

**Commission** on the  
Future of **Health** and  
**Social Care** in England



**Background paper**

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# The social care and health systems of nine countries

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# **The social care and health systems of nine countries**

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**This paper was commissioned by the independent Commission on the Future of Health and Social Care in England.**

**The views in this paper do not necessarily represent the views of the commission or of The King's Fund.**



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## About this paper

This paper describes the health and social care systems of nine developed countries, selected to represent a range of approaches, and to include countries that have undertaken interesting and novel reforms in recent years. Selections were based on recommendations from experts about countries whose systems would be of interest to the Commission, and the authors' prior knowledge of international health and social care systems.

Each profile briefly describes the entitlements, funding arrangements, approach to delivery, and key issues for health and social care. The profiles are not designed to be comprehensive summaries of the major issues facing each country. Rather, they explore select initiatives, reforms and debates in these countries that are considered to be relevant to the Commission's deliberations on the future direction of health and social care in England. In line with the Commission's core areas of interest, we focus on the funding and entitlement arrangements and do not look in detail at reforms to the way services are organised and delivered.

The paper provides basic details of how each system works, and has drawn heavily on summaries put together by the Commonwealth Fund, European Observatory, Personal Social Services Research Unit (PSSRU) and the Organisation for Economic Co-operation and Development (OECD). Readers seeking more detail are encouraged to consult these comprehensive source documents, which are referenced below.

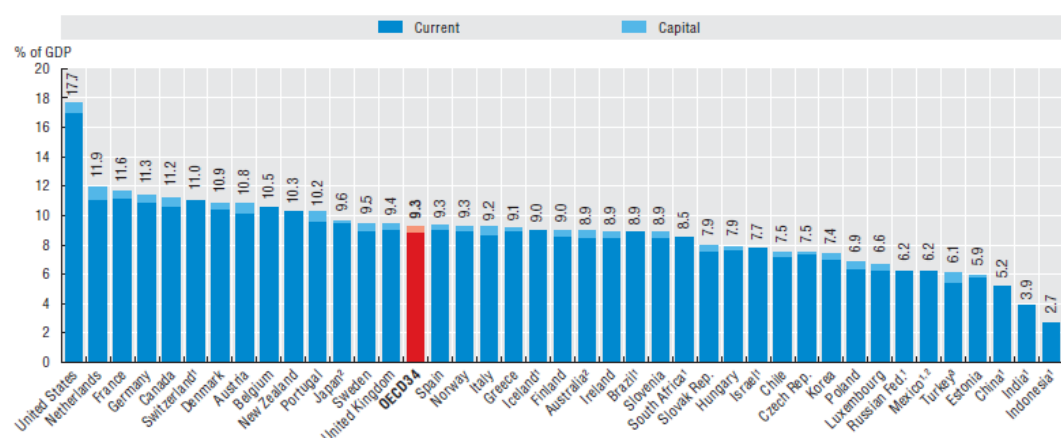
Note: Most monetary amounts have been converted to pounds sterling by the authors using xe.com on 7 February 2013, unless marked with\*\* where conversion to sterling was made in the report referenced.

# 1 Introduction: health and social care spending

The health and social care systems of developed countries face common challenges. Many governments across the Organisation for Economic Co-operation and Development (OECD) have cut or frozen welfare spending since the global financial crisis began in 2007, populations are ageing, and as technology advances, the cost of health care continues to rise.

In 2011, OECD countries spent an average of 9.3 per cent of gross domestic product (GDP) on health care (OECD 2013a). The United States is by far the highest spender, devoting 17.7 per cent of GDP to health care. Meanwhile, the eight other countries profiled in this report have lower expenditure levels, ranging from 7.4 per cent GDP in Korea to 11.9 per cent GDP in the Netherlands (see Figure 1 below). The United Kingdom sits in the middle of that group, spending 9.4 per cent of GDP on health, just above the OECD average. This data includes both public and private spending on health care, including capital investment in health care infrastructure.

**FIGURE 1 Health expenditure as a share of GDP, 2011 or nearest year**



1. Total expenditure only.
2. Data refers to 2010.
3. Data refers to 2008.

Source: OECD Health Statistics 2013, <http://dx.doi.org/10.1787/health-data-en>; WHO Global Health Expenditure Database.

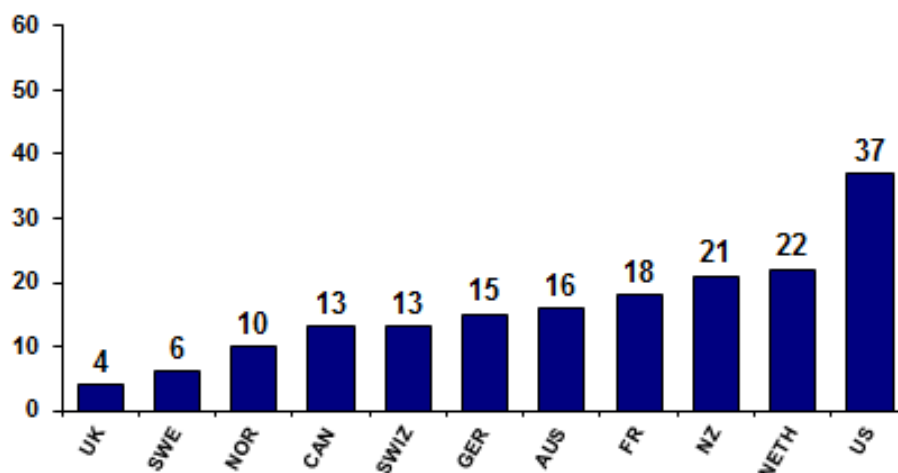
StatLink <http://dx.doi.org/10.1787/888932918871>

High levels of spending do not guarantee affordable access to health care. The Commonwealth Fund’s health policy survey of 2013 found that respondents from the United States and the Netherlands – the two countries that spend the highest proportion of their GDP on health – were those most likely to report that they had gone without needed health care in the past year because of its cost (Schoen *et al* 2013). This included, because of cost: not filling a prescription, not visiting the doctor with a medical problem or not getting recommended care. The lowest level of these cost-related issues getting needed health care was reported in the United Kingdom, where just 4 per cent reported this problem (see Figure 2).



**FIGURE 2 Cost-related barriers to accessing needed health care in the past year**

**Percent experienced cost-related access problem\***



\*Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care.



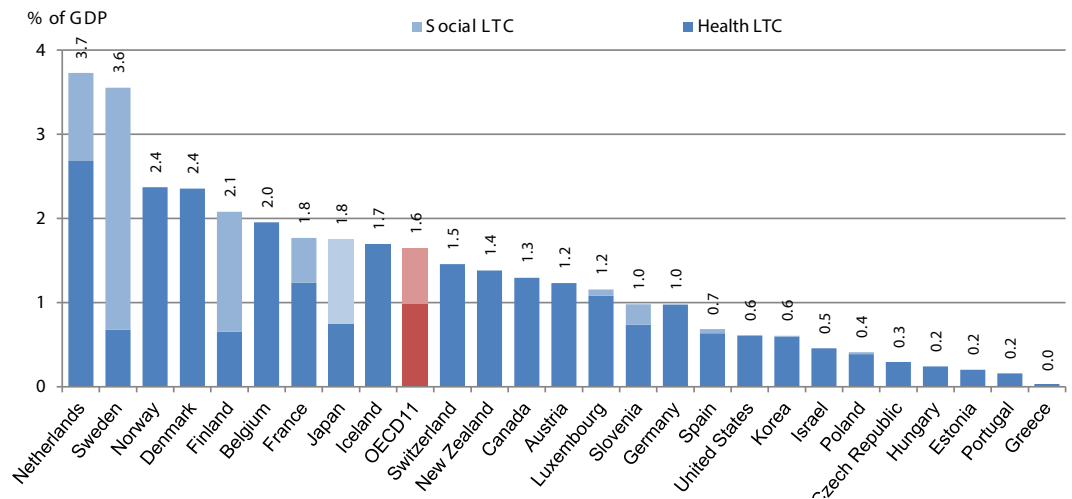
Source: Schoen *et al* (2013). Reproduced with permission from the Commonwealth Fund.

Countries spend a far lower proportion of their GDP on 'long-term care'; public spending in the OECD was an average of 1.6 per cent GDP in 2011 (see Figure 3). This includes spending on health and social care support services for those with chronic conditions who require ongoing support (see Figure 3). However, social care expenditure is increasing at a faster rate than spending on health, particularly public spending on home care, which grew by about 5 per cent a year between 2005 and 2011 (OECD 2013a). There is a wide variation between the amounts spent in different countries. Unsurprisingly, the Netherlands and Sweden, both countries with universal government-funded social care insurance schemes, have the highest rates of public spending on social care among those that report this data to the OECD (see Figure 3). The highest rate of expenditure growth was seen in Korea, which introduced a universal system of long-term care insurance in 2008, and saw real-terms growth in public spending of 44 per cent between 2005 and 2011 (compared with an OECD average of 4.8 per cent) (OECD 2013a). The United Kingdom does not submit data to the OECD on this measure, but information from the Office for Budget Responsibility shows that UK public spending on long-term care was 1.2 per cent of GDP in 2009/10 (The Commission on Funding of Care and Support 2011). It is important to note that countries use different definitions for this data, and some important items that could be defined as social care spending are not included in these figures. For example, in England, the Attendance Allowance is defined as welfare spending.

Data on private spending on social care is more difficult to find, and suffers from under-reporting. However, from the data that is available to the OECD, Switzerland has the highest level of private spending (0.8 per cent of GDP), and among countries profiled in this report, residents of Germany and the United States spend the largest share of GDP on long-term care – 0.4 per cent of GDP (OECD 2013a). This is mostly out-of-pocket spending, as the private insurance market for long-term care is very small.

Unfortunately there is no international survey showing cost-related problems accessing social care that can be compared with the Commonwealth Fund’s survey for health. For this reason we are not able to compare the success of various countries in ensuring access to social care.

**FIGURE 3 Long-term care public expenditure (health and social care components), as share of GDP, 2011 (or nearest year)**



Note: The OECD average only includes the 11 countries that report health and social components of long-term care.

Source: OECD (2013a)

Definition/comparability: The OECD figures for public spending on long-term care include spending on health and social care support services for people with chronic conditions and disabilities who need care on an ongoing basis. The health component includes spending on nursing, personal care services and palliative care and covers services provided in residential care and at home. The social care portion includes assistance with instrumental activities of daily living (ADLs). Social care services sit in different places in different country’s welfare systems, and countries’ reporting practices for allocating spending to the health and social care components may differ.

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## 2 Overview of country profiles

This paper profiles nine countries that take a range of approaches to the provision of health and social care. Nearly all have in common that they have recently reformed their system of health or social care, or that they are currently doing so. Although different histories and contexts make transferring lessons from other countries notoriously difficult, looking across those profiled in this report, a number of observations stand out as relevant to the Commission's deliberations.

- **The NHS is unique in its low level of cost sharing.** All of the health systems profiled in this report, including universal systems that are considered comprehensive such as Sweden and France, charge users fees. These include co-payments for each visit to a health professional, a per day charge for hospital stays, prescription co-pays, deductibles or co-insurance whereby individuals cover a set proportion of their health care costs. These cost-sharing obligations range from minimal (around 80p to visit the GP in France) to more substantial out-of-pocket outlays (20 per cent of the cost of inpatient care must be paid by the user in Korea). Most countries provide means-tested assistance to help those with low incomes meet their cost-sharing obligations, and in some countries private insurance policies are commonly held to cover these costs (see below). While some countries have sought to decrease individual's cost-sharing obligations in recent years (eg, Germany), the principle of paying at least a small fee for each use of the health service is not controversial in other countries.
- **Cost sharing has multiple purposes.** In addition to raising revenue, user charges can be used to manage levels of demand, the location of care or choice of treatment/drug. For example, a lower charge for a GP visit compared with a visit to the accident and emergency department can encourage patients to seek care outside of the hospital. Value-based co-pays, whereby individuals are encouraged to use high-quality or low-cost services through lower co-pays for those services, have been used in many countries, particularly the United States. There is some evidence that they can be effective in encouraging the use of generic drugs, although in countries where private insurance covers cost-sharing obligations, the impact of this approach is lessened.
- **In other countries large portions of the population have private health insurance.** In seven of the nine countries surveyed, between around 50 and 90 per cent of the population have private plans (see Table 1). The role played by private insurance varies between countries and the industry can take on multiple roles in each country. These range from providing comprehensive insurance plans, either as the main coverage provider (in the United States), as administrators of a mandated system of private insurance (the Netherlands) or as an alternative to the statutory health insurance system (eg, Germany), to a complementary role covering cost-sharing obligations in the public system (eg, France, Germany, Japan, Korea, Ireland), covering benefits not available in the public system (eg, Australia, the Netherlands, France), or providing quicker access to care and access to private facilities (eg, Ireland, Australia, England, Sweden). England is unusual

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compared with the countries surveyed in its low level of private health insurance coverage (although the industry is smaller in Sweden). This can be seen as a sign of the comprehensiveness of the NHS benefits package and the financial protection it provides users, as individuals do not feel they need to buy additional private insurance to cover their out-of-pocket liabilities or services that are outside of the NHS benefits package. In Australia, government policies that encourage enrolment in private insurance, including tax incentives and penalties, have been controversial with some because of concern about the equity of diverting government funds away from the public system. The increase in private insurance enrolment in Australia has not produced the hoped for reduction in the demand and financial pressures on the public system.

- **A number of countries have introduced mandatory insurance to cover social care costs; countries have struggled financially and some have had to cut benefits.** The Netherlands was the first country to introduce a universal system of long-term care insurance in 1968. In Sweden, legislation established the right to tax-funded social care in 1982/3. And over the past 20 years, mandatory long-term care insurance (LTCI) schemes have also been introduced in Germany (1995), Japan (2000), France (2002), and Korea (2008). These schemes are universal in that they provide at least some support to all those above a certain level of need, irrespective of their financial situation. However, many are now struggling with financial viability and have had to restrict benefits or raise contributions. The Japanese originally included cover for accommodation costs in their benefits package. By cutting this benefit and tightening eligibility for others, their growth in costs has been kept in line with the growth in the elderly population. In the 1990s the Dutch government addressed rising costs in their system by capping budgets, but this led to waiting lists and the caps had to be abolished. More recently, they have raised the needs threshold for accessing care and have detailed care duties that family members are expected to perform that will not be covered by the programme. In Germany, persistent deficits in their programme between 1999 and 2007 were halted when contribution rates were increased in 2008, although pressure to increase contributions remains. Although both universal and means-tested systems have been under pressure financially in recent years, it can be more difficult to cut eligibility in the entitlement-based universal systems.
- **Most countries surveyed do not have well-functioning private insurance markets to cover social care needs.** Where private markets have emerged they tend to be small and plans are expensive. As in the health system, private insurers take on different roles both within and between countries. For example, in the United States, where insurers provide comprehensive plans that fully reimburse care costs up to a monthly or annual limit, a small market exists in which only the wealthy can afford cover. Comprehensive plans are also available in Germany, where it is mandatory to have long-term care insurance, and higher earners must sign up with a private plan. But this market is highly regulated: premiums must match those in the public system and insurers cannot usually charge higher prices to those with pre-existing health conditions. The exception in terms of the scale of enrolment is France, where 15 per cent of over 40 year olds have private LTCI. Here private plans are mainly brokered through former employers and

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they complement the public system, helping enrolees cover their cost-sharing obligations through a predetermined monthly payout for life once a person becomes 'dependent'. A number of explanations have been put forward for the emergence of this market in France and not elsewhere. These include: France already has a model for this type of complementary private insurance in its health sector; LTCI contributions are tax-exempt; many insurance products provide cash benefits rather than services in kind; plans complement rather than substitute for the statutory LTCI scheme; the cost to insurers of indemnity-type policies is easier to predict as payouts are not linked to the cost of care; and private insurance schemes have adopted some of the same eligibility criteria as the public system. When the Australian Productivity Commission looked into the idea of introducing private LTCI, it concluded that a voluntary scheme would not be financially viable and that it was too late to establish a compulsory scheme, as it would not be possible to collect enough money from people of working age to cover the care costs of their ageing population. In the United Kingdom just 0.05 per cent of the over-40 population have LTCI.

- **Most countries provide more comprehensive coverage of health care than social care needs, but the gap between the two is generally less stark than in England.** Most of the countries profiled provide universal coverage of health care needs with limited out-of-pocket responsibility, and in many countries private insurance markets cover out-of-pocket costs. Notable exceptions are the United States, where 50 million people do not have health insurance; and Ireland, where primary care provision is not universal. Although most countries profiled also provide some form of universal coverage for social care needs, they generally (although not always) leave users with large out-of-pocket costs and few have private insurance to cover these. The distance between a country's health and social care coverage varies between countries, and the prominence of means testing in social care means that the gap between the two benefits packages is usually greater for individuals with higher incomes who often have to pay their full accommodation costs for residential care (see below). It is noticeable that in England, the distance between the relatively generous NHS and the heavily means-tested system of social care support, lies in stark contrast to countries that cover both health and social care needs through social insurance.
- **In most countries, accommodation and daily living costs in residential care are not covered by the social insurance programme and make up a large proportion of residents' total bills.** Government support for accommodation costs is generally restricted to those with low incomes, and some countries set limits on the amount that can be charged based on an individual's assets (eg, Australia, Ireland). Japan was previously an exception, as accommodation costs were originally fully covered by the social insurance system. However, in 2005 this became unaffordable and was stopped. In Australia, residents in 'low-level' residential care can buy a bond on entering the facility. To cover their accommodation costs, the residential institution keeps any interest made on the bond and a proportion of the principal. Similar schemes have been tried in some retirement homes in the United Kingdom.

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- **The family's role in care and the way this is recognised by government differs between countries.** Informal care is treated differently across countries. In Australia and England, for example, the amount of informal care provided by relatives is considered in the social care needs assessment. In Germany, childless adults have to pay an extra 0.25 per cent insurance contribution to reflect the lower level of informal support they have access to. Some other countries make 'carer blind' needs assessments that do not consider informal care when deciding on the level of service to provide (eg, France, Japan). Direct budgets for social care needs are available to individuals in many countries and can be used to pay relatives for informal care (eg, the Netherlands, Australia, Germany, Sweden, France). Often the cash budget is worth less than the value of 'in kind' benefits they could take as an alternative, but they provide more flexibility. Interestingly, in Japan, benefits cannot be taken in cash, a decision taken in part to protect female participation in the workforce.
  - **Means testing can create perverse incentives.** For example, in Australia differences in the means-testing rules for community and residential care mean people sometimes select a type of care based on financial rather than needs-based criteria. Also in Australia, the way providers are reimbursed for the accommodation costs of low income residents can create incentives for care homes to seek out richer patients.
  - **In Australia and the United States, government commissions have been established to find a sustainable settlement for the future funding of social care.** Policies under consideration include home equity release programmes, schemes that encourage individuals to save during their working years to cover care costs later in life, and government-run long-term care insurance initiatives. Agreeing an affordable future funding approach is difficult, and in the United States the Federal Long Term Care Commission failed to reach agreement. It put forward two alternative models for the future funding of long-term care: a social insurance and a private insurance model. These each reflected different underlying beliefs about where responsibility for financing long-term care ultimately lies – with society or the individual.
  - **The funding base for public insurance schemes is changing in some countries.** Traditionally social insurance schemes were funded by income-related contributions from employees and employers. However, in recent years the French statutory health insurance scheme has shifted its funding base so that a third of revenues now come from a bundle of non-wage taxes. This change has shifted the make-up of the insurance fund closer to that of household income, a decreased proportion of which has come from wages in recent years. In addition, the French long-term care insurance scheme and the Australian statutory health insurance scheme are both funded through general taxation. These new funding models blur the line between tax-funded systems and the traditional European model of social insurance based on work-based contributions.
  - **In some countries the administration of their health and social care systems is integrated; none have pooled budgets.** For example in Korea and Sweden their long-term care insurance schemes are administered by the national health insurance programme. In



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Germany health insurance funds administer the long-term care insurance programmes and most people get both types of insurance from the same provider. The United States was the one example among the countries profiled of more integrated funding of health and social care, as the Medicaid programme provides safety net coverage of both health and some social care for Americans with very low incomes. Although we did not consider delivery models in detail, it was notable that in Japan health care providers are expanding into social care provision, integrating delivery in one organisation.

- **Major reforms are possible.** The profiles include a number of examples of radical changes to the funding and entitlements available in health and social care. These include: in the Netherlands, a move from social insurance model for health care to managed competition between private insurers; in the United States, sweeping reforms of the private health insurance market with government subsidies to expand coverage; in France, Germany, Japan and Korea, the introduction of social insurance schemes to pay for long-term care; and in Ireland the move currently underway towards a Dutch-style system of health care financing.
- **Major reforms take time and are dependent on local context.** A long period of time and political consensus is required to successfully agree and implement a major reform package. Even apparent 'big bang' approaches were often preceded by failed attempts at reform and the incremental introduction of smaller initiatives that paved the way for more radical change. Health system reform in the Netherlands took 20 years; there were two failed attempts at reforming the social care system in France before success in 2002; the United States had numerous failed attempts to agree comprehensive health reforms before the Affordable Care Act was passed in 2010, and attempts to agree reform to the funding of social care have so far failed; and in Korea it took 30 years to move from the initial establishment of a national health insurance scheme to a comprehensive system with a single insurer. Although this shows reform is possible, crucially, the structure of health and social care systems in each country and their potential for reform is very country specific – they are governed by history and cultural context. A model that is highly effective in one country may have a completely different impact if transferred to another.
- **No one country or model of provision emerges as an ideal.** In a comparative analysis of the extent to which health systems deliver cost-effective care, the OECD found more variation within groups of countries with similar characteristics than between them, and that no one model could systematically be viewed as the most effective (OECD 2010). Across the countries profiled in this report there is no one star performer.

**TABLE 1: Characteristics of the health and care systems of England and nine other countries**

	<b>UK</b>	<b>Australia</b>	<b>France</b>	<b>Germany</b>	<b>Ireland</b>
Population (1) (millions)	61.3*	22.3	63.2	81.8	4.6
Population over 65 (%)* (2)	16	14	17	21	11
Life expectancy (2))	81.1	82	82.2	80.8	80.6
<b>HEALTH CARE</b>					
Health spending (% GDP) (2)	9.4	8.9*	11.6	11.3	8.9
Type of public coverage	National Health Service	Public insurance – Medicare	Statutory health insurance	Statutory health insurance	National Health Service
Universal	Yes	Yes	Yes	Yes	Not primary care
Main funding source	General taxation (inc employment-based national insurance contributions)	General taxation, 1.5% income tax	Employer/employee contribution, earmarked income tax + other taxes	Employer/ employee + pensioner/ pension contributions	General taxation
Private insurance role	~11% in England have it to access private facilities (3)	50% have it for private facilities + additional services (3)	~90% have it for cost sharing, some provide additional services or alternative to SHI (3)	~10% take private plan as alternative to SHI; ~20% have for cost sharing and private facilities (3)	47% have private insurance for hospital cost sharing, quicker access to care (4)
<b>SOCIAL CARE</b>					
Social care public spend (% GDP) (2)	–	–	1.8	1	–
Type of public coverage	Means tested government assistance	Means tested government assistance	Statutory LTC insurance (c.2002)	Statutory LTC insurance (c.1995)	Means tested government assistance
Universal	No	No	Yes	Yes	No
Public funding source	General taxation	General taxation	General taxation	Employer/employee + pensioner contributions	General taxation
Private insurance role	Very small LTCI market 0.05% of over 40 population (7)	Wealthy pay out of pocket. Tiny LTCI market (7)	15% of population age 40+ have private LTCI to cover cost-sharing obligations in the public system (8)	Option to take private plan to fulfill statutory requirement (~9% have). Supplementary plans available for costs not covered by statutory LTCI (3.5% age 40+ have) (7)	No

(1) OECD country statistical profiles: <http://stats.oecd.org/>, figures are for 2011, except \* indicates 2010 data.

(2) OECD (2013). *Health at a glance: OECD indicators*. Paris, France: OECD Publishing. Available at: [www.oecd.org/health/health-at-a-glance.htm](http://www.oecd.org/health/health-at-a-glance.htm). Figures are for 2011, or nearest year. See Figure 8.1.1; figure 1.1.1; figure 7.2.1; figure 8.9.1

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	Japan	Korea	Netherlands	Sweden	USA
Population (1) (millions)	127.8	49.8	16.7	9.4	311.6
Population over 65 (%)* (2)	23	11	15	18	13
Life expectancy (2))	82.7	81.1	81.3	81.9	78.7
<b>HEALTH CARE</b>					
Health spending (% GDP) (2)	9.6*	7.4	11.9	9.5	17.7
Type of public coverage	Statutory health insurance	Statutory health insurance	Statutory private health insurance	National health service	Medicare for 65+, Medicaid for low income
Universal	Yes	Yes	Yes	Yes	No
Main funding source	Employee/ employer contributions, general taxation	Employer/ employee contributions + general taxation	Premium, employer/ employee contribution + general tax revenue	General taxation	Premiums (employer +/- or employee), federal + state general tax revenue, Medicare tax
Private insurance role	70% have plans linked to life insurance policies that give cash pay-out when ill, some have for cost sharing (3)	76% have for cost sharing and cash payouts when ill (5)	Main insurer for mandated core benefits + ~90% have for cost sharing + non-covered services (3)	<5% have for private facilities (3)	56% of population have private employer or individual plans + some Medicare enrollees buy private top up plans (3)
<b>SOCIAL CARE</b>					
Social care public spend (% GDP) (2)	1.8	0.6	3.7	3.6	0.6
Type of public coverage	Statutory LTC insurance (c.2000)	Statutory LTC insurance (c.2008)	Statutory LTC insurance (c.1968)	National LTC service	Means tested government assistance (Medicaid)
Universal	Yes	Yes	Yes	Yes	No
Public funding source	Age 40+ employee/ employer contribution, age65+ pensioner contributions. General taxation	Employer/employee contributions + government contributions	Employee/employer contributions	Local taxation and government grants	State and federal tax revenue
Private insurance role	Small market exists - plans available as alternative to public system, and to cover cost sharing in public system (8)	No	No	No	Approx 5% of 40+ year old population have LTCI (7)

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## Report sources

The following are the major sources of data for this report.

Commonwealth Fund international country profiles

Available at: [www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717\\_Thomson\\_intl\\_profiles\\_hlt\\_care\\_sys\\_2013\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf).

*Health systems in transition* series

Published by The European Observatory on Health Systems and Policies.

Available at: [www.euro.who.int/en/about-us/partners/observatory/health-systems-in-transition-hit-series](http://www.euro.who.int/en/about-us/partners/observatory/health-systems-in-transition-hit-series).

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## 3 Country profiles

### *Australia*

#### **Context**

Australia has a population of 22 million, the overwhelming majority of whom (89 per cent) live in urban areas located around the country's coastline. Average life expectancy of 82 years is one of the highest in the world. Australia's health expenditure in 2010 was 8.9 per cent of GDP, just below the OECD average.

#### **Entitlements**

##### ***Health care***

The publically funded health care system, known as Medicare, provides universal coverage for all citizens and permanent residents (Healy and Dugdale 2013). This includes free or subsidised access to inpatient and ambulatory health services, prescription drugs, and some allied health services. A range of additional services such as population health, mental health, some dental and physical therapy, rural and indigenous health programmes, and veterans' programmes are also provided, usually jointly funded by national and state/territory governments. Inpatient care is free to users, and the government reimburses between 85 and 100 per cent of the cost of out-of-hospital services. Either patients pay upfront and claim money back from the Medicare programme, or providers 'bulk bill' Medicare directly without charging the user. There are caps on out-of-pocket expenditure that are lower for the old and those with low incomes, and subsidies are available to help patients cover pharmaceutical co-pays.

Approximately half of the population has private health insurance that provides access to private hospitals, and private facilities in public hospitals, and also covers services that are not in the Medicare benefits package such as dentistry, eye care and complementary medicine (Healy and Dugdale 2013).

##### ***Social care***

As in England, the Australian social care system is not universal and government assistance focuses on those with low incomes. The services provided are based on an assessment of an individual's need, and charges are determined by a means test. A range of services are offered by national and local government. These include residential care for individuals with high (complex care, equipment and therapy needs) and low (everyday accommodation and some personal care services) care needs; community care packages for those who are eligible for residential care, but prefer to stay at home; and home and community care (HACC), a lower level of support, often for less than two hours a week, that includes cleaning and personal care (Forder and Fernandez 2011).

In residential care, individuals make a means-tested contribution to their care costs, and pay accommodation costs and daily living expenses themselves. Regulations define a maximum amount each person can be charged for accommodation, based on their assets, and a maximum daily living charge. In

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low-level residential care, residents can be asked to buy an accommodation bond to cover their accommodation costs, which is effectively an interest free loan to the residential provider. In 2009/10 the average cost of high-level residential care was £850 per week and the average recipient paid 26 per cent of that cost themselves (Forder and Fernandez 2011). In low-level residential care user contributions are higher; on average individuals pay half of their costs themselves. Users pay less of the cost of their community care, between 4 and 10 per cent on average, depending on the type of package delivered (Forder and Fernandez 2011). The government covers the full cost of HACC services (lower level community support such as cleaning) in states that signed up to the National Health Reform Agreement, and since 2012 there has been an option for individuals to receive a personal budget and tailor the service to their own needs (Healy and Dugdale 2013).

Community and residential services are rationed by limiting entitlement approvals and operating waiting lists. There is a maximum number of people who can receive care services at any one time, based on a set proportion of the at-risk population. HACC services are prioritised within a set budget based on need (Forder and Fernandez 2011).

## **Funding**

### ***Health care***

Medicare is funded through a combination of general taxation, patient fees and a means-tested 1.5 per cent income tax. In 2010/11 private health insurance accounted for 7.6 per cent of total health expenditure (Healy and Dugdale 2013). Overall, more than two-thirds of health expenditure in Australia is government funded with the rest funded through out-of-pocket contributions and private insurance payments (Healy and Dugdale 2013).

### ***Social care***

Social care services are mainly financed through tax revenue and user charges. As in England, wealthier people often pay the full cost of their care out of pocket, up to the government defined limit, and it is difficult to buy private insurance to cover these costs (Forder and Fernandez 2011). Two-thirds of government spending on social care goes towards the costs of residential care, while one third is spent on community, assessment and information services (Forder and Fernandez 2011).

## **Delivery**

### ***Health care***

GPs act as gatekeepers and are mostly self-employed, working in group practice. Patients are not required to register with a GP, but Medicare will only reimburse specialist care that follows a GP referral. Nurses play an important role in general practice and are usually employed by GPs to work alongside them. A small number (8 per cent) of GPs are now contracted by private agencies (Healy and Dugdale 2013). GPs are paid fee-for-service (FFS) and also receive incentive payments for achieving Royal Australian College of General Practitioners accreditation standards, which focus on areas such as health IT, managing patients with chronic conditions and teaching students. There are a

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variety of arrangements in place for out-of-hours care, with the most common being provision through a private company arranged by the GP practice.

Around two-thirds of hospital beds are publicly owned, and a third located in private and non-profit hospitals. Physicians are either salaried for work in public hospitals and paid FFS for their private patients, or do the majority of their work in private hospitals and receive FFS payments when treating public patients. Many physicians work exclusively in private practice. In rural areas, GPs often have admitting rights to the local hospital, but this is rare elsewhere (Healy and Dugdale 2013).

### ***Social care***

Non-profit organisations are the main providers of residential care (59 per cent of beds), a third (35 per cent) is provided by for-profit providers and just 6 per cent by national and state governments (Forder and Fernandez 2011). Community care is also predominantly provided by non-profit organisations (more than 80 per cent) with a small amount of for-profit and government provision (Forder and Fernandez 2011).

### **Key issues**

#### ***Moves to expand private health insurance coverage***

Following the introduction of Medicare in 1984 rates of private health insurance (PHI) coverage declined. In response to this, the government introduced a series of reforms during the 1990s to encourage Australians to buy private health insurance. The reforms had three key components.

- A rebate of 30 per cent of the cost of private health insurance premiums, provided by government to all enrollees whose plans covered hospital care (originally only open to those with low incomes, then opened up to all, but now means tested) (Department of Health 2014).
- The Medicare Levy Surcharge – an additional 1 per cent income tax for individuals who did not have private health insurance and earned more than around £27,000 a year.
- Lifetime health cover (LTHC) – a policy whereby the insurance premiums of those who did not sign up for private health insurance early in life were increased by 2 per cent for every year after age 30 that they were uninsured. The enrollee was required to pay the additional premium for the rest of their life, but the excess charge was capped at 70 per cent.

There is some debate about the relative effect of each component of these reforms on levels of private insurance cover, however, the lifetime health cover policy is widely regarded as having had greatest impact (Butler 2002). Although private insurance cover levels rose slightly after the rebate policy was introduced, the major enrolment gains occurred between the announcement of the LTHC policy and its implementation, when coverage levels increased from 31 per cent to 43 per cent of the population (Butler 2002). It has been argued that if the LTHC policy had been introduced on its own, without the rebate policy, it would have achieved much of the increase in enrolment without the large government outlay (Butler 2002). Private insurance subsidies is the fastest growing component of health expenditure and cost the government around £2.5 billion in 2010/11 (Australian Institute of Health and Welfare 2012, p 27).

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Despite successes in increasing enrolment, the reforms did not achieve their ultimate aim of easing financial and demand pressures in the public system (OECD unpublished note). The reforms have also been criticised for disproportionately benefiting the rich, who in general pay more for their health plans meaning they received a greater subsidy, and of diverting government funds away from the public system. To address this inequity, from 2007 onwards, further reforms introduced a means test for the premium subsidy, and increased the Medicare tax levy for high earners who did not have private health insurance. Still, the extent of support provided by government to the private health insurance industry is an issue of much political debate in Australia.

### ***The Australian Productivity Commission – the future funding of social care***

In the social care system, there are concerns about ongoing financial stability, and it is likely that user contributions will increase in the near future. Although many benefits are means tested, the Australian system is more generous than the English system: public spending per capita for those aged over 65 is 60 per cent higher; the government covers more community services; and user contributions are lower (Forder and Fernandez 2011). The Australian Productivity Commission's Inquiry into Aged Care investigated three different options for the future funding of older people's care (Productivity Commission 2011).

The first option was to encourage working-age individuals to save money during their working lives to pay for care in older age, either via private savings accounts or superannuation. One problem with this approach is the unpredictable nature of long-term care costs. Most people will have moderate care costs and will save more than is needed to cover them. A small number will have very high care costs, but these are likely to be the people least able to save, so they are unlikely to have enough money to pay for their care. Because of this, the Commission viewed the ideal policy solution as one that protects people from high social care costs, while encouraging them to save money during their lifetime to cover normal/predictable costs of long-term care.

The second option was a home equity release scheme in which new financial products are developed to allow older people to draw on the equity in their homes to pay for care. As many people already save during their lifetimes through buying a house (83 per cent of Australians aged over 65 own or are buying their home), freeing up this money to pay for social care could solve the funding problem without crowding out incentives to save for other things earlier in life, such as a house (Productivity Commission 2011). Home equity release schemes already exist in Australia but are not widely used. They can be complex, with high interest rates and fees, and are vulnerable to changes in property prices and interest rates. The Commission recommended the establishment of a public equity release scheme which would build public confidence in these financial products, reduce the risk of exploitation and, by operating at scale, reduce the administrative costs of providing these products.

Finally, the Commission considered long-term care insurance policies. It felt that ideally the government or insurance companies would play a role in redistributing money from low- to high-intensity users. However, it concluded that voluntary long-term care insurance was unlikely to be financially workable,



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and due to the ageing population it is now too late to establish a compulsory insurance system that would collect enough money from the working-age population to cover the increasing care needs of the ageing population (Productivity Commission 2011).

### ***Perverse incentives in long-term care***

The Australian social care system suffers from a complex set of means-testing rules, which are difficult to understand, and can create perverse incentives. For example, differences in the means-testing rules for community and residential care mean people sometimes select a type of care based on financial rather than need-based criteria (Forder and Fernandez 2011). There is also an incentive for care providers to 'cream skim' patients with higher incomes. In residential care, individuals with lower incomes pay lower accommodation costs because of government subsidies. However, due to the way the subsidy is calculated, providers still bear some of the accommodation costs of low income residents themselves (Forder and Fernandez 2011). In community care, individuals with incomes higher than the full state pension pay more towards their care. In both settings it financially benefits providers to seek out patients with higher incomes. The Productivity Commission recommended a number of changes to the regulations on accommodation cost reimbursement to address this.

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## *France*

### **Context**

France has a population of 63 million. Average life expectancy of 82 years is one of the highest in the OECD, second only to Japan among countries profiled in this report. Spending on health care was 11.6 per cent of GDP in 2011, the third highest among OECD countries. Public spending on long-term care was also above the OECD average at 1.8 per cent of GDP.

### **Entitlements**

#### ***Health care***

France has a universal statutory health insurance (SHI) system that covers all residents. Services covered include hospital care, rehabilitative services, outpatient services provided by GPs, specialists, dentists and midwives, diagnostic services, prescription drugs, medical appliances and health care related transport. Some long-term care and mental health services are covered, and the SHI makes a small contribution to dental and eye care. There is more limited coverage of preventative services, although adults aged over 65, those suffering from chronic disease, pregnant women, and newborns receive full reimbursement of certain immunisations and screening services (Durand-Zaleski 2013).

Individuals are required to cover a proportion of their care costs through co-payments, co-insurance and extra billing (when a provider charges more than the SHI reimbursement rate). These charges vary by the type of care provided. Individuals must pay co-insurance payments for inpatient care (20 per cent of full cost of care), doctor visits (30 per cent) and dental care (30 per cent). Drugs defined as highly effective are exempt from co-insurance, while others are subject to co-insurance rates of between 40 and 100 per cent. Most of the population have private health insurance to cover these cost-sharing obligations, but there are various additional co-payments that cannot be reimbursed by private plans (Durand-Zaleski 2013). These include approximately £15 per day for inpatient stays, £11 per day for care in psychiatric wards, 80p per doctor visit, 40p per prescription, £1.60 per ambulance journey, and £15 for hospital treatment that costs more than £100 (Durand-Zaleski 2013). The co-payments are capped at £40 a year. People with low incomes receive free or low-cost supplementary private health insurance and free vision and dental care. Chronic condition sufferers are exempt from prescription co-pays.

#### ***Social care***

France has a universal mandatory long-term care insurance scheme called the Allocation Personnalisée Autonomie (APA) that was introduced in 2002. It provides at least some assistance to all residents aged over 60 who have care needs above a government determined threshold (Forder and Fernandez 2011). Needs are categorised on a six-point scale that accounts for capacity to conduct daily activities and mental health status. The needs assessment is 'carer blind' meaning it does not take into account the amount of care provided by relatives when assessing a person's care requirements. The means test is based on taxable income and some assets, but does not include the value of



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someone's home, as long as a close family member (spouse, child, grandchild) is still living there.

In residential care individuals pay for their own accommodation costs and personal expenses, and those with low incomes receive a subsidy towards this. Their nursing care is paid for by the state health insurance system, and other personal care ('dependent care') is paid for by the individual using their APA benefit and their own contributions (Forder and Fernandez 2011). The average per person out-of-pocket payment for nursing home care is approximately £1,230 a month (Durand-Zaleski 2013).

For home care, the extent of financial support and the type of service provided depends on an individual's level of need, and their financial means. The government covers between 0 and 90 per cent of the cost of a person's care package, up to a maximum which differs by the level of care provided. Above that threshold, individuals must pay the full cost of their care. Although the APA subsidy cannot be used to pay a spouse or partner for providing informal care, it can be used to employ another relative or carer to perform specific tasks that are part of a defined care package (Forder and Fernandez 2011).

## **Funding**

### ***Health care***

The statutory health insurance system is funded through payroll taxes (43 per cent), a national earmarked income tax (33 per cent) and other revenue streams such as tobacco and alcohol taxes and state subsidies (Durand-Zaleski 2013). The vast majority (92 per cent) of the population have private health insurance to cover their cost-sharing obligations, provided through employers or via a mean-tested vouchers programme (Durand-Zaleski 2013). Supplementary private health insurance that covers services not included in the statutory benefits package is also available from non-profit and private providers.

Three major statutory health insurers cover more than 90 per cent of the population. Enrolment is based on occupation, so there is no competition between funds but levels of contribution and benefits vary between funds. Most private health insurance is provided by non-profit mutual associations and provident institutions. Private providers are beginning to enter the market and offer comprehensive plans covering SHI and additional services. However, overall, more than three-quarters of total health expenditure in France remains publicly funded (Durand-Zaleski 2013).

### ***Social care***

The APA is funded by general taxation at central and regional government level. The scheme covers part of the cost of care for those aged over 60, depending on need and financial means. For some people with home care needs below the level covered by the APA, a home help allowance is available called Caisse Nationale d'Assurance Vieillesse (CNAV) (Forder and Fernandez 2011).

To cover additional costs there is a fairly large private long-term care insurance market; around 15 per cent of the population aged over 40 had private plans in 2010 (OECD 2011b). Insurance premium payments are not taxable, and are not included in the APA means test. Indemnity policies, whereby individuals

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receive a predetermined income once they reach a certain level of dependency, are the most popular type of LTC insurance policy (OECD 2011b).

The government has also introduced tax incentives to encourage people to pay privately for their own care. Families can deduct 50 per cent of the cost of employing personal and domestic staff at home from their tax contributions, and 25 per cent of residential care costs, up to a maximum set by government. The incentives do not apply to private payments for care covered in part by the APA subsidy (Forder and Fernandez 2011).

## **Delivery**

### ***Health care***

Most GPs (68 per cent) and many specialists (51 per cent) are self-employed, and most work in offices as solo practitioners (Durand-Zaleski 2013). They are paid through fee-for-service payments. Since 2009, various pay-for-performance schemes have been introduced that reward physicians for the care of patients with chronic conditions, prescription of generic drugs, and completing some preventative care and screening activities. GPs have not traditionally performed a gatekeeping role in the French system, however in 2004 a voluntary scheme was introduced that allows adults aged 16 and over to pay lower co-pays for visits and prescriptions if they register with either a GP or specialist gatekeeper. Although the majority of the population choose a GP as their gatekeeper, a small proportion select a specialist to take on this role. Out-of-hours care is provided in a variety of ways including public out-of-hours facilities financed by SHI and some public and private hospitals.

Around two-thirds of hospital beds are in government or non-profit facilities, with the remaining third privately owned (Checreul *et al* 2010). Hospital physicians are salaried, and the hospital reimbursement system is based on diagnosis related groups (DRGs).

### ***Social care***

Residential care is provided at three levels: collective housing, where almost no medical care is available (154,000 places in 2007); retirement homes, which offer some medical care (470,000 beds in 2007); and long-term care units, located in residential homes or hospitals, which provide more complex medical care (70,000 beds in 2007) (Checreul *et al* 2010). 57 per cent of residential care facilities are publicly owned, 27 per cent are not-for-profit private institutions and 16 per cent are for-profit facilities (OECD 2011a). Intermediary services have also been introduced over the past decade to provide respite care for frail older people who are not in residential homes (Checreul *et al* 2010).

Home care is mainly provided by self-employed physicians and nurses, with some provided by community nursing services. Community nursing services are mainly private non-profit organisations, although some are publicly owned and this care is paid for by the public health insurance system (Checreul *et al* 2010).

## **Key issues**

### ***Health care cost control***

The French health system is considered by some to be one of the best in the

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world, because of its universal coverage, fast access to treatment and high patient satisfaction scores (Durand-Zaleski 2013). However, levels of health care expenditure are high, and cost control is a major issue for the French government; the statutory health insurance scheme has reported large deficits for the past 20 years. A number of initiatives have been introduced to help reduce the deficit, including: the introduction of gatekeeping (see above); a reduction in the number of hospital beds; the introduction of a basic benefit package for the management of chronic conditions; some restrictions on reimbursement of transportation for patients with chronic conditions; and a number of initiatives aimed at controlling pharmaceutical costs, the most effective of which has been a scheme whereby patients who agree to receive a generic version of their prescriptions are exempt from co-pays (Thomson *et al* 2013). However, the impact of lower co-pays for generic drugs in the social insurance programme is mitigated by the fact that much of the population has private health insurance to cover co-pays (Thomson *et al* 2013). Together, these measures have helped reduce the SHI deficit from 12 billion euros in 2003 to 7.7 billion euros in 2013 (Durand-Zaleski 2013).

### ***Changes to health care funding base***

In recent years, France has also sought to broaden its health care funding base. Statutory health insurance was originally funded solely through wage-based contributions from employees and employers. However, more than a third of SHI funding now comes from the Contribution Social Généralisée (CSG). This is a group of taxes applied to non-wage income sources such as financial assets, investments, pensions, unemployment benefits, disability benefits and gambling, as well as wages. France has changed the make-up of its health care funding base in response to the changing nature of household incomes. The share of French household income that comes from labour (mainly wages) decreased from 80 to 71 per cent between 1970 and 2011 (World Bank, forthcoming).

### ***Introduction of mandatory social care insurance***

France reformed its social care system in 2002, introducing a universal social insurance scheme in which care and support are provided based on need and financial means. These reforms were driven by social values and the view that financial risks of long-term care faced by older people should be mitigated communally by the welfare state (Forder and Fernandez 2011). There were two previous attempts to introduce reforms to the social care system, but they failed following low take-up (Gleckman 2010). The new system has been popular, however, and both the number of people receiving assistance and the cost of implementation have exceeded initial predictions (Forder and Fernandez 2011). However, despite being a universal system that provides some assistance to all in need, the APA is not a generous programme. Individuals must have relatively high levels of impairment to qualify, and many pay large amounts out of pocket. Someone earning more than £26,000 a year would pay 90 per cent of their care package costs (Forder and Fernandez 2011).

### ***Private insurance for social care needs***

Unlike England, the French have a fairly large and developed long-term care private insurance market, with three million policy-holders in 2010 (Forder

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and Fernandez 2011). This is the largest market in the OECD in terms of the proportion of the population covered by these plans (OECD 2011b). Reasons put forward for the take-up of private LTC insurance in France and not in many other developed countries include: France already has a model for this type of insurance in its health sector; long-term care insurance contributions are tax exempt; many insurance products provide cash benefits rather than services in kind; and private insurance schemes have adopted some of the same eligibility criteria as the public system (Forder and Fernandez 2011). Also, the French LTC insurance market complements rather than substitutes for the public system, providing a fixed income to those who are determined as being 'dependent' that can be used to pay expenses which are not covered by the APA (OECD 2011b). These indemnity policies help insurers manage financial risk, as payouts are fixed and not related to the cost of care.

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## *Germany*

### **Context**

Germany has a population of 82 million and average life expectancy is 81 years. In 2011 Germany spent 11.3 per cent of its GDP on health care and public spending on long-term care was 1 per cent of GDP.

### **Entitlements**

#### ***Health care***

Germany has a statutory health insurance (SHI) scheme that covers all employed citizens who earn less than around £3,600 per month (Blümel 2013). Those earning more than this, as well as civil servants and the self-employed, can choose to buy a private health insurance plan (that often covers a wider range of services), or to be covered by the SHI scheme. Health insurance is mandatory for pensioners, and if they were formerly insured with an SHI they are entitled to membership of an SHI of their choice. Otherwise they must insure themselves privately.

The SHI scheme covers preventative services, inpatient and outpatient hospital care, physician services, mental health care, dental care, optometry, physical therapy, medical aids, rehabilitation, hospice and palliative care, sick leave compensation and all prescription drugs. SHI preventive services include regular dental check-ups, well-child check-ups, basic immunisations, check-ups for chronic diseases, and cancer screening at certain ages. There is a co-payment of around £8 per inpatient day for hospital and rehabilitation stays (for the first 28 days per year), and £4 to £8 for prescribed medical aids. There is also a co-payment of £4 to £8 per outpatient prescription, unless the price is at least 30 per cent less than the reference price – in practice more than 5,000 drugs are effectively free of charge (Blümel 2013). Individual health services out of the range of SHI coverage are offered to patients on an out-of-pocket basis.

Cost sharing is capped at the equivalent of 2 per cent of household income. The cap is set at 1 per cent for chronically ill people, but to qualify for this reduction people have to prove that they attended recommended counselling or screening tests before becoming ill. Children under 18 are exempt from cost sharing.

#### ***Social care***

A mandatory system of long-term care insurance (LTCI) covers both the old, and disabled people of working age. It is not intended to cover all costs (as health insurance is), but to cover basic needs; individuals are expected to contribute private funds, or to apply for means-tested welfare payments (Arntz and Thomsen 2010). LTCI is administered by health insurers, but the care funds are independent self-governing bodies (Forder and Fernandez 2011). All working people must have some form of long-term care insurance, but individuals with higher incomes can choose to take out private insurance rather than participate in the government programme, and around nine million people do so (Forder and Fernandez 2011). The private LTCI market is highly regulated, premiums must match those in the public programme and insurers cannot usually charge higher premiums to those with pre-existing conditions

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(OECD 2011). Individuals are usually insured for LTCI with the same insurer as for SHI. Only around 0.5 per cent of the population are not covered by any long-term insurance (Arntz and Thomsen 2010).

People in need of social care are assessed by the Statutory Health Insurance Medical Review Board and, if they meet the threshold for care, are put into one of three levels, according to their needs (Blümel 2013). Eligibility for support is dependent on how often help is needed with personal care and housekeeping and also the amount of care provided by informal carers (Forder and Fernandez 2011).

People may receive benefits in cash, which they can use to pay family carers, to pay an agency for care or even to carry out house renovations to make their accommodation accessible; or they can choose to receive in-kind service benefits, where care is provided by an agency under contract to the insurance company. They can also choose a combination of both (Gleckman 2010). The direct service benefit is financially worth more than the cash payment. For example, in 2008 a patient who needed 24-hour care at home would receive in-kind benefits to the value of £1,200 per month, but would receive cash payments of only £550 (Gleckman 2010).

Levels of support range from £370\*\* to £1,300 for services in-kind, and are between £870 and £1,280 per month for residential care (Forder and Fernandez 2011). Payments are not made until six months after an individual is assessed as being in need of care. LTCI benefits are not expected to cover the full costs of care, and the scheme does not cover the cost of accommodation in institutional care, so people are advised to buy supplementary private insurance to cover these costs (Blümel 2013). In 2009, around 3.5 per cent of the German population aged over 40 had this type of LTCI plan, which is an indemnity plan that pays out a set annual sum once someone is considered to be 'dependent' (OECD 2011). There is a safety net in the form of means-tested social assistance administered by the Lander (federal state), for those who are not able to cover non-insured costs. The number of people relying on means-tested assistance has fallen since the introduction of SHI (Forder and Fernandez 2011).

All benefits are universal across the country. They are reviewed to check that they are adequate every three years (Gleckman 2010).

## **Funding**

### ***Health care***

Statutory health insurance is provided by 134 not-for-profit sickness funds, financed through mandatory contributions by employees/pensioners (8.2 per cent of gross wages), and employers/pension funds (7.3 per cent) up to a combined monthly ceiling of around £500 per month (Forder and Fernandez 2011). The government contributes to SHI on behalf of the long-term unemployed. People who are unemployed in the short term contribute in proportion to their unemployment entitlements. Around 86 per cent of the population receive coverage through SHI and around 11 per cent through private health insurance (Blümel 2013).

Contributions to sickness funds are centrally pooled and then redistributed to each sickness fund based on a risk adjusted capitation formula. Sickness funds



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can charge an additional nominal premium if the fund has insufficient revenue. They can also reimburse patients if there is surplus revenue.

### ***Social care***

A universal pay-as-you-go social insurance system was instituted in 1995. Contribution rates were set at 1.7 per cent, but rose to 1.95 per cent of wages in 2008 (Blümel 2013). Contributions are collected as an income tax (which among the working population) is divided equally between employer and employee. Pensioners also make contributions. In 2005 an extra 0.25 per cent premium was imposed on people without children who are less likely to receive informal support from family in old age (Gleckman 2010). Lower rates are paid by students, unemployed people and pensioners.

### **Delivery**

#### ***Health care***

Physicians tend to work in their own private practices – around 60 per cent in solo practices and 25 per cent in dual practices (Blümel 2013). Registration with a GP is not required and GPs have no formal gatekeeping function.

About half of all hospital beds are provided by public hospitals and one-third are provided by private not-for-profit hospitals. Private for-profit hospitals provide about a sixth of beds. Hospitals are staffed mainly by salaried doctors. Inpatient care is paid for per admission through a system of diagnosis related groups (DRGs). Hospitals doctors do not usually treat outpatients.

Regional associations of GPs and specialists in ambulatory care negotiate contracts with the sickness funds on behalf of their members. The regional associations co-ordinate care requirements within their region and organise out-of-hours care. Physicians are generally reimbursed on a fee-for-service basis, negotiated by the regional association with the SHI. GPs receive a financial bonus for patients enrolled in a disease management programme.

#### ***Social care***

Federal states are responsible for providing the infrastructure for social care, for example, ensuring that there are enough nursing homes (Arntz and Thomsen 2010)

Nearly all social care, including institutional and home care, is delivered by private providers – either for-profit or non-profit organisations. In 2001 there were 9,200 accredited nursing homes; 8 per cent were owned by public providers, 36 per cent by private for-profit providers and 56 per cent by non-profit organisations (Busse and Riesberg 2004).

### **Key issues**

#### ***Cost sharing in health care***

Cost sharing in the social health insurance system is relatively new. Co-payments of £8 were introduced in 2004 for the first visit to a GP, dentist or specialist per quarter and for subsequent visits without a referral. These co-

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payments were removed in January 2013, although others remain (see section on entitlement) (Blumel 2013).

### ***Long-term care insurance introduced in 1995***

Until 1995, financial support for social care was granted as a means-tested benefit. Since 1995 each health insurance system has had an affiliated long-term care insurance fund and only a tiny proportion of the population lacks insurance to cover social care needs (Arntz and Thomsen 2010). LTCI benefits are not expected to cover the full costs of care. They are well below the benefit levels in Japan, for example. However, the LTCI fund faces shrinking revenues and increasing expenditures. Many commentators believe further reforms will be necessary (Forder and Fernandez 2011), one estimate is that the payroll tax rate for LTCI will have to increase to 4.5 and 6.5 per cent by 2055 (Arntz and Thomsen 2010). The German social insurance system is built around the contributions of family as care givers, the algorithm used to assess the level of care awarded takes into account informal carers. Childless people are required to pay 0.25 per cent more in insurance contributions than those with children, and benefits in cash (which can be used to pay family carers) are of less value than those given in services (Forder and Fernandez 2011). The German system does not pay out until someone has needed care for six months – this is not the case for means tested social care in England, although it is the case for Attendance Allowance/Disability Living Allowance (Forder and Fernandez 2013).

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## *Ireland*

### **Context**

Ireland's population is around 4.6 million. Life expectancy is 81 years, and the population is relatively young, with just 11 per cent aged over 65 in 2010. Health expenditure in 2011 was 8.9 per cent of GDP, close to the OECD average.

### **Entitlements**

#### ***Health care***

The Irish National Health Service provides universal coverage of some services to the whole population, but care is only free to those on low incomes. Ireland is unusual in that it does not offer universal coverage of primary care. Anyone without a GP visit card or a medical card (around 60 per cent of the population) must pay the full cost of almost all primary care services, minimal charges for hospital treatment and up to £108 a month for prescriptions (Burke *et al* 2013).

An individual's entitlement to services is set at one of two levels, defined by a means test. Individuals assessed as category 1 have either a 'full medical card' that entitles them to free public hospital, primary care and other community care and personal social services, or a 'GP visit card' for which the income threshold is 50 per cent higher. This entitles them to free GP care, but they must pay some inpatient and outpatient charges. Individuals with higher incomes are defined as category 2. They must pay in full for their primary care and pay some inpatient and outpatient charges. Many, but not all, of those people in category 2 buy private health insurance to supplement their cover (Brick *et al* 2012). In 2012, 40 per cent of the population held a full medical card or a GP card (Burke *et al* 2013). That figure is far higher for older people – 91 per cent of people in their 70s and 97 per cent of people over 80 had medical cards in 2012 (Thomson *et al* 2012).

In 2011, the government made a commitment to provide free GP care for those with a long-term illness by March 2012, and for those on the high-tech drug scheme (ie, those receiving drugs previously supplied by hospitals but now dispensed through community pharmacies – for example, drugs used in conjunction with chemotherapy) by March 2013. These changes have not been implemented, but in 2013 it was announced that free GP services would be introduced for children aged five and under during 2014 (Burke 2013a). There is free access to prescription drugs for people with specific long-term conditions.

There is an £100 charge if you present at the emergency department without a GP referral and if you do not have a medical card. There is a £60 a day charge for inpatient hospital treatment capped at £615 a year (Burke *et al* 2013).

About half the population have private health insurance to cover their cost-sharing obligations for hospital care and to allow them to avoid waiting lists, often by being treated in a public hospital as a private patient (McDaid *et al* 2009).

#### ***Social care***

Social care is provided through a combination of means testing and state support. Eligibility to some services such as public health nursing and home

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care is not clear. Public health nursing is a universal service but those with medical cards may be prioritised over those without. Technically everyone is entitled to a home care package, however, who gets such services varies from area to area (Considine and Burke 2013). Under the Nursing Home Support Scheme, eligibility for nursing care is assessed under a care needs assessment. Someone deemed in need of nursing care then undergoes a financial assessment to determine the level of financial support the state will provide (see *Funding* below for more details) (Department of Health 2014). A means-tested carer allowance is available to pay relatives for informal care (OECD 2011).

Day services and outpatient care are largely provided without charge. No individual contributes more than 80 per cent of their disposable income and 7.5 per cent of their assets towards the costs of their residential care in any one year – the first £30,000 of assets is not taken into account in the means test and an individual's principal residence is only taken into account for the first three years of assessment. This is known as the 'three-year cap' and has some parallels with the Dilnot proposals in England (Department of Health 2014). The Health Service Executive (HSE) pays the balance of the cost of care through state support. Where assets include land and property, the charge can be deferred until after death with the HSE paying the balance in the meantime (Department of Health 2014).

## **Funding**

### ***Health care***

Health is largely funded from general taxation, though this is lower than in other OECD countries; in 2011 public expenditure was 67 per cent of the total expenditure on health compared with the United Kingdom at 83 per cent and the OECD average of 72 per cent (OECD 2013). At the end of 2011, 47 per cent of the population had private health insurance, although enrolment is falling due to the increasing cost of insurance (Burke 2014; Considine and Burke 2013).

### ***Social care***

Social care is funded through a combination of general taxation and means-tested user contributions (OECD 2011).

## **Delivery**

### ***Health care***

The Health Service Executive (HSE) is responsible for delivery of health services. The HSE has four regional administrative areas: Western, Southern, Dublin/North-east, Dublin/Mid-Leinster (McDaid *et al* 2009). Since 2013, there are new directorates in place – health and wellbeing, acute hospitals, primary care, social care, and mental health, overseeing all service developments (Burke 2013b).

GPs are self-employed and often work in solo practices. Hospitals can be organised in three ways. They can be owned by the HSE and funded through general taxation, run privately (usually by the Roman Catholic Church) and

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funded through general taxation, or fully private and run for profit (McDaid *et al* 2009).

The half-state, half-privately owned non-profit insurer, Vhi Healthcare, is the main provider of private health insurance. Many private insurance plans are work-based and deduct premiums directly from employees' wages (McDaid *et al* 2009).

### **Social care**

A limited number of care homes are run directly by the HSE. The remainder are privately owned and managed. A small number of homes are contracted by the public sector (McDaid *et al* 2009).

### **Key issues**

#### **Major health system reform**

The Irish government is currently carrying out a major restructure of its health system, developing a system of compulsory health insurance for all citizens, known as Universal Health Insurance (UHI), basing its plans on the Dutch health care system. There will be full or part financial support for those who cannot afford to meet the costs of insurance contributions. It is intended to give everyone access to the same package of benefits, regardless of whether they are insured in the private or public sector. Insurers will be the purchaser of health care, commissioning from not-for-profit hospital trusts, private hospitals and primary care providers (Department of Health 2013). Although the government's goal is universalism, it has suffered from budget constraints since the global economic crisis of 2009 and has had to substantially increase co-payments for essential medical services.

#### **Limits on individuals' liability for nursing home costs**

Funding of social care was reformed under the Fair Deal on Nursing Home Scheme, and there is now a limit on what can be charged (see Entitlements section, p 31 for more detail). Previously, an individual's liability was unlimited (Department of Health 2014).

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## *Japan*

### **Context**

The population of Japan is estimated to be nearly 128 million. Average life expectancy was 82.7 years in 2011, the second highest in the world behind Switzerland. In 2010, 23 per cent of the population were aged 65 years and over and it is estimated that by 2050, this figure will rise to 40 per cent (Curry *et al* 2013).

Japan's health care expenditure was 9.6 per cent of GDP in 2010 and public expenditure on long-term care was 1.8 per cent of GDP in 2011.

### **Entitlements**

#### ***Health care***

The health insurance system in Japan provides universal coverage. Employees of large firms are required to sign up for coverage offered by their employer, those working for smaller firms get coverage through the Japan Health Insurance Association, and the rest of the population is covered by a government run plan (Matsuda 2013). Health care for those aged 75 or over (the 'old old') is covered by health insurance plans operated by insurers established in each prefecture (Matsuda 2013). Central government determines the health services to be covered by health insurance. These include medical treatment, prescription drugs, unlimited hospital stay and dental care. Eye glasses and contact lenses, surcharges for private beds and some new technology medicines are not included. All health care services require co-payment at the point of accessing treatment. For most of the population these payments are set at a maximum of 30 per cent of the cost of treatment. For children under 3 the maximum charge is 20 per cent and for people over 70 years on lower incomes the maximum charge is 10 per cent (Matsuda 2013).

In addition, more than 70 per cent of adults have some form of private health insurance which is linked to their life insurance policy (Matsuda 2013). These plans pay out a lump sum in cases of severe illness or long-term disease. More recently some private insurance plans that complement the statutory insurance scheme have emerged to cover cost-sharing obligations.

#### ***Social care***

A separate compulsory long-term care insurance (Kaigo Hoken) covers the needs of the population aged 40 and over. Benefits are generous by international standards, designed to cover the costs of care less a 10 per cent co-payment (reduced on a mean-tested basis for lower income people). A third of accommodation costs are covered, with the remainder subject to a means test. Assessment is carer-blind – it does not take informal care provided by an individual's community into account. The intention is that social care services provide a substitute for informal care (Forder and Fernandez 2011).

The LTCI scheme is primarily designed to cover the care needs of those aged 65 and over; for adults aged 40–64 the system only covers long-term care needs arising from age-related disease (such as dementia, osteoporosis, Parkinson's disease) (Forder and Fernandez 2011).

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In 2009, benefit rates for people in institutional care ranged from around £1,500\*\* to £3,250 a month. The value of home and community care services ranged from around £380 to £840 a month for those with lower care needs and £1,270 to £3,000 a month for those who require more intensive care. Benefits cannot be taken as cash, as is often the case in other countries; they must be taken as formal services in kind (Forder and Fernandez 2011). This is in part to protect female participation in the labour force.

## **Funding**

### ***Health care***

Health care for those under 75 years old (60 per cent of the population) is funded through a health insurance system for employees and their families and a national health insurance (NHI) system for the self-employed, retired and unemployed (40 per cent) (Tatara and Okamoto 2009). Premium rates vary: for employer-based plans they range from 3 to 10 per cent of payroll, with half paid by employees and half by employers (Matsuda 2013). The NHI receives 43 per cent of its costs through general tax revenues reflecting its lower revenue raising capacity (Tatara and Okamoto 2009).

### ***Social care***

Roughly one-half of revenue for the long-term care insurance scheme comes from general taxation, one-third from premiums from people aged between 40–64 (at a rate of 1 per cent of income) and one-sixth from people over 65 (according to a fixed tariff of premium rates). User co-payments account for the rest (Forder and Fernandez 2011).

A small proportion of the population have private long-term care insurance as an alternative to the public system. Private plans are also available to cover cost-sharing obligations in the public system, but again take-up is low (OECD 2011).

## **Delivery**

### ***Health care***

Both primary and specialist care are provided at clinics and the two are not considered as separate disciplines. There is no gatekeeping and patients do not need to register with a particular primary care physician in order to access treatment. Japan has a heavy reliance on hospital care, with a large number of hospital beds, long average length of stay and high utilisation rates (Tatara and Okamoto 2009). There is a range of providers, including non-profit medical corporations, private organisations as sole proprietors and public institutions (such as prefecture or municipal governments).

The reimbursement system in Japan has traditionally been fee-for-service. Reimbursement to doctors is based on a national uniform fee schedule. In 2003, a system known as diagnosis procedure combination was introduced. This is a flat fee-per-day payment that reduces over time and is designed to discourage prolonged stays in hospital.

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## **Social care**

Japan has traditionally relied on hospitals to provide care for the long-term sick, although use of residential care is increasing. Residential care institutions are not allowed to be profit-making (Matsuda 2013).

The majority of home help providers are private for-profit or non-profit organisations, with some publicly owned providers. Services expanded rapidly after the introduction of long-term care insurance. In 2000, there were slightly more than 11,000 home help providers, but by 2010 there were almost 28,000 (Curry *et al* 2013). The government's intention was to provide a market where people can choose from competing providers and there are many small providers of services. However, existing health care providers also took the opportunity to expand into social care, hoping to attract patients by offering health and social care within one organisation. Some of these providers provide integrated care across both health and social care (Curry *et al* 2013).

An individual assessed as eligible for care chooses a care manager who is able to commission services from a range of providers. Most care managers are employed by a provider, and there is a tendency for them to commission services from their own organisation. The government has tried to discourage this by fining organisations when a care manager they employ commissions more than 90 per cent of an individual's care from them (Curry *et al* 2013).

## **Key issues**

### ***The introduction of long-term care insurance***

Japan's compulsory public long-term care insurance scheme was implemented in 2000. Uptake of services was higher than anticipated: in 2000, 10 per cent of the over-65 population were found to be eligible for social care services; this had risen to 16 per cent by 2005 (Curry *et al* 2013). This has led to the introduction of a number of restrictions to entitlements. In 2005 means tested fees for accommodation in institutional care were introduced and home help was restricted to those with severe disabilities, or those who lived alone. In 2006 those with the lowest level of need were given access to preventive care only but demand continues to rise (Bernabei 2009 cited in Curry *et al* 2013). The government is currently considering raising the co-payment from 10 to 20 per cent for wealthier older people, and raising the eligibility threshold (Curry *et al* 2013). There is a concern that since the introduction of user contributions in the form of co-payments and hotel fees, fewer poorer people are taking up their entitlements. However, overall demand has been strong which suggests access is good.

Around 10 per cent of the population evade their compulsory insurance payments and so do not have the insurance cards needed to access treatment. These people are likely to delay seeking treatment (Tatara and Okamoto 2009).

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## *The Netherlands*

### **Context**

The Netherlands has a population of 16.7 million. Life expectancy is 81 years, and the population is ageing. Health expenditure accounted for 11.9 per cent of GDP in 2011, second only to the United States among OECD countries, while public spending on long-term care was the highest in the OECD, at 3.7 per cent of GDP.

### **Entitlements**

#### ***Health care***

Since 2006, the Dutch have been required to purchase statutory health insurance from a choice of private not-for-profit insurers. There is near universal coverage, with fewer than 0.2 per cent uninsured (Westert and Wammes 2013). The government defines a core set of health benefits that insurers are legally obliged to cover. These include services provided by GPs, hospitals, specialists and midwives; prescriptions; maternity care; medical aids and devices; limited access to therapeutic services and ambulatory mental health care; outpatient and inpatient mental health care for up to a year; all dental care for under 18s; specialist dental care and dentures for adults. There are some limits on the services covered and certain treatments are excluded. Preventative care is not included in the standard benefits package but is paid for separately by government through general taxation (Schafer *et al* 2010). Some insurers provide financial incentives to encourage people to buy care from providers who have signed up to their network (Thomson *et al* 2013b).

Premiums are community rated, which means individuals cannot be charged more because of factors like health status or age. Overall, the Dutch have relatively low out-of-pocket expenses (Schafer *et al* 2010). Children's insurance plans are paid for by the government and are exempt from cost sharing. Adults have to pay around £290 before the insurance cover starts to pay (the 'annual deductible'), but certain services such as GP visits are excluded from the deductible (Westert and Wammes 2013). Most people (about 90 per cent) take out additional private health insurance to cover their cost-sharing obligations, and services excluded from the statutory benefits package (such as dental care for adults, contraceptives and physiotherapy).

#### ***Social care***

The universal social insurance scheme, called AWBZ, pays for care of older and disabled people. It covers home care and care provided in residential facilities, including accommodation costs. It also has close links with the health insurance system as long-term hospitalisations, rehabilitative services and nursing care are also covered by the programme (Gleckman 2010). The extent of care provided is determined by a needs assessment, and a complex set of cost-sharing arrangements apply (Schafer *et al* 2010). Patients have the option to receive services 'in kind', or to receive a personal budget to pay for personal care, home nursing, and support with daily activities. The budgets are calculated based on the number of hours of care needed, and patients must top up their budget with income-related contributions to buy the level of care they are assessed to need. Most recipients simply spend the money provided

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by the scheme and buy less care than their assessed need (Glendinning 2010). The budget can be used to pay relatives for providing informal care, and carers can also apply for a 'compliment for carers' payment worth around £200 (Glendinning 2010). Demand for personal budgets has been high and the system has struggled to cover costs. In 2010 the programme ran out of money in July and 13,000 applicants had to join a waiting list to receive their benefits (Health Foundation 2011). The government has restricted eligibility to help it meet rising demand (van Ginneken *et al* 2012)

## **Funding**

### ***Health care***

The statutory private health insurance system is funded through a community rated 'nominal' premium that is set by the insurer and averages around £1,000 a year, and an income-based contribution that is mainly covered by employers, although workers must pay tax on the employer's contribution (Westert and Wammes 2013). Funds are pooled centrally and distributed to insurers based on a risk-adjusted capitation formula. A government fund covers care costs for illegal immigrants and asylum-seekers and tax credits are provided on a sliding scale to help families with low incomes pay for their plans.

Most people (around 90 per cent) also have additional private health insurance to cover services not included in the standard benefits package (Thomson *et al* 2013a).

### ***Social care***

The compulsory social care social insurance scheme is administered by private insurance companies and paid for via an income-related premium deducted from the wages of all citizens aged 16 and over, and an employer contribution paid for via payroll taxes (Gleckman 2010). Individuals who use services also have cost-sharing obligations that vary depending on their income level, their family status and the location of their care. Approximately three-quarters of the programme's costs are paid for by individuals via co-pays or premium contributions, with the rest covered by the general insurance fund (Gleckman 2010).

## **Delivery**

### ***Health care***

Around 80 per cent of those enrolled get their statutory health benefits from one of five large private insurers (Westert and Wammes 2013).

The system is based on GP gatekeeping, meaning patients need a referral before seeing a specialist. GPs are mainly independent contractors. The majority work in partnerships, although one in five operate singlehandedly and there are a small number of salaried GPs. Payments are a mix of capitation, fee-for-service, and bundled payments, which have been introduced for certain chronic conditions. Some primary care fees are nationally determined, while others are freely negotiable (Westert and Wammes 2013).

Hospitals are run as non-profit organisations and, aside from a few pilots to test new approaches, are not allowed to operate as for-profit organisations.

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Although mainly based in hospitals, the majority of specialists are self-employed (65–70 per cent) and paid via fee-for-service rates negotiated with insurers. Around a third are salaried. Out-of-hours services operate through GP co-operatives which are usually run by hospitals. In 2012, the system had 132 hospital sites, 97 outpatient specialty clinics, and 150 non-profit treatment centres that focus on elective day cases (Westert and Wammes 2013). Hospital care is paid for with diagnosis related group type payments (since 2005), and rates are negotiated by insurers and providers.

### ***Social care***

In 2009, the social care system contained 479 nursing homes for people needing constant nursing care, and 1,131 residential homes for those with lower level care needs (Westert and Wammes 2013). There are also 290 combined institutions. Home care is provided by residential homes, nursing homes and home care organisations. The level of support they provide varies, but for almost 40 per cent the support is very low level help with housework (Schafer *et al* 2010). The number of people receiving home care is on the rise, while the numbers in residential and nursing homes has been falling (Schafer *et al* 2010).

### **Key issues**

#### ***Health system reform***

Historically the Dutch health system was based on the Bismarkian model of social insurance with health care provided through a mixture of public sickness funds, and private health insurance for higher earners. However, in 2006 sweeping reforms introduced a single compulsory private health insurance scheme in which individuals choose health plans from competing private insurers, and all plans must cover a statutory set of benefits. The insurers are not allowed to reject applicants and cannot vary premiums based on age or health status. They can be profit-making, and have some freedom to negotiate with providers on price, quality and volume for certain treatments. Oversight of the system is mainly conducted by independent bodies at arm's length from the government and the government's role is restricted to safeguarding that oversight process. It was hoped that competing insurers would push providers to increase the efficiency and quality of their services in order to attract customers (Schafer *et al* 2010). Evidence on whether the new system has achieved this goal is mixed. Some competition is taking place – 18 per cent of people switched plans in the reforms' first year, although this dropped to 4 per cent the following year. But insurers seem to be competing on price rather than quality, despite government aims to push them to focus on the latter (Cohn 2011).

The Dutch experience of health reform shows that it is possible to fundamentally change the underlying model of health service financing. However, this was not a 'big bang' approach; it took more than 20 years for the Netherlands to unite its social insurance and private health insurance systems into a single scheme. Earlier attempts at reform in the 1990s failed due to opposition from insurers, employers and clinicians. There were also a number of changes in government during this time. However, the gradual implementation of smaller reforms contained in those original plans helped

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enable more fundamental changes to be introduced in 2006 (Schafer *et al* 2010).

### ***Financial sustainability of social care provision***

The Netherlands was the first country to establish a universal social insurance scheme for social care needs in 1968. The system provides generous benefits, but has struggled to cover ever increasing costs (Gleckman 2010). Dutch expenditure on long-term care is the highest among those who report this data in the OECD at 3.7 per cent (OECD 2013). To control costs, the government introduced capped budgets in the 1990s, but these resulted in long waiting lists, and were abolished in 1999 (Gleckman 2010). Recently the government has taken further measures. It restricted eligibility criteria for personal budgets, explicitly detailed the 'customary care' that family members are expected to provide that would not be covered by the programme, removed services such as home cleaning from the programme, and targeted care on those most in need through stricter needs assessments (Glendinning 2010, Gleckman 2010, van Ginneken *et al* 2012 ). There is debate about how to ensure the future sustainability of the system. Cost control proposals include no longer reimbursing residential costs in nursing and residential homes, or merging the programme into the national health insurance scheme (Gleckman 2010).

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## *Republic of Korea*

### **Context**

The population of the Republic of Korea is estimated to be nearly 50 million. The country has undergone rapid economic growth over the past 30 years. Life expectancy is among the highest in developed countries at 81 years, but health care expenditure as a proportion of GDP is one of the lowest in the OECD, at just 7.4 per cent in 2011.

### **Entitlements**

#### ***Health care***

Korea has a statutory national health insurance (NHI) programme that provides universal coverage. A small proportion of the population with very low incomes are covered by the separate Medical Aid Programme (MAP). Both NHI and MAP cover diagnostics, inpatient care, outpatient care, primary care, pharmaceuticals, dental care, rehabilitation, pre-hospital emergency care, medical aids/devices for the disabled, organ transplantations and some complementary medicine procedures (Chun *et al* 2009). Services not covered include patient transportation, some eye care, cosmetic surgery and high cost services. A separate programme, the Public Health Service (PHS), is responsible for preventative services and health promotion, and the Medical Relief Programme (MRP) provides foreign workers and the homeless with emergency medical care services through public and private sources.

Patients are required to pay a percentage of their care costs. This is set at 20 per cent for inpatient costs; outpatient care rates range from 30 per cent to 60 per cent. This is the highest level of cost sharing among the 20 OECD countries that require co-payments (Jones 2010). Certain groups covered by MAP are exempt from cost-sharing obligations. These include households where no person is able to work due to disability, people aged 65 or over, pregnant women, and people in nursing and welfare facilities. Services that are not included in the NHI/MAP package must be paid for in full by patients themselves.

Around three-quarters (76 per cent) of the population have private insurance to covers cost-sharing obligations in the public system, and private plans can also cover additional services (Jones 2010).

#### ***Social care***

In July 2008, Korea introduced a mandatory long-term care insurance (LTCI) scheme that covers a proportion of the home and residential care costs of all residents aged 65 and over, people suffering from certain diseases such as dementia and stroke, and disabled people. Services are provided based on an individual's level of need, which is assessed by the Long-term Care Needs Assessment Committee to fall into one of three categories that are based on capacity to undertake daily activities and level of cognitive impairment (Chun *et al* 2009). Benefits are provided as services, rather than cash, except where long-term care facilities are unavailable. Care workers in home care services visit the individual's home and help with personal needs such as bathing, going to the toilet, dressing, cooking and cleaning.

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Individuals pay a share of their care costs: 15 per cent for home care and 20 per cent for residential care. Those with very low incomes are exempt (Chun *et al* 2009).

## **Funding**

### ***Health care***

The compulsory national health insurance programme is funded by a combination of employee and employer contributions (set at 5.08 per cent of salary in 2009), government payments (including general tax revenues and contributions by the state as an employer of civil servants), and out-of-pocket charges (Chun *et al* 2009). All Koreans, except those in the lower income groups, have to pay health insurance premiums. In 2007, public expenditure on health was 55 per cent of total health expenditure, and out-of-pocket payments were 36 per cent (Chun *et al* 2009). Korea spends less on health care than other OECD countries, but is experiencing faster rates of growth in health care costs contributed to largely by hospital services.

The NHI system was previously operated as a multi-insurance fund system, with more than 370 insurers established on a regional or occupational basis. Since 2000, the National Health Insurance Corporation (NHIC) has been the single insurer providing health insurance for all citizens living in Korea.

### ***Social care***

The long-term care insurance scheme is paid for via income-related premiums and administered by the wider national health insurance scheme. The long-term care contribution rate is 4.8 per cent of a person's NHI contribution. In addition to this, government subsidies pay for 20 per cent of long-term care costs, and individuals who use services have cost-sharing obligations that depend on the type of service used and category of beneficiary (Chun *et al* 2009).

## **Delivery**

### ***Health care***

The vast majority (approx 90 per cent) of primary care services in Korea are provided by independent private providers who operate in singlehanded and group practices. Unlike most other developed countries, primary care is provided in both clinic and hospital settings. Services are run by physicians who are not specialists in general practice or primary care, but are specialists in other areas. There is no GP gatekeeping function, so patients can easily access hospital care without a GP referral. Service delivery is determined by provider interests, and the focus of primary care is towards curative rather than preventative services or health promotion. Primary care physicians are paid fee-for-service.

Hospitals in Korea are often run by doctors, universities, religious groups or non-governmental organisations. Although they are mostly privately owned, the Medical Act 2009 does not allow them to have for-profit status. However, hospital owners and managers are given a great deal of autonomy to manage their facilities as they wish, leading many to behave as for-profit organisations



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(WHO 2012). There is limited co-operation between primary and secondary care, which further encourages the use of secondary care (as opposed to primary care) whether or not the presenting illness is appropriate for higher levels of care. Hospitals are paid via fee-for-service and diagnosis related group type case payments (Chun *et al* 2009).

### ***Social care***

Most social care is provided by private organisations, although there is a small amount of public provision. The supply of social care for older people has expanded rapidly since the introduction of the mandatory long-term care insurance scheme. There were 534 long-term facilities in 2005 and 2,455 by the end of 2009. There are also many more providers of home-based care (Jones 2010).

### **Key issues**

#### ***Universal national health insurance***

Korea established a statutory national health insurance (NHI) scheme 30 years ago. As the economy has expanded, so has the coverage of the NHI scheme – from 9 per cent of the population in 1977 to almost universal coverage in 1989 (Chun *et al* 2009). To facilitate this rapid expansion, the range of benefits covered by the national health insurance scheme was initially quite slim, and prices were fixed at low levels (Jones 2010).

The scheme was originally established with multiple insurers, and political debate as to whether to merge financing into a single payer raged for years. Establishment of a unified single insurer was eventually passed into law in 1999, the insurer was created in 2000, but was not fully implemented until 2003 (Chun *et al* 2009). Since 2000 a series of additional reforms have been introduced to expand the benefits package and reduce cost-sharing obligations. The Korean experience of health reform demonstrates the amount of time needed for major reform, and the incremental development of the programme. It took 30 years to get from the initial, limited social health insurance scheme provided by multiple funds, to a more comprehensive programme administered by a single insurer.

#### ***Reforming social care***

Korea established a mandatory long-term care insurance scheme in 2008, separate to, but administered through, its national health insurance programme. Again, there was a long road to reform. Proposals for the scheme were first developed in 2001, pilot projects began in 2005 and the Act creating the programme was passed in 2007.

The changing role of the family in the provision of social care support was an important impetus to reform. Traditionally in Korea care was provided by family members, but the ageing population and increasing female workforce made that family-orientated model increasingly unsustainable. At the same time, the health care system was straining under the rising cost of treating older people who were staying in hospital for increasingly long periods of time. While the new system helps Korea cope with the decreasing availability of informal care, a number of incentives have been introduced to encourage family caregiving to



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ensure it does not completely disappear under the new system. Informal carers benefit from tax exemptions and are given more opportunities to get public housing.

The scheme has received positive initial feedback with high reported levels of satisfaction. However, it suffers from the limited supply of residential care providers, especially in urban areas around Seoul. This has resulted in long waiting times (Chun *et al* 2009).

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## *Sweden*

### **Context**

Sweden's population of 9.4 million is one of the oldest in the world. Nearly one in five (18 per cent) is aged over 65 and one in twenty is aged over 85 (OECD country profile). The country is characterised by relatively high levels of welfare spending, and a decentralised system of government, in which many decision-making powers are delegated to the county and municipality levels. Spending on health care is similar to the OECD average at 9.5 per cent of GDP, and public spending on long-term care is higher than any other OECD country except for the Netherlands, at 3.6 per cent of GDP.

### **Entitlements**

#### ***Health care***

The Swedish health system provides universal coverage to all legal residents, children who are seeking asylum and undocumented children (Glenngård 2013). The government-funded system is comprehensive, covering primary care, inpatient and outpatient specialist care, emergency care, prescription drugs, mental health care, rehabilitation services, public health and preventative services, disability support services, patient transport, dental care for children and young people and much of the cost of adult dental care. Patients must pay a co-payment for each health care visit and for hospital stays. There are annual limits on the amount an individual can pay out of pocket each year on health care visits (£100) and prescriptions (£200). The level of cost sharing is determined locally and differs across the country, but in 2013 a GP visit cost between approximately £10 and £20, a visit to a hospital specialist cost between £20 and £30 and the charge per day in hospital was around £7 (Glenngård 2013). Individuals must pay for their out-of-hospital prescriptions up to around £100 a year, and receive a sliding scale subsidy above that rate which eventually covers 100 per cent of costs. Inpatient prescriptions are paid for in full by the county council. People aged under 20 do not have to pay visit co-payments and have free dental care (Glenngård 2013). A small proportion of the population (fewer than 5 per cent) have private health insurance that gives them quicker access to care (Glenngård 2013).

#### ***Social care***

Sweden provides universal and comprehensive coverage of social care to all citizens. The Swedish system is considered very generous by international standards and cost sharing is minimal (OECD 2013). As with health care, decision-making powers are held at the local level. Needs assessments are conducted by municipalities and the level of help provided is based on factors such as functional limitations, age, and whether someone lives alone (Socialstyrelsen 2008). There are limits on the maximum amount individuals can pay out of pocket for their care needs, and the level of co-payments is income related. Residential care is provided for varying levels of need. Coverage includes accommodation and daily living costs, but users make a contribution based on their income.

Covered home care services include help bathing, dressing, shopping and cleaning. The care package also includes home adaptations and supports as

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well as transportation. A significant amount of care is provided by informal carers and some municipalities reimburse informal carers for some of this through 'relative care benefits'. The maximum charge per month for home help was around £165 in 2011 (The Swedish Institute 2013).

## **Funding**

### ***Health care***

The majority of health care in Sweden is funded by the government at the national, municipal and county council level (82 per cent), with the rest paid for privately (Glenngård 2013). As in England, a small proportion of the population has private health insurance, which is usually paid for by their employer (Glenngård 2013). Government funding comes mainly from income taxes levied by municipalities and county councils, and some national and indirect tax revenues. County councils/regions are responsible for the organisation and provision of health services in their areas, and the national government takes an oversight role.

### ***Social care***

Long-term care expenditure is mostly financed through local taxation at the municipal level (85 per cent) and some national government grants (11–12 per cent) (OECD 2013). Public spending on long-term care is the highest among OECD countries, and private out-of-pocket spending is low compared with other OECD countries, making up just 3–4 per cent of total expenditure (OECD 2013).

## **Delivery**

### ***Health care***

Around one-third of the country's 1,100 primary care practices are privately owned. GPs and other primary care staff in both public and private facilities are mainly salaried employees (Glenngård 2013). GPs do not take on a formal gatekeeping role, but are generally the first point of call for people seeking care. Primary care providers are funded through a mix of capitation-based payments, fee-for-service and some performance related payments (Anell *et al* 2012). After-hours care is provided by acute hospitals, and national phone and internet services provide advice 24 hours a day.

Most hospitals are publicly owned and run by county councils, with fewer than 5 per cent of beds located in privately owned hospitals in 2009 (Anell *et al* 2012). The majority of specialists and other hospital staff are salaried employees. The way hospitals are paid varies between counties, but the most frequently used mechanisms are global budgets or a mix of global budgets, diagnosis related group type case based payments and performance related payments (Anell *et al* 2012).

### ***Social care***

Residential care facilities ('special housing') are run by private companies commissioned by municipalities (Socialstyrelsen 2009). Individuals have the choice of receiving home help from public or private providers. The number

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of private home help companies is increasing and in 2011 19 per cent of older people receiving home help got their care from private providers (The Swedish Institute 2013).

## **Key issues**

### ***Decentralised health care system***

The Swedish health system is highly decentralised with decision-making power concentrated at the country council and municipality levels. This means that services reform and develop in different ways and to different timescales across the country. Data on health system performance shows variation between counties, but there is no clear link between a particular approach and the quality of service provided. The main problem in the health system in recent years has been long waiting times. In this area and some others, central government has begun to take a stronger role, and nationally defined waiting time guarantees have now been codified into law (Anell *et al* 2012).

### ***Choice in social care***

Swedish provision of social care is seen as a 'best practice' example by international standards, because of the generosity of its coverage and low user charges (OECD 2013). The Swedish government spends a higher proportion of GDP on social care than any other OECD country except the Netherlands (OECD 2013). One of the biggest reforms to the system in recent years has been the introduction of choice and competition into the home health sector in an attempt to improve quality. Older people can choose an accredited home care provider from the public or private sectors. There has also been extensive use of financial incentives to promote improvement in the social care sector. Since 2010, central government has included performance targets that are based on outcomes for older people's care into the annual transfer payments they make to municipalities (OECD 2013). Although choice in social care has been shown to improve patient satisfaction, the impact of these new initiatives on quality and efficiency is not yet known (OECD 2013).

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## *United States*

### **Context**

The United States has a population of 312 million people, the majority of whom (82 per cent) live in urban areas. The population is relatively young, with just 13 per cent aged over 65. Despite being one of the wealthiest countries in the world, life expectancy is 78.7, 1.4 years below the OECD average. In 2011, the United States spent 17.7 per cent of its GDP on health care, significantly more than any other developed country, and almost double what is spent in the United Kingdom. Public spending on long-term care made up 0.6 per cent of GDP, significantly below the OECD average.

### **Entitlements**

#### ***Health care***

The US health insurance system is not universal. There are significant gaps in coverage, particularly among young and low income Americans and in 2012, 21 per cent of adults between the ages of 19 and 64 were uninsured (Kaiser Family Foundation 2014). Coverage is provided by private insurance companies, and government-funded Medicaid (for people with low incomes) and Medicare (for older people and disabled) programmes.

Benefits differ between and within coverage types, but in general most plans include inpatient, outpatient and primary care services from specialists and GPs. Some plans also cover mental health, preventative health, physical therapy, and prescription drugs. Some private health plans cover dental and eye care, although often people buy separate insurance for these benefits (Commonwealth Fund 2013). Most plans require enrollees to cover some of their care costs through deductibles, co-pays and co-insurance payments. Many plans restrict enrollees to using an approved network of providers, and prescriptions are often organised into tiered formularies with lower cost sharing for generic drugs. Although the majority of health providers accept patients with Medicare coverage, fewer treat patients covered by the Medicaid programme, as its reimbursement rates are lower. Medicaid operates differently in each state, and in some states enrollees are offered individual budgets to pay for care of long-term conditions and mental health care. Many Medicare beneficiaries also buy private health insurance policies called Medigap plans which pay for extra charges and additional services that are not covered by the core Medicare plan.

People without health insurance have some access to care. All hospitals that accept Medicare (that is the majority of hospitals) are required to stabilise the condition of any patient who comes to them in an emergency. They are not, however, required to provide any ongoing care. The uninsured can also access care through public hospitals, government-funded community health centres and some private providers who offer charity care (Commonwealth Fund 2013).

#### ***Social care***

Most Americans enter residential homes as private payers, spending their assets until they qualify for coverage from the Medicaid programme, which provides a safety net for those with low income. The Medicaid programme does not consider the family home in an individual's assets assessment, but

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thresholds are very low on non-housing assets. Still, as residential care home places are expensive, averaging £45,800 a year, it does not take long for many Americans to spend personal wealth and qualify for Medicaid assistance (Rice *et al* 2013).

The Medicare programme covers a limited number of days nursing home care for rehabilitative services, usually after discharge from hospital. If people need to stay beyond the Medicare limit, they must pay privately or qualify for Medicaid coverage.

For those not requiring nursing care, residential assisted living centres are available and, although not covered by private health insurance or Medicare, in 40 states waivers are available so some low income residents are covered by Medicaid.

Home nursing care is expensive and, again, private health insurance policies and the Medicare programme do not cover these benefits (Rice *et al* 2013), although in some states Medicaid does cover these services (Commonwealth Fund 2013).

## **Funding**

### ***Health care***

The majority of Americans get health insurance through an employer (their own or a family member's), funded by a combination of employee and employer tax-exempt premium contributions. People who cannot get health insurance through their employer, such as the self-employed, often buy plans themselves in a separate 'individual' insurance market. Since the beginning of 2014, government subsidies have been available to reduce the cost of these plans for families with low and moderate incomes (see Major health insurance reforms section below).

In addition to the private market there are two major publicly funded health insurance programmes. Government spending makes up around half (48 per cent in 2011) of annual health expenditure (Commonwealth Fund 2013). The federally administered Medicare programme covers adults aged 65 and over and some disabled people and is funded through payroll taxes, general federal revenues and user charges (premiums). State-run Medicaid programmes are jointly funded with the federal government, and provide cover for families with very low incomes and some others, such as pregnant women. The joint state/federal Children's Health Insurance Programme (CHIP) provides cover for children from low income families.

### ***Social care***

The majority of social care costs are paid for privately by individuals. The main source of public funding is the Medicaid programme, which covers nursing home and some home nursing care for those with low incomes who have spent their assets. Medicare does not cover social care costs, except for a small amount of rehabilitative residential care – it contributes to the cost of care in skilled nursing facilities for up to 100 days. Some wealthy Americans have private long-term care insurance to cover the costs of residential and long-term nursing care, although take up is low and many policies are liability capped,

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limiting their use in protecting against catastrophic costs. Approximately 5 per cent of the population aged 40 and over has this type of insurance in 2011.

## **Delivery**

### ***Health care***

The majority of primary care and specialist physicians work in small private practices and there is no formal primary care gatekeeping system, except in some managed care plans. Payment varies depending on insurance type, and one physician will be paid in different ways by different public and private insurers. Some pay-for-performance arrangements are in place. There is relatively little out-of-hours care available aside from accident and emergency services in hospitals; only a third of primary care physicians reported having arrangements in place for their patients to see a doctor out of hours in 2012 (Commonwealth Fund 2013).

More than two-thirds of hospital beds are in non-profit hospitals with the remainder located in either for-profit (15 per cent) or public (15 per cent) establishments (Commonwealth Fund 2013). Hospitals are paid in a variety of ways, including fee-for-service and capitation-based payments depending on the service provided and the insurer. Some hospital physicians are salaried, but the majority are paid via fee-for-service. The Medicare programme pays hospitals via diagnostic related group payments using a schedule set by government, but physician fee-for-service payments are separate from this. The Medicaid programme works in different ways across the country.

Private health insurers can be non-profit or for-profit organisations. They negotiate payment rates with providers and use a variety of payment approaches including fee-for-service, diagnostic related group type and capitation-based payments.

### ***Social care***

The majority of nursing homes in the United States are for-profit (61 per cent), one-third are run by non-profit providers (31 per cent) and there are a small number of government-run facilities (8 per cent) (figures are for 2004, Rice *et al* 2013). In 2009, 1.9 million Americans were resident in nursing homes, a number that has slightly declined in recent years as more services have developed in home and day care settings (Rice *et al* 2013).

There have been some experiments with pay-for-performance initiatives to promote high-quality nursing home care. The Centers for Medicaid and Medicare Services ran a three-year pay-for-performance programme from 2009 in three states, rewarding high performing nursing homes as well as those improving their performance significantly (Rice *et al* 2013).

## **Key issues**

### ***Major health insurance reforms***

The US health system is unique among developed countries in that more than 55 million people did not have health insurance coverage for at least part of 2012, and an additional 30 million were under-insured, meaning they had a health insurance plan that would not adequately protect them from financial



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risk if they were to become sick (Collins *et al* 2013). The country is in the middle of implementing a far-reaching set of reforms to address this, passed by Congress in the 2010 Affordable Care Act (ACA). An important characteristic of these health insurance reforms is that they are mainly being implemented at the state level and will work in different ways across the country. The reforms include the establishment of health insurance marketplaces in each state, where people without employer health coverage can buy health plans that cover a government-defined set of 'essential health benefits', with sliding scale subsidies available for those with incomes up to £27,180 (for an individual) or £56,100 (family). The mandatory health benefits include some services that were previously excluded from many individual market plans, such as maternity care.

Another major component of the ACA reforms is an expansion of the government funded Medicaid programme, to cover all Americans with incomes up to 138 per cent of the federal poverty level (eligibility previously differed by state). A decision by the Supreme Court in 2012 ruled that states' participation in this expansion should be optional, and around half have indicated they plan to take part (Garber and Collins 2013). The reforms are projected to decrease the number of uninsured in the United States by 25 million by 2022 (Congressional Budget Office 2013).

### ***Failed attempts at social care funding reform – the Commission on Long-term Care***

Attempts to agree a solution to the long-term care funding challenge have been less successful, hampered by affordability concerns and a lack of consensus. Plans for a national, voluntary, self-financed long-term care insurance scheme called the Community Living Assistance Services and Support (CLASS) Act, were included in the Affordable Care Act of 2010 (Commonwealth Fund 2014). However, the CLASS Act was repealed in January 2013 before implementation had begun, following concerns about financial stability and the need to find savings during budget reconciliation negotiations. Congress then established the Federal Commission on Long-term Care to look for an alternative solution, but it failed to reach agreement (Commission on Long-term Care 2013).

In their report, published in September 2013, the Commission outlined two alternative models for the future of long-term-care: a social insurance and a private insurance model that each reflected different underlying beliefs about where responsibility for financing long-term care needs ultimately lies; with society or the individual. Their private insurance model included tax incentives to encourage enrolment in private plans; new products that combined annuities and insurance; reverse mortgages to allow individuals to draw on home equity to pay for care; and arrangements to allow enrollees to still qualify for Medicaid safety net support once their private insurance benefits were used up. Their social insurance model included two possible approaches; an extension of existing Medicare benefits to cover a comprehensive set of long-term care needs, financed through increased payroll taxes and premiums; or a basic long-term care plan that covers catastrophic care costs, financed by savings made in the Medicare programme and an extra income tax that would be higher for people nearing retirement. The Commission's failure to agree a comprehensive solution highlights the difficulty of designing an affordable solution and the impact of ideology on the recommended approach.

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### **Value-based cost sharing**

Many private health insurers in the United States use value-based approaches to cost sharing to encourage the use of high-quality and low-cost services. Commonly used approaches include financial incentives to encourage enrollees to access care from a list of preferred providers; lower cost sharing for more effective or lower cost/generic drugs; lower drug cost sharing for people who meet certain clinical criteria associated with the efficacy of a particular drug, for example, diabetics; financial incentives for participation in preventative health initiatives such as smoking cessation schemes and incentive payments for achieving outcomes such as lower cholesterol levels. Some insurers also use reference pricing, whereby the insurer sets a reference price for a particular type of drug and enrollees pay the extra cost of more expensive drugs. A review of evidence on value based cost sharing by Sarah Thomson and colleagues found some evidence of value-based approaches successfully changing behaviours, for example, reference pricing in the United States did get people to switch to lower cost drugs, and there was some evidence that wellness programmes reduced both overall health care costs and workplace absenteeism (although there were some methodological concerns with this cost-benefit analysis). However, the authors also noted that this policy approach has high administrative costs and the potential to increase inequalities as people with lower incomes or poor health may be less likely to enrol in certain programmes (Thomson *et al* 2013).

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