Global report on long-term care financing. Geneva: World Health Organization; 2022 (https://www.lse.ac.uk/business/consulting/reports/global-report-on-long-term-care-financing, accessed 9 October 2023).

63. The long-term care insurance in Japan. Tokyo: Ministry of Health, Labour and Welfare, Japan; 2023 (https://www.mhlw.go.jp/english/topics/elderly/care/2.html, accessed 9 October 2023).

64. Huang Y, Zhang Y, Zhuang X. Understanding China's long-term care insurance pilots. Technical note. Washington (DC): World Bank Group. Technical note; 2021 (https://documents1.worldbank.org/curated/en/496061563801421452/Technical-Note.docx, accessed 20 October 2023).

65. Guiding opinions on initiating the long-term care insurance pilots. Ministry of Human Resources and Social Security Beijing, China; 2016 (https://www.gov.cn/xinwen/2016-07/08/content_5089283.htm, accessed 20 October 2023) (in Chinese).

66. Da Roit B, Le Bihan B. Similar and yet so different: cash-for-care in six European countries' long-term care policies. Milbank Q. 2010;88(3):286–309. doi:10.1111/j.1468-0009.2010.00601.x.

67. Feng Z, Glinskaya E. Aiming higher: advancing public social insurance for longterm care to meet the global aging challenge. Comment on "Financing long-term care: lessons from Japan." Int J Health Policy Manag. 2020;9(8):356–9. doi:10.15171/ijhpm.2019.121.

68. Wiener JM, Feng Z, Zheng NT, Song J. Long-term care financing: issues, options, and implications for China. Washington (DC): World Bank Group; 2018;191–213 (https://elibrary.worldbank.org/doi/10.1596/978-1-4648-1075-6_ch5, accessed 9 October 2023).

69. Glinskaya E, Feng Z, Suarez G. Understanding the "state of play" of long-term care provision in low- and middle-income countries. Int Soc Secur Rev. 2022;75(3–4):71–101.

70. Rodrigues R, Leichsenring K, Winkelmann J. To make or to buy long-term care? Part I: learning from theory. Vienna: European Centre for Social Welfare Policy and Research; 2014 (https://www.euro.centre.org/downloads/detail/1486, accessed 9 October 2023).

71. Ikegami N. Financing long-term care: lessons from Japan. Int J Health Policy Manag. 2019;8(8):462–6. doi:10.15171/ijhpm.2019.35.

72. Da Roit B, Le Bihan B, Österle A. Long-term care policies in Italy, Austria and France: variations in cash-for-care schemes. Soc Policy Adm. 2007;41(6):653–71. doi:10.1111/j.1467-9515.2007.00577.x.

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