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### RESEARCH ARTICLE

## CHALLENGES TO THE LONG-TERM CARE POLICY: LESSONS FROM EXPERIENCES OF OTHER COUNTRIES

Mika Ito<sup>1</sup> and Purnawan Junadi<sup>2</sup>

1. Faculty of Public Health, University of Indonesia, Depok, West Java Province, Republic of Indonesia  
International Studies, Care Environmental Laboratory Co., Ltd. Tokyo, Japan.
2. Professor, Faculty of Public Health, University of Indonesia, Depok, West Java Province, Republic of Indonesia.

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#### Abstract

The world has faced a critical demographic change as the population ageing, and the increased number of elderly people aged over 65 has brought several challenges in the healthcare system. Living longer with good health is not easy, a challenge to all people. The disease trend has been shifted from communicable diseases to non-communicable diseases including cancers as well as support needs of people living with chronic health problems, physical limitations and cognitive impairment that affect their ability to perform every activities of daily living. As results, the expenditures in the healthcare have increased dynamically and most of countries have faced difficulties to sustain their healthcare system, the national scheme social welfare and insurance in particular. Despite many countries have introduced a new scheme of healthcare policies as well as reformed the existing policies, challenges to deal with the population ageing are not yet overcome. In this paper, several healthcare systems, the Long-Term Care policy in particular, are reviewed and lead to some recommendations for sufficient and sustainable systems. Each system has its advantage and disadvantage, meaning there is no perfect policies for healthcare including the long-term care. Keys are not only the hard factors such as available facilities and funds but also soft factors such as management and operation mechanism as well as how to minimize the moral hazard and to emphasize the importance of prevention in order to reduce the total healthcare expenses. As there is no perfect LTC system or policy yet, it is strongly recommended to use the mixed systems for sustainable healthcare and long-term care system.

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#### Introduction:-

The world is facing a critical demographic change. In the long history, the population aged younger than 5 years has outnumbered the population aged over 65. However, now it is a turning point that the population aged over 65 would be greater than population under aged 5. According to The World Health Organization Report, it was estimated that 524 million people were aged over 65 that is approximately 8% of the total world's population and will increase to 1.5 billion, 16% of the total world population by the year 2050. It is predicted that the population of

**Corresponding Author:- Mika Ito**

Address:- Faculty of Public Health, University of Indonesia, West Java Province, Republic of Indonesia. International Studies, Care Environmental Laboratory Co., Ltd. Tokyo, Japan.

older people would increase 71% in developed countries and more than 250% in the less developed countries between 2010 and 2050 (WHO, 2011).

Living longer with healthier lives is greatest ideal, but the reality is not always living longer with good health. If we are living longer with poor health, what are consequences? As living longer and better hygienic environment, the disease trend has shifted from communicable diseases to non-communicable diseases or chronic diseases as well as the disease trend has shifted from mortality from communicable diseases to non-communicable diseases. At the early 21st century, causes of mortality from non-communicable diseases are dominant as 86% in high-income countries and 67% in middle-income countries. In contrast, causes of mortality from communicable diseases still major dominant in low-income countries as more than 50%. However, it is projected that more than 50% of disease cases would be related to non-communicable diseases in low-income countries by 2030 (WHO, 2002).

Then the increased number of population with dementia, cognitive impairment and disabilities is another severe issue. The World Health Organization estimated that 47 million cases of dementia were reported worldwide in 2015 and predicting that this may be tripled by 2050 owing to ageing of the population (Prince et al., 2015). The number of people with disabled and cognitive impairment in most developing countries is estimate to increase as the number of older people continually increases comparing to its population in developed countries.

It is often argued that population ageing has a negative impact on the expenditure in health care because chronic diseases and non-communicable diseases usually require longer treatment period, longer staying at hospitals and advanced medical facilities, and medicine that are relatively higher medical costs. The expenditure in health care is estimated to have increased by 2.8% in 2013, the total of 7.2 trillion US Dollars equaling to 10.6% of global gross domestic product (GDP) (WHO, 2002). Despite of the high pressure of health care cost reduction, it is expected that health care expenditure will be increased averagely 5.2% a year from 2014 to 2018 due to the increased populations in general, the increasing aging population, the increasing prevalence of chronic diseases, emerging market expansion, infrastructure development in health care and treatment and technology advances (UN, 2018).

As facing to these factors, the demands and needs for Long-Term Care (LTC) have been increased within the past 30 years globally, and many of countries with long enough history and experiences of implementation of social health insurance scheme introduced LTC system. As most of developed countries have had faced the rapid population aging, the demands for LTC services have increased much faster that expectations. Consequently, the shortage of facilities such as elderly care institution, the shortage of professionals and workforce, the heavier burden on informal caregivers as well as heavier fiscal burden have been focused as challenges are becoming serious issues that lead to lowered quality of care services, patients satisfaction and quality of live.

#### **Long-Term Care:-**

Long-Term Care refers to a continuum of medical and social services designed to support needs of people living with chronic health problems, physical limitations and cognitive impairment that affect their ability to perform every activities of daily living (Okem, 2011). The LTC includes activities undertaken for persons that are not fully capable of self-care on a long-term basis, by informal caregivers such as family and friends, by formal caregivers including professionals and paraprofessionals, and by traditional caregivers and volunteers (WHO, 2002). The aim of LTC services is to improve the quality of life while reducing the negative consequences of old age or disability. Therefore, the services include medical services, nursing care, prevention, rehabilitation, and palliative care, along with home care for sustaining daily and social life (WHO, 2002).

The responsibility for LTC lies between the health care and the social care systems. The main purpose of the health care is to prevent diseases and cure the patient. Professionals involved into LTC are physicians, geriatric specialists, geriatric or LTC nurses, pharmacists, social workers, dieticians, physical therapists, occupational therapists, speech language pathologists, case managers, respiratory therapists, physician assistants, and other members working in the LTC setting as labor intensive (Okem, 2011). Among all of them, the key player in LTC is geriatric or LTC nurses because they manage patient care, perform various nursing skills including assisting activities of daily living, address changes in condition and provides interventions as well as support and education to their families. In order to determine the level of disability and eligibility for LTC, usually needs assessment methods such as an assessment of activity of daily living and an instrumental activity of daily living. There assessments are done by professionals such as a general practitioner, a qualified nurses or a social worker.

LTC services are provided at an institution such as nursing-home called institutional care or at home called home-based care. However, there is no standard for LTC yet. The LTC structure should be associated with health care, social security or welfare system as well as social values, cultural values and tradition preferred by each place.

What to be concerned is who and how are responsible for cost of LTC. In the public social welfare, the most of the social policies can be categorized into three models - the state responsibility model known as the Nordic Model referring to the welfare policies of the Nordic countries, whose social welfare systems are fully funded by the public through high taxation (Nordic Council, 2014; Xiong, 2013), the family care model known as the Mediterranean Model like Greece, and the German Model referring a social welfare system which cost is share by the public and private by tax-funded or subsidies, contribution or monthly premier through tax-payroll and co-payment/out of pocket, and widely applied to countries such as Germany, the Netherlands and Japan. In addition to these types, there is the means-tested safety net scheme like United States and United Kingdom (excluding Scotland) that is the funding of long term care targets those who are unable to pay for care services only employed. Furthermore, the mixed model is practiced in countries like Ireland, Italy, Spain and Switzerland. The mixed model is a new scheme model where the source of financing is a combination of taxation, insurance, and out of pocket. It is observed that there has been a general movement based on the rationale of fairness and efficiency (Colombo et al., 2011). The LTC system has been implemented in many countries and each country has own LTC policy under philosophies and concepts with advantages and disadvantages. The three different types of LTC from Japan, Sweden and Singapore are reviewed as following.

#### **Long-Term Care in Japan:-**

The one of the German Model is LTCI in Japan. There is no clear definition of LTC in Japan, but the Japan's LTCI targets the two groups: 1) elderly individuals aged 65 years old and above who require assistance in daily living, and 2) individuals aged between 40 to 64 years who suffer from aged related diseases such as cancers and cardiovascular diseases, also disabilities (Tsutsumi, 2014).

In prior to the public LTCI policy was launched, elderly care services in Japan was provided through the tax-based social welfare scheme, and this service was limited for the low-income elderly and without families. Between 1973 and 1981, free medical services were provided to people aged over 70 which brought severe increased medical expenditure and shortage of medical facilities (Oku et al., 2017). As a solution to these issues, the Act on Health Care for the Elderly was launched in 1982, basically the free medical care to elderly was abolished and required co-payment which is lower than regular people but increased gradually until 1997 (Tsutsumi, 2014) .

The Japanese government introduced the mandatory LTCI in 2000. The principles underlining this new scheme of public insurance are: 1) universal coverage, financing through social insurance combined with the public fund finance (50%) and private contribution (50%); 2) freedom of choice by service users; and 3) reliance on service market (Esther, 2010; Caroline, 2009). The system is operated by municipalities under central government legislation. The major purposes of the scheme of LTCI are: 1) Shifting a major responsibility for caregiving from informal sector to formal sector; 2) integrating medical care and social services through unified financing; 3) enhancing consumer choice and competition by allowing free choice of providers; 4) requiring elders themselves to share the costs through insurance premiums as well as co-payments; and 5) expanding local government autonomy and management capacity in social policy (Gleckman, 2010; John, 2000) .

Similar to other LTC schemes, the Japanese model provides home-care services and institutional services, while distributing cash grants. The beneficiaries are able to receive in-home services such as home-visit nursing care services and out-patient rehabilitation, as well as institutional care services provided by formal healthcare providers and community based services. The significant practices in Japan's LTC system lies in the personalized services provided for each patient. It works that care managers evaluate the level of assistance needed and paly a role as a contact point between services providers and the beneficiaries. The eligible person is obligated to take healthcare assessment supervised by the care manager. The results will be passed onto case conferenced and supervised by healthcare professionals and municipal long term care council. The beneficiaries will be categorized into six groups based on severity of health status. Each group is entitled for different types of care, care intensity and fee schedule. This helps to reduce time, costs and the provision of unnecessary care services for the beneficiaries (OECD, 2013).

Despite the quality level of the workforce for LTC are strictly controlled by trainings and experiences, the capacity is in shortage. To become an entry level care providers, the individual must undertake 130 hours of training. The

care takers are required to take state examination and acquire training for 2-4 years or education attainment at colleges (OECD, 2013). As for care managers, they are seen as sophisticated professionals who have at least 5 years of clinical experience and are responsible for the entire LTC services for each individual, starting from pre-entry assessment to case updates and LTC discharge (OECD, 2013). These demanding requirements of training and comparatively lower wages are causing problems of a shrinking workforce.

Unlike other countries, Japan's insurers bare major costs. Under the LTCI scheme, the insured person pays merely 10% of the cost of services. The program funding comprises of 5 sources: the primary premium deducted from the monthly income of elderly population age over 65 (21%), the secondary premium from the working population aged 40-64 years old (29%), tax revenue from the central government (25%), prefectural government (12.5%) and municipal government (12.5%) (Ministry of Health and Welfare, 2012).

However, the medical expenditure in health has remained increasing continuously. At the introduction of LTCI in 2000, the percentage of GDP spent on LTC services was 0.7%, increased to 1.8% in 2012, and then 2.0% in 2016. The annual increased rate largest increase rate was 7.3% from 2008 to 2009 (Arjen et al.). Although the major reform in 2006 as well as frequent reviews and several minor reforms have been imposed within the short period of time such as increasing percentage of co-payment rate, the increased age for eligibility to receive LTC services and restricting eligibility levels, Japan has not yet achieved a reliable solution to sustain LTCI for the future.

#### **Long-Term Care in Sweden:-**

Sweden is well recognized as a nation with the strong social welfare known the Nordic Welfare Model with over 100 years of experiences. As the fundamental concept is that the elderly care is a social right in Sweden, the first Swedish care services for elderly people was introduced in 1918, and then was developed in three phases in order to expand available services (Edebalk, 2010; Marten et al.).

Sweden is a well-known country where implements the state-responsible social welfare system. In the 1970s, Sweden launched Long-Term Care policy that is a decentralized and fully tax-funded system under the Social Service Act stating that the municipality has an obligation to provide assistance if the person's needs cannot be met any other ways (Marten et al.). Available LTC services are home help in regular housing, institutional care, day activities, home-nursing care, meal services, personal safety alarms, a home nursing adaptation and transportation services. By the end of the 1980s, home help services became expensive and heavier burden resulting in the insufficient elderly care due to the accelerated population ageing and reached the aged society. As its consequence, a Community Care Reform was enacted, by which the municipalities were appointed the sole authority for all care and home-based nursing for the elderly in 1992 (Edebalk, 2010). Furthermore, the local authorities were made liable for payment of costs for elderly who were in hospital not for curative treatment (Edebalk, 2010). As result of this reform, 80-85% of LTC expenditure is funded by local municipals and the rest is by the central government. In addition, promotion and effort shifting from the institutional care to home care, the expenditure in the institutional care was decreased approximately 10% between the period of 1998 and 2008 (Nanna et al., 2010). However, there is no major policy changes have been observed with the long lasting Swedish LTC during the period of 2000-2010.

Despite of the one of the best welfare nation, its LTC has been facing serious challenges to sustain the system due to the rapid ageing population. The population aged over 65 is projected continuously increased in the future; therefore debates for reforms have been taken place including abolishment of the tax-based financing LTC to cost-sharing scheme (WHO, 2003).

#### **Long-Term Care in Singapore:-**

Another model can be seen in Singapore. In Singapore, no medical provision is provided free of charge. This Singaporean philosophy is shaped by the first Prime Minister, Lee Kuan Yew, who strongly advocated that the free welfare will lead to moral hazard in the healthcare system (Gill, 2013). The individual or family members are expected to take main responsibility to make payment by out-of-pocket spending, through cash, insurance or savings, which make them more aware and selective of the services they engage in and avoid overconsumption in healthcare (Yiling, 2012). However, the Singaporean government has also provided subsidies to alleviate healthcare burden of the people. The government ensures that no Singaporean is denied from access to basic health care as providing the public healthcare institutions. Then, the government implement a healthcare scheme consisting of the compulsory personal saving to pay medical expenses is called Medisave which every working Singaporean contributes 8 to 10.5% of monthly salary, a voluntary medical insurance called Medishield-life that provided basic

health insurance to offset large costs from unexpected catastrophic illnesses that Medisave was inadequate to cover, also to seek better serve the needs of an older population by extending insurance coverage to the end of life and allows for the inclusion of persons with pre-existing illnesses, and a safety net for low income Singaporeans called Medifund (Ministry of Health, 2015 & 2016).

As regards LTC under Medisave, available subsidies are dependent on household income levels by means-testing and patients must apply for and be eligible to receive these subsidies. In addition, there is another coverage scheme called Eldershield that is a severe disability insurance scheme under which all Singaporean citizens and permanent residents who have a Medisave account are automatically covered from aged at 40. In order to be eligible for this scheme, individuals must have hardship to perform at least three out of six basic activities of daily living. Furthermore, there is the Pioneer Generation Package introduced in 2015 by the government, a package of health subsidies for persons aged over 65, which includes automatic top-ups to Medisave accounts, 50% discounts off subsidized fees at polyclinics and specialist outpatient clinics, and special subsidies under the Community Health Assist Scheme which are available at approved medical and dental clinics (Ministry of Health, 2016).

In order to overcome the issue of population ageing, the Singaporean Government commenced preparing for the ageing population ahead of time, a ‘many helping hands’ approach that seeks to emphasize the primacy of the family as the chief caregiver was developed by the Ministry of Health’s Committee on the Problems of the Aged in 1982. The government also established The Maintenance of Parents Act of 1996 enforcing the family’s financial contribution to a person aged over 60 years who cannot provide for him or herself may claim for maintenance from his/her children who are in a position to make a contribution, as well as the “Ageing Planning Office” in 2016, which “oversees the planning and implementation of strategies to respond to the needs of Singapore’s ageing population,” effectively establishes a ‘ministry of ageing’ cutting across the health and social divide (Yiling, 2012). It is deemed as a coordinating Ministry by many and seeks to provide an oversight role in the designing and implantation of ageing policy. It further works to enhance the capacity and capability of aged care.

Furthermore, the government has emphasized the promotion and implementation of the primary prevention in designing programs to improve health before such care becomes necessary and in aiming the reduction of financial burden on elderlies. The health promotion plays a critical role in engendering healthy lifestyles and empowering self-care in a nation to prevent disease and maintain health and independence into old age under the Health Promotion Board (Yiling, 2012).

Despite of implementing the efficient and comprehensive health systems, the Singaporean Government has had fears toward the rapid ageing population. The rapid ageing of the Singapore population poses multiple challenges, not least in the provision of healthcare for an increasing proportion of older persons. The more sufficient LTC policy is urged in Singapore.

### **Discussions:-**

It can be seen that none of the LTC model and system are yet successfully sustained. Each model has its advantage and disadvantage, but very much related to the fiscal aspect. Two traditional models that are the state responsibility model and the subsidiary model seem to have severe financial difficulties. There is a high risk for the moral hazard under the state responsibility model as the Singaporean Government emphasized as well as the Japanese experiences during the 1970s. In contrast, the Singaporean philosophy “the healthcare is personal responsibility” is effective for individual to keep awareness of the healthier life including prevention, and the Singaporean Government denied to adopt the Japanese healthcare system. What to be mentioned that is the Singaporean government does not provide the state responsibility in finance but in policies such as “Medishield” and “Eldershield” which can assure the payment of the healthcare services and the pooled funds are not transferable rather than the family members (Ministry of Health, 2016). This unique system eventually reduces the expenses in LTC services and also provides the assurance to access to the services. Only the weakness of the Singaporean system is that the system is not mandatory although more than 80% of the population participate to the “Medishield” (Central Provident Fund Board, 2016).

The moral hazard can easily take root under the state responsibility model including the Hong Kong model as often argued. Like the Nordic countries where the state responsibility system applied for very long period, it is not easy to reduce the level of moral hazard. The mean-tested may be effective to control and decrease the number of beneficiaries along with the promotion and preventive services for the healthier and longer life that is also under the

state responsibilities. The state responsibility model is obviously not suitable for nations where the population of elderly increases along with the decline in birthrate and where economy is not stable. The ratio support to the elderly will be lowered consequently the tax revenue for the government also becomes smaller and instable. In another word, the burden on the government will be extremely heavier.

The subsidiary model is like to have wider and various range of system. In the Netherland and Germany the government has heavier roles in financing LTCI, in contrast the insured has rather heavier burden in Japan as the 50% of funding are by premium of insured and 10% of co-payment in addition. Under this condition, the solidarity of the Japanese citizens is rather untied. The flat rate of co-payment and the capped amount should be determined by not the level of age but the level of income and the used service amount. Salary deducted premium is a sufficient method to collect funds consistently, but some argue that income deduction dis-incentivizes workers to work and employers may prefer to substitute capital for employees, which are increasingly the trend with the changing nature of jobs (Rothgang et al., 2009).

Having a position of care manager or case coordinator like in Japan may have positive impacts reducing the overconsumption of services, increasing efficiency in communication and information sharing and increase satisfaction on service recipients. At the same time, strict in assessment to determine the care needs level is absolutely necessary. As LTC involves wide range of care services provided various professionals and personals, it is strongly required to have a personnal who is responsible for coordination of services with sufficient quality.

In the German system, benefits to caregivers for home care are imposed such as providing proper trainings and educations, and cash benefits. The OECD report discussed that this form of cash-benefits can control the pressure of increasing costs from formal channels and reduces demand for expensive forms of care (OECD, 2015). This is a key to not only financial aspect but also to encourage shifting from the formal care to informal care with high quality of care and risk management.

The LTC systems in Singapore and Hong Kong with their unique concepts sound successful and sustainable although these two systems are almost opposite concept, the non-state responsibility and the state responsibility. However, it is good to consider their population size as well as the territory size. It is uncertain if these systems are applicable for the large population size and the large territory. In facts, the municipal or regional government offices are to play main and important roles in other systems, this is because the central government is not eligible to take major responsible in its operation and management of the systems.

As the most serious challenge and issue is financing in LTC system, the capacity, the capability, the coordination and quality of care or life have been rarely discussed among policymakers. However, the LTC policy is for the own citizen not for the policymakers. Therefore, the review and evaluation of LTC system should be based upon the beneficiaries' points of view by applying the WHO framework for evaluating healthcare systems covers six dimensions – effectiveness, efficiency, accessibility, patient-centeredness, equity and safety (WHO, 2006).

### **Recommendations:-**

There are several recommendations for nations where willing to develop and introduce the LTC policy. For the issue of financing, the system should impose requirement of co-payment or out-of-pocket with a clear capped amount in order to prevent overconsumption and moral hazard. The capped amount and co-payment level should be determined by the level of income and conditions not by age, not flat rate. The government also should enforce a mandatory participation at certain age like 40 years old.

Then, the system should set a standardized management system including the care coordination as a part of the LTC infrastructure as well as prices of LTC services so that individuals can access the information and benchmark the quality of service providers, improving transparency levels and reducing the problem of asymmetric information. There should be a sector in charge to efficient coordination of services such as case managers or care coordinator under standard criteria of available services accordance with care needs like in Japan. Furthermore, the issue of manpower should be included in this scheme, the balancing between qualified or certified staffs and care providers and non-qualified or informal staffs and care provides including the assuring payments or incentives. For assuring quality of care, training and education programs should be offered to non-certified staffs, informal staffs and care providers in the state responsibility.

Furthermore, the several sectors should be involved into the policy making process, and each sector should have different roles in aspects of the LTC capacity, the LTC capabilities, the LTC coordination and the LTC financing. The sectors may be public sectors, private sectors and citizen sectors for the combination of top-down and bottom-up approach.

Finally, the LTC system as well as the regular healthcare system should include promotion and prevention program for the healthier and long life like in Singapore to reduce the amount of elderlies who needs the LTC services.

### **Conclusion:-**

Each LTC model or system has its advantage and disadvantage, but very much related to the financial aspect. However, the aspect of provision is also very important for the sustainable LTC system. Under the provision umbrella, it can be categorized the issues according to capability, capacity, coordination and quality of care as well as quality of life. It may be recommended to use the reverse methods that is the financial system is to determine based upon the provision with the statistic of projected needs and demands.

What must be remembered is that the beneficiaries are satisfied with the services and the Quality of Life for the elderlies is to remain high. In this sense, policymakers must focus not only the financial sustainability but also types of care services, quality of care, capacity of facilities including medical and care personal are important issue.

As it is not readily and a simple process to develop sufficient and sustainable model and system, it is not too early to begin to considering developing efficient, sufficient and sustainable possible long-term care policy and system in middle- and low-income countries. As discussed in this paper, there is no single solution to the integrated health and social care components for LTC. The balance among facilities including infrastructures, manpower and finance are the most important for a sufficient system. Therefore, it is strongly recommended to learn from other countries' lessons and combine and modify with several factors including projections, then to seek the best suitable, affordable, sustainable and sufficient LTC policy.

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