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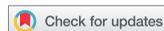
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Designing Long-Term Care Systems: Elements to Consider

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ABSTRACT

Population aging presents huge challenges for most countries around the world. In this context, long-term care systems appear as a feasible solution to the multidimensional issues arising from demographic change. However, designing a long-term care system is complex. This article presents a structure to analyze long-term care systems based on four components: beneficiaries, benefits, providers, and financing. It uses the experience of three countries to illustrate the many choices available when designing the system, emphasizing the need to understand each component and their interactions. The analysis highlights the existence of several alternatives when designing and implementing long-term care systems.

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Introduction

Many countries around the world are facing the challenges posed by aging and the increase in long-term care needs. This new scenario has generated debate about the best design to meet these needs (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011; Ikegami & Campbell, 2002; Swartz, 2013), resulting in multiple schemes for a long-term care (LTC) or long-term services and support (LTSS) system (Brodsky & Clarfield, 2008; Ikegami & Campbell, 2002; Pot, Briggs, & Beard, 2017; Weiner, 2011; World Health Organization [WHO], 2017). Despite this wide range of alternatives, there are common elements; likewise, recent experiences in LTC show elements of convergence that are useful to think about the design of these systems in other contexts (Colombo et al., 2011; Norton & Newhouse, 1994; Swartz, 2013).

Health and LTC systems are complementary elements of social security (Villalobos Dintrans, 2018). Although LTC has an important social component, it also shares goals with the health system; in many countries, LTC systems are hosted within the health system while in others they are explicitly separated. Because the roles and limits of each system are fuzzy, the design of LTC systems requires clarity and explicit definitions, in order to better coordinate actions and policies. As pointed out by Ikegami and Campbell

(2002) “Establishing an independent, comprehensive system for LTC is preferable to leaving it in an ambiguous status within the medical and social service system”.

The aim of this article is presenting a structure to illustrate the design of a generic LTC system, emphasizing the choices involved in the process, and highlighting the need for coherence when deciding about different schemes. These alternatives are exemplified using the experience of three countries with LTC systems already in place. The debate on LTC is relevant today for many countries facing the challenges of demographic transition. In this context, LTC systems arise as the best solution to deal with complex and multidimensional problems (Ikegami & Campbell, 2002). The discussion on the design of LTC systems is much needed, in a debate that has evolved almost exclusively around financing (Brown & Finkelstein, 2009; Costa-Font & Courbage, 2012; Costa-Font, Courbage, & Zweifel, 2017; Ikegami & Campbell, 2002). The lack of structure hinders the analysis and prevents action. As highlighted by WHO (2017): “... few regional or national frameworks exist to guide more specific action. Focused debate has been largely absent, reflecting the low policy and political priority accorded to long-term care ...” This article contributes to filling this gap, encouraging debate around the design of LTC systems. The analysis is intended to help policy makers around the world in designing and understanding the many complexities of LTC systems, acknowledging that their implementation is a challenge that every country will face in the near future (WHO, 2017).

LTC systems in theory and practice: components and interactions

An LTC system can be thought as the interaction of four components (Colombo et al., 2011; Ikegami & Campbell, 2002; Norton & Newhouse, 1994; Rhee, Done, & Anderson, 2015): i) beneficiaries; ii) benefits package; iii) providers and; iv) financing. It is necessary to bear in mind that these classifications are arbitrary and the boundaries proposed, diffuse. Beyond the options for each component, it is important to acknowledge the concept embedded in term “LTC system”, i.e. that the structure is more than the sum of the parts. In this sense, it is crucial to consider not only each element but also the way in which they interact.

As stated above, the four components of an LTC system require adopting several design decisions. As well as the separation of the LTC system into four components is arbitrary, options presented for each of the elements are not intended to be complete, exhaustive or exclusive. The analysis aims to illustrate complexities, options, and interactions involved in the design of an LTC system, under the precept that there is no single paradigm or model (Brodsky & Clarfield, 2008; Ikegami & Campbell, 2002; Pot et al., 2017; Weiner, 2011; WHO, 2017). Alternatives, often presented as binary and

mutually exclusive, represent rather points of a continuum where gray areas are the rule; the experience of countries with LTC systems in place shows that they have usually chosen to combine instead of selecting options. Considering this, the exercise of disentangling the LTC system into components is still useful for structuring the discussion, making explicit links between these elements, and exposing the fuzziness of their definitions.

In order to understand how trade-offs between alternatives have been faced in practice, three countries—Germany, the Netherlands, and the Republic of Korea—are used as concrete examples of the difficulties posed by the design of an LTC system. The selection of countries was based on the principles of comparative studies, used as a way to approach an institution or policy and understand it from different perspectives (Yin, 2014). The strategy is usually problematic due to the existence of “many variables, small N” (Lijphart, 1971). In order to deal with these problems, the selection of cases was based on the following criteria (Lijphart, 1971; Putnam, Leonardi, Nanetti, & Pavoncello, 1983): restrict the scope of the analysis, focusing exclusively in LTC systems; selecting “comparable cases” or units with similar institutions, in this study, countries with formal LTC systems in place; focus only in “key” variables (the components described in the previous section); look at the same institution—in this case, LTC systems—in diverse settings.

The three proposed cases have well-defined LTC systems in place, systems that went through important reforms in recent years. Moreover, each system has particular features that make them interesting for the analysis. Germany has a long tradition of social security and LTC has been prioritized as one of the pillars of its social security system. The Netherlands has one of the oldest LTC systems in the world that permits to draw lessons from a mature system that recently went into a major transformation; the Dutch LTC system is also interesting because it has also been prioritized within the social security and health system: the country devotes 30% of the health expenditure to LTC, equivalent to 3% of its gross domestic product (Organisation for Economic Co-operation and Development [OECD], 2018). Finally, the Republic of Korea offers the experience of a recent reform in a non-European country that allocates fewer resources to LTC (OECD, 2018), an experience that can be helpful in anticipating challenges and thinking about the design and implementation of an LTC system, particularly in developing countries.

Beneficiaries: who uses LTC?

A first element of the LTC system is the definition of who will be the users of its services provided. Identification and selection of beneficiaries are crucial and countries have used different approaches to this task. Despite this heterogeneity, countries have focused on the standardization of eligibility

criteria, key to ensuring transparency and fairness in the system (Brodsky, Habib, & Mizrahi, 2000; Ikegami & Campbell, 2002).

Universal or targeted coverage? Eligibility criteria

The first questions that need to be answered are: i) how to identify people with LTC needs? ii) how to define the beneficiaries of the system? While at first glance these seem like the same question, they contain fundamental differences. The first question is related to the identification of LTC needs in the population. Traditionally, LTC needs have been operationalized through the concept of (care) dependency, usually associated with difficulties in carrying out activities of daily life (ADL). This process requires a definition and an instrument to measure dependency, typically a *sine qua non* condition to be eligible. In turn, selecting the instrument to measure dependency implies other decisions, for example, the use of standardized instruments versus individual evaluations.

The lack of an official definition of dependency has pushed countries to adopt national definitions, with numerous ways of operationalizing them. For example, the Netherlands bases its evaluation on standardized instruments to determine eligibility (Government of the Netherlands, 2017), while Germany and the Republic of Korea have generated their own tools (Federal Ministry of Health, 2014; Kang, Park, & Lee, 2012; Won, 2013). On the other hand, while the latter have standardized classification for dependents, the Netherlands uses an individual evaluation to define the needs and services to be provided by the system (Kroneman et al., 2016; Ministry of Public Health, Welfare and Sport [MPHWS], 2016).

Beneficiaries' selection is different from LTC needs identification (dependency evaluation). Eligibility criteria are usually based on dependency but can include other factors such as age, income, or family situation (Brodsky et al., 2000; Colombo et al., 2011). For example, while the Dutch and German systems are exclusively based on LTC needs, the Korean system adds age (people over 65 years of age) as an eligibility criterion (National Health Insurance System [NHIS], 2014, 2017).

Both processes—identification of dependency and selection of beneficiaries—can be seen as a trade-off between universality and targeting: in the first case, the decision refers to who should be considered as care-dependent while, in the second case, the system must decide whether to include all dependents or a just fraction of them as beneficiaries. Both alternatives have pros and cons: on the one hand, targeting is useful as a cost containment strategy, increasing the system's financial sustainability; on the other hand, universal programs decrease the risk of fraud in the system, as well as some problems commonly associated with targeted programs, such as delivery of low-quality services (Brodsky & Clarfield, 2008).

Defining LTC needs? Dependency versus need for help

The previous point raised the dilemma of selecting instruments for measuring dependency. Here, the emphasis is on the perspective adopted to define LTC needs. When choosing definitions and instruments, will they be used to identify dependency? Autonomy? Need for help? Again, although alternatives may seem equivalent, they have proven to be crucial, for example, when discussing about including new groups of beneficiaries (e.g., people with dementia or children) and how to focus interventions (e.g., treatment versus prevention).

The German case illustrates this point. In 1995, the country established the basis for its current LTC system by implementing a compulsory LTC insurance as complement for its health insurance. Initially, the system set eligibility standards based on the need for help with ADL, using four categories: personal care, food, mobility, and household chores (Arntz, Sacchetto, Spermann, Steffes, & Widmaier, 2007; Geraedts, Heller, & Harrington, 2000; Schultz, 2010). Under this criterion, beneficiaries were classified into three levels. The system's reform began in 2005, motivated by exclusion of people with limited competence to perform ADL due to dementia, and its inability to assess LTC needs in children (Federal Ministry of Health, 2009). The reform aimed to establish a new definition for LTC and a novel (reliable and unique) instrument to determine LTC needs in the country. The main modification consisted of shifting from a three-level system to one with five levels, aiming to better reflect the beneficiaries' needs. In the new system, physical, mental and psychological impairments have equal weight in the evaluation of LTC needs.

The Dutch system is grounded on the concept of need for care as a gateway and guide to define services to be delivered: the basic requirement to access the benefits is the need for constant care or supervision (24/7) (Government of the Netherlands, 2017). This evaluation is used to define the services to be delivered to each beneficiary.

Finally, the Republic of Korea adopts a definition focused on the traditional concept of dependency, considering as beneficiaries people with difficulties in performing ADL (NHIS, 2014, 2017). The evaluation process is carried out through home visits where individual needs are evaluated using a standardized instrument (Kang et al., 2012; Won, 2013). According to NHIS (2017), the target population of the long-term care insurance are all residents, eligible population are those over 65 with geriatric diseases, while beneficiaries are people (over 65 years) with difficulties to perform ADL for a period of at least 6 months. Like in Germany, this definition was questioned as being excessively reliant on physical functionality, and eligibility was recently extended in order to include people living with dementia (Jeon & Kwon, 2017).

Benefit package: what services are provided?

As in the case of the definition of beneficiaries, there is no LTC benefit package that can be considered as “standard” (Brodsky and Clarfield 2008). Services offered are closely related to beneficiaries’ needs and providers in the market, highlighting the interaction between the system’s components.

Health or social? Type of benefits delivered

LTC spending is usually divided into health and social; the first includes benefits such as palliative care, nursing and care services, and health services to support families, while the second comprises initiatives such as domestic help, support in carrying out activities, and residential services. In general, LTC systems include both types of benefits (Brodsky et al., 2000; Colombo et al., 2011; Weiner, 2011).

The kind of service delivered is directly related to the types of providers available (Brodsky et al., 2000). For example, while in institutional care housing is considered as the main service, the range of alternatives at home and community care is very broad, including nursing visits, home adaptations, vacations for caregivers, technical aids, respite programs, night care, among others. Brodsky and Clarfield (2008) identify a wide range of services that can be classified both, as health and social, and delivered on an outpatient basis or through institutional care, including health status monitoring, rehabilitation, or opportunities for recreation and socialization. As illustrated by the cases of the Netherlands and the Republic of Korea, fragmentation of services is an unsolved problem for many LTC systems, with this lack of integration being crucial for the quality and efficiency of the services delivered (Brodsky & Clarfield, 2008; Pot et al., 2017).

In the Dutch case, the LTC system has different services that can be used according to individual specific needs, such as i) stay in long-term care institutions; ii) personal care (assistance with bathing, dressing, going to the bathroom and feeding); iii) services to increase autonomy; iv) nursing care; v) medical treatment; vi) transportation services (MPHWS, 2016).

Unlike the Dutch system, LTC insurance in Korea is focused on social rather than health benefits. In fact, health professionals are not allowed to deliver medical services in LTC institutions. The LTC insurance provides assistance in: home services such as care visits, nursing, baths, day/night care, equipment; services in long-term care institutions; and monetary benefits (food purchase, dental health), depending on the individual level of limitation (Kang et al., 2012; Won, 2013).

In-kind or in-cash? Nature of the benefits

Broadly speaking, the literature identifies two major options for delivering benefits: *in-kind* direct service delivery and *in-cash* money allowances (Brodsky et al., 2000; Brodsky & Clarfield, 2008; Colombo et al., 2011; EC, 2016). From the system's point of view, these options impose trade-offs in terms of efficacy (resources devoted to solve LTC needs), freedom to choose (better match between LTC services and needs), control over the benefit (fraud), and cost-control. As emphasized before, the potential advantages and disadvantages of each alternative are linked to the other elements of the system (Ikegami & Campbell, 2002).

Other issues arising from this decision refer to the definition of the primary caregiver, the involvement of family members in care, distortions and incentives to work, and working conditions of caregivers (Colombo et al., 2011). Monetary compensation to informal caregivers—understood as a compensation for their effort and opportunity cost—is an interesting initiative because it recognizes the value of informal care for society but presents a series of challenges in terms of design. Despite its advantages, financial support should not be the only policy for caregivers: because it generates incentives, mainly in the labor market (disincentive formality, creation of unregulated markets), these benefits should be combined with in-kind services, such as respite and labor policies to allow participation of caregivers in the formal labor market (Brodsky et al., 2000; Colombo et al., 2011).

The German system provides both in-cash and in-kind benefits, such as nursing training and subsidies for caregivers, day and night care services, and supplies and equipment (Colombo et al., 2011; Federal Ministry of Health, 2014). In 2015, the Netherlands underwent an important reform of its LTC system, whose goal was to situate the patient in the center of the system. In order to achieve this goal, the reform encouraged the use of home-based care over institutional care, as well as the use of in-cash benefits instead of in-kind benefits (Maarse & Jeurissen, 2016; MPHWS, 2016). Finally, the Korean LTC benefit package is mostly comprised of in-kind services, although the LTC insurance allows for some exceptions (NHIS, 2014; Won, 2013).

Generous or limited? Standardized or customized? The interaction between beneficiaries, needs, services, and financing

A crucial element influencing the cost and financial stability of the system is the benefits package's generosity. Depending on resources availability, infrastructure, and providers' capacity, the system may choose to deliver a limited or a broad set of services. This variable, as well as the beneficiaries' eligibility criteria, can be used to control costs in the system. As Brodsky et al. (2000) point out, most countries set maximum and minimum levels for their benefits,

balancing coverage and sustainability. In addition, many countries offer different levels of benefits to different types of beneficiaries. The Dutch case is a good example of a personalized system, in which evaluation is performed on a case-to-case basis, and the system—comprised by individuals, government agencies and managers—decides the best way to address people's LTC needs, selecting providers and quality of services (MPHWS, 2016).

Finally, the cost of the services is related to a broad definition of coverage in the system. Coverage can be seen from a financing perspective (who pays what?) or from a benefits' point of view (what services are included?). In this logic, the design of the LTC system has to consider not only what services to offer, but also how much to finance (and who pays for the rest). This decision is linked to the rest of the elements of the system: if the LTC offers only partial financial coverage, how to cover the rest of the cost? Out-of-pocket spending or insurance? Is coverage the same for everyone? Can coverage vary for different beneficiaries? Is coverage the same for all services? Can the system opt for a "zero co-payment" scheme for "basic" services? As noted by Colombo et al. (2011), co-payments, out-of-pocket expenses, and deductibles are present in all LTC systems, including those defined as with universal coverage. In these cases, income—although not considered as eligibility criteria for selecting beneficiaries—it is used to define benefits and, consequently, payments to cover services not included in the benefit package. In some systems, co-payment is the general rule for accessing the system, while in others, it exists for some benefits only, and is used both as a financing mechanism and as a cost-containment strategy via reduction of demand for services (Brodsky et al., 2000).

Providers: who delivers the services?

LTC needs can be addressed through formal or informal care. Traditionally, formal care has been provided in nursing homes but recently many countries have been experiencing with new ways of providing care, such as cash benefits, counseling strategies and home-based care (Colombo et al., 2011; Norton, 2000, 2016; Swartz, 2013). On the other hand, informal care is usually an unpaid activity, often provided by family members. People demand different services offered by different types of providers according to their health condition, economic and family situation, and individual and social preferences (Brodsky & Clarfield, 2008; Colombo et al., 2011; Gentili, Masiero, & Mazzona, 2017; Norton, 2000; Rhee et al., 2015).

Formal or informal? Basic dilemmas in an LTC system

LTC services include a continuum of alternatives ranging from sporadic and informal care provided by family and friends to institutional care (Borrayo, Salmon, Polivka, & Dunlop, 2002; Brodsky & Clarfield, 2008; Colombo et al., 2011; Norton, 2000). Although many countries have implemented formal

LTC systems, informal care is still key for the provision of services; nevertheless, countries need a system of formal services provision to cover LTC needs, preventing that these end up being assumed exclusively by families (Colombo et al., 2011).

LTC systems face a dilemma between promoting formalization and encouraging labor participation of informal caregivers. On the one hand, informal care has negative effects on the labor market, the income-generating capacity of families, and the health of caregivers. However, dependents often prefer being cared for from relatives and friends and, given their economic value, informal caregivers help keeping the system's costs controlled. This trade-off justifies the existence of a mixed system, in which the responsibility of care does not rely exclusively on formal caregivers but where informal caregivers have access to support and help to perform their tasks, and relieve their burden (Colombo et al., 2011).

The proper mix between formality and informality arises, again, from the interaction between the goals and elements of the system: what kind of needs exist in the population and what kinds of services are demanded? How can the system take into account families' preferences? How much money is available to finance the system? How does the design of the LTC system affect caregivers' behaviors? What kinds of providers are currently available?

Institutional or home-based care? The setting in which services are delivered

Regardless of the existence of a continuum of care alternatives in LTC, the discussion has usually revolved around the two extreme options: nursing homes and home-based care. These alternatives have been traditionally linked to formal and informal care, although formality constitutes a different dimension of the service provision. This paradigm—linking home-based care to informal care—is debatable, especially considering the recent trend observed in many countries that have included home-based services as part of their formal LTC systems (Colombo et al., 2011; MPHWS, 2016; Swartz, 2013).

In the German system, services are delivered in both modalities: more than 70% of the beneficiaries opt for home-based care, both in public and private insurance. In this case, they can choose to receive a money transfer that varies according to the level of care required. The system also includes benefits for caregivers, such as a payment for services, and pension and accident insurance (Federal Ministry of Health, 2014). As noted above, the Dutch system was recently redesigned to encourage changes in the provision of services, moving from a system based mainly on institutional care to one that promotes home care (MPHWS, 2016). Finally, the Korean system also separates services between those provided in specialized institutions and home care, which includes help with household chores and tasks of daily living, nursing services, as well as day

and night care. In 2013, LTC expenditure was evenly distributed between care in institutional settings (52%) and home-based care (48%) (NHIS, 2014).

Centralized or locally managed? Integrated or atomized? Private or public? Organizing the system's administration

Colombo et al. (2011) distinguish three types of systems based on the way services are provided: i) single system (centralized); ii) multiple benefits and; iii) services and programs. This classification refers to both, the system's management and its decision-making process.

The centralized system has the advantage of ensuring broad access to services, guaranteeing coverage, and facilitating coordination in the provision; its main disadvantage is its cost: because coverage is larger, these schemes are typically more expensive. The three countries chose as examples, fall into this category, with services provided through a single, well-defined LTC system.

Mixed systems provide services through different programs, including some with universal coverage and others with limited coverage. In this case, countries do not have a single service delivery system, but multiple benefits, programs, and entitlements, according to their target populations and service offered. These schemes can be, in turn, divided into three groups:

- (1) Universal parallel schemes: include countries where different schemes provide universal coverage for different services. For example, in Scotland, nursing services are universal and provided by the health system, while personal care services are also universal but provided through the social system.
- (2) Income-related universal benefits: a single system in which beneficiaries are chosen based on their care needs but benefits are adjusted according to their income (as in France or Australia).
- (3) Mix of universal and means-tested benefits: systems that usually offer universality in some benefits (such as access to home-based or institutional care) with others in which access is restricted according to socioeconomic status (for example, monetary subsidies).

Finally, there are countries where there is no central coordination for the delivery of LTC services; instead, benefits are provided through a set of programs and initiatives, like in Chile (Villalobos Dintrans, 2017).

Financing: who pays for LTC, in what setting, and at what cost?

The discussion on financing LTC can be carried out from different angles. On the one hand, there is a distinction between sources and uses of resources, i.e. how money is collected and allocated. This perspective poses

a dilemma, typically, between public and private resources. Although the discussion regarding the origin of the resources can be seen as irrelevant (money always come from individuals), the focus of the analysis has been traditionally put on the way in which resources are collected (taxes, voluntary contributions/mandatory, private pocket expense). Additionally, when discussing on LTC, a different dimension is added: not only the debate about public versus private matters but also the discussion of LTC as health or social expenditure. As stated before, the existence of an LTC system recognizes the need to generate a financing scheme under the assumption that the financial burden of these services exceeds the families' ability to pay and cannot be covered by the private market (Brown & Finkelstein, 2009; Geraedts et al., 2000; Mot, 2010).

Private versus public? Central or local government? General taxes or social insurance? Compulsory or voluntary contributions? Sources of financing

Although in general LTC systems are financed through public expenditure (*via* taxes), recently a group of countries have implemented social insurance to deal with the financial risk of an LTC system. As stated by Ikegami and Campbell (2002) both alternatives have their pros and cons: while tax-based models are more flexible in providing benefits according to people's needs and allowing fiscal expenditure control, providers usually face weak incentives for performance. On the other hand, social insurance schemes are more rigid but give explicit entitlements to individuals based on objective selection criteria, sometimes causing "waste" of resources by financing people that could afford the services, and because it requires paying the costs of running the system.

Like the other LTC system's components, financing alternatives are multiple and the essential issue is to ensure coherence between these elements. For example, the United States tried to implement an LTC insurance, as part of the health reform (Affordable Care Act, ACA) carried out in 2010. The initiative—known as CLASS Act (Community Living Assistance Services and Supports Act)—sought to create a market for LTC insurance, identified as small (Brown and Finkelstein, 2007, Brown & Finkelstein, 2009). CLASS was designed as a voluntary LTC insurance, where people would contribute to the system during their working years and then could access LTC services (institutional or home-based care). This design was weak since it wanted to fulfill two opposing objectives: being non-mandatory and self-financing. The system was subject to adverse selection (given its voluntary nature) and moral hazard (since the benefits could be used in different ways), threatening its financial sustainability (Gleckman, 2011; Norton, 2016). These problems explain why this initiative was deleted from the budget and finally repealed in 2013.

Germany has an LTC insurance scheme that is part of the country's social security system. The scheme was established in 1995 (Long-Term Care Act) and institutes a compulsory insurance for all residents, in order to cover the needs of people who cannot live independently. Prior to this scheme, LTC was financed directly via out-of-pocket expenditure. The system is financed through compulsory contributions, corresponding to 2.35% of the salary; paid in equal parts between employee and employer, and is administered by LTC funds. The system works as a pay-as-you-go scheme, where LTC funds negotiate with providers on the conditions of the service (quality) and prices and the Ministry of Health is the legal responsible and regulator of the system (Colombo et al., 2011; Federal Ministry of Health, 2014).

Long-term care insurance is part of the Dutch health insurance scheme. LTC services entitlements are supported by different legal bodies, such as the Exceptional Medical Expenses Act of 1968 and the Long-Term Care Act of 2015. LTC funds are collected and deposited in the Long-Term Care Fund, administered by the National Institute of Health Care. The fund is financed through mandatory contributions and public funds: i) 9.65% of taxable income; ii) contribution based on income; iii) public funds (if necessary). The fund's administration and payments are carried out at central level through health insurers (for institutional care), while payment for home care is made through the municipalities (Government of the Netherlands, 2016; MPHWS, 2016; Schäfer et al., 2010).

Likewise, the Republic of Korea established a specific fund for long-term care (Long-Term Care Insurance Act of 2008), with the aim of preserving and improving the quality of life of older adults and their caregivers, promoting better health and a stable life, and reducing the burden of care (Kang et al., 2012). The fund is managed by the National Health Insurance Corporation, while the services are delivered by private providers. The fund is financed by a combination of i) mandatory contribution to LTC insurance, corresponding to 6.55% of contributions made to compulsory health insurance (6.12% of salary) (68% of financing); ii) contributions from the central government and municipalities (12% of financing); iii) co-payments (20% of financing) (NHIS, 2014).

Health or social expenditure (or other)? Labeling the money

The health-social divide reemerges when analyzing LTC financing. The debate regarding the “institutional ownership” of LTC is related to the administration of its budget and if LTC spending should be considered as health expenditure, social spending or something else, trying to answer the question: who should pay for what? For example, Colombo et al. (2011) make explicit this tension when classifying LTC schemes between those financed

with taxes, systems with LTC insurance, and systems financed through the health system.

Regardless of whether the services offered are classified as health or social, a decision about who should manage the system is also needed. This choice is relevant because it ties the LTC system not only to the budget but also the rules and organizational culture (definitions, access to information, intervention strategy, regulations) of the hosting institution.

Among the selected countries, Germany represents an interesting case, since it allocates its LTC system as an independent pillar of the social security system, along with health, pensions, unemployment, and accidents (Federal Ministry of Health, 2014). In the case of the Netherlands, the LTC system is part of the health system; the Dutch health system explicitly divides curative care, long-term care, and public health, with separate legal bodies, financing, and provision (MPHWS, 2016). The Korean LTC system separates the social and health functions of LTC, with two separate financing schemes (National Health Insurance and Long-Term Care insurance), but a single administration body: the National Health Insurance Services (Kim & Lim, 2015).

Conclusion

The aim of this article is to present a structure to analyze the design of a generic LTC system, highlighting the many choices faced in this process and the need for coherence when deciding between alternatives. Information presented can be used to structure the discussion around the LTC system, making explicit this selection process and promoting discussion on the available alternatives.

The analysis emphasizes the importance of coordinating all the elements within the system, but also coordinating between systems within social security (Villalobos Dintrans, 2018). This is an unsolved issue in many countries (Ikegami & Campbell, 2002; Jeon & Kwon, 2017). Healthcare and social services have different logics that need to be aligned with LTC, especially considering the overlap of beneficiaries and services, as well as the different goals and processes involved.

The article has some limitations that are important to keep in mind. First, the use of three countries to guide the discussion and use real-life examples restricts the whole spectrum of possibilities for an LTC system. The rationale was based on the trade-off between completeness and profundity of the analysis. The chosen examples illustrate the complexity of many decisions regarding LTC but other cases could emphasize different issues and offer alternative solutions. Additionally, the analysis presented ignores an important issue that needs to be considered when thinking about the design of an LTC system: caregivers. Caregivers, particularly informal caregivers, constitute an important piece of any LTC system. Despite their relevance, the analysis is usually carried out

assuming people with LTC needs as the only beneficiaries, following the traditional way to define benefits' recipients in both the health sector and social sector. Moving from a single-beneficiary perspective to a dyad perspective is important and has enormous consequences for the system's design: all decisions regarding the design of the LTC system are now multiplied by two since it should also consider caregivers when defining beneficiaries, benefits, providers, and financing strategies.

It is important to take into account caregivers not only because they are also beneficiaries of an LTC system but also because policies need to consider its impact on other areas. For example, system needs to consider, if its focus is on improving the caregivers' current situation (by providing them support) or generating incentives to increase their participation in formal labor markets (Rodrigues, Schulmann, Schmidt, Kalavrezou, & Matsaganis, 2013). Similarly, policies that encourage the substitution of family caregivers for formal caregivers should also be aware that informal care can have positive effects on patients and caregivers: it can be emotionally rewarding because it can strengthen family ties, honor past service the caregiver received from the person in need of care, and save family resources (Adelman, Tmanova, Delgado, Dion, & Lachs, 2014; WHO 2015). Finally, the LTC system should assess its ability to reduce or perpetuate the gender bias associated to LTC: it is able to offer new opportunities to female caregivers or just replicate the structure of the informal care scheme? (Colombo et al., 2011).

The article presents several choices that need to be considered by policymakers, scholars, and practitioners when thinking of an LTC system. The proposed structure is meant to guide the process but, most likely, will not cover all contingencies and questions. Its goal is not to present the best LTC system but to highlight the complexities of designing one. This is the main message: designing an LTC system entails choices; there are no default options. Countries embarked on the challenge of designing and implementing an LTC system need to consider all the elements and alternatives, prioritizing coherence between choices and taking into account institutional and cultural context. There is no single model that performs systematically better than others; as a result, there are as many LTC systems as countries that have implemented them (Brodsky & Clarfield, 2008; Pot et al., 2017; Weiner, 2011; WHO 2017): the question is not what is the best LTC structure but how to choose between alternatives, in order to have a system that responds to the country's needs, goals, and possibilities. We hope the information presented will be helpful as a guide for the design and implementation of LTC systems—particularly in low and middle-income countries—and will contribute to foster the debate around this important issue.

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