Long-term care financing: lessons for low- and middle-income settings

Brief 5. Aligning financing and delivery in long-term care

Key messages

– Countries allocate long-term care (LTC) resources across different delivery settings to balance the aims of financial protection, financial sustainability and equitable service coverage for beneficiaries with wide variations in need.

– Nursing homes remain a major expenditure category in developed LTC systems; however, trends show a shift in service provision from institutions to home and community settings, which may reflect individual preferences.

– Among high-income settings, it is unclear whether shifting services to the community or home is cost saving because such shifts require significant investments, including ensuring sufficient skilled caregivers and visits to homes and communities, as well as systems for guaranteeing quality, safety and needed medical referrals.

– Offering choices about the location of palliative and end-of-life care may reduce pressure on hospitals and may better address individual preferences; however, these choices require considerable investments to ensure that health and social needs are met.

– Integrating health or social services within LTC financing and delivery systems may promote access among beneficiaries who might otherwise face difficulties in navigating systems to meet their care needs.

– Governments can choose to provide care directly or purchase LTC services from private non-profit or for-profit organizations; however, when purchasing services, governments remain responsible for implementation decisions, such as enrolling and accrediting eligible providers, establishing beneficiary eligibility, setting reimbursement rates and monitoring compliance with quality standards.

– Some countries offer cash subsidies to beneficiaries so they can purchase personal or health services in their communities; the impact of cash subsidies is unclear, however, and concerns exist that such subsidies may pressure women to remain in traditional informal caregiving roles.
Countries allocate long-term care resources across different delivery settings to balance the aims of financial protection, financial sustainability and equitable service coverage for beneficiaries with wide variations in need

Once needs have been assessed, the next set of decisions involves how to deliver needed services (Fig. 1). Long-term care (LTC) is complex in that it covers different kinds of services, including skilled nursing, and social and personal care, as well as medical care. As such, LTC involves different categories of health and social care providers (e.g. physicians, nurses, skilled personal caregivers) working across a range of settings, from homes to clinically oriented institutions.

Fig. 1. How will long-term care services be delivered?

![Diagram of how will long-term care services be delivered]

**Source:** Figure adapted from Wismar et al. (1).

Fig. 2 describes the breakdown of total LTC expenditures by source of care in 24 high-income settings. Generally, such reports reflect the allocation of resources for heavy care users who have higher needs and require institutional care. Residential care in nursing homes accounts for half of total LTC expenditures across these countries, followed by care in hospitals, home care and care by social service providers (2).

The wide variation in spending patterns by source of care across countries is notable. This reflects policy choices in the allocation of resources and in utilization. While the Netherlands (Kingdom of the) delivers LTC almost entirely through nursing homes, Portugal does so through social care providers, and Poland and Bulgaria rely on households. Most LTC in the Republic of Korea is provided in hospital settings, which is the predominant location for end-of-life care (3). In Japan, 24% of non-psychiatric hospital beds are LTC beds, and in Spain, LTC beds represent 9% of total beds in government facilities, which typically offer palliative care for those in need (4). Belgium, Denmark, Norway and the United States of America (USA) rely heavily on home-based services.
OECD: Organisation for Economic Co-operation and Development.

“Social providers” refer to providers whose primary focus is helping with instrumental activities of daily living or other social care (2).

**Source:** Figure adapted from the OECD (2).

**Countries are shifting the focus of publicly funded care from nursing homes to community and home care settings**

Trends indicate a decline in the number of beds in residential LTC facilities in many high-income settings (Fig. 3). Because of the high cost of institutional care and patients’ preferences for home care, nursing homes – once the mainstay of LTC facilities – are now being phased out and replaced by alternatives that focus on more specific needs. This could occur, for example, if systems exist to provide medical care or rehabilitation outside of institutions (e.g. administering medications or carrying out physical therapies at home).
Countries have implemented a series of policies that shift patients from institutional to alternative delivery settings, such as community and home care. These policies include enacting stricter assessment criteria for accessing residential care and offering financial incentives to encourage care at home (4). The steepest declines in Finland and Norway may be explained in part by policies that shift end-of-life care to alternative settings closer to individuals’ homes (5). Sweden reported declines in “eldercare” beds between 2011 and 2021, resulting from a comprehensive set of policies across the economic, social, and health and LTC sectors that aim to promote independent living among older people (Box 1).

Traditional nursing homes are also being replaced by assisted living communities, which create settings that allow older adults to live relatively independently while being able to access non-medical assistance for moderate personal care needs. In Japan, the number of older persons in such quasi-institutional settings has grown, and assisted living facilities in communities offer health and social service on-site (7).
Box 1. Sweden's active ageing policies focus on older people living at home

A remarkable 96% of Sweden’s population older than 65 years remained in their own homes as opposed to care homes in 2019. The share of the population aged 80 years and older living in care homes declined from 20% to 9% between 2000 and 2021. The shift away from institutional long-term care in Sweden was enabled by a focus on delivering medical and personal care and rehabilitation through home care services. Some municipalities in Sweden use mobile care teams of medical professionals to visit patients with specific needs, such as early-stage palliative care or emergency care at home to avoid hospitalization. Digital monitoring devices and training for older people are used to enable self-monitoring and to identify care needs. Social care workers use home visits to assist with activities of daily living, including showering and getting dressed, as well as instrumental activities of daily living, such as cleaning and shopping. Many municipalities also offer daily ready-made food deliveries to older people. It is notable that such policies require substantial investments, and Sweden dedicates more than 3.1% of gross domestic product in public spending to long-term care.

Sources: Bergstra (6), OECD (2).

Community- and home-based long-term care are frequently aligned with patients’ preferences; however, this approach may not save costs to public payers because providing services outside of institutions requires investments to ensure quality and safety

There is an assumption that shifting LTC from institutional settings to home care achieves cost savings. However, studies of established LTC systems in high-income countries show that the share of spending on home care is not correlated with total spending on LTC (8). This suggests that countries with developed LTC systems that primarily deliver more intensive LTC services at home do not spend less on LTC in comparison with those that deliver such care through institutions such as nursing homes. As illustrated in the case of Sweden (Box 1), this could be explained by the investments needed in extensive policies and programmes to ensure that older people can remain safely in their homes and receive necessary health and social care.

Some countries have faced difficulties in developing the infrastructure required to transition from institutional to community-based LTC, see, for example, the USA (Box 2). In the USA, there are concerns about whether the most vulnerable groups have access to needed care, with one argument being that investments in LTC infrastructure have not kept pace with the ageing population, resulting in insufficient beds in high-quality nursing homes to meet the care needs of vulnerable older adults (9).
Box 2. Challenges in shifting from institutional to home-based care: the Community First Choice program in the United States of America

Under the United States Affordable Care Act, extra federal funding was offered to states that spent more than half of their Medicaid long-term care (LTC) resources on home- and community-based services to shift additional care from institutions to homes. Medicaid is the health care safety net for the poor in the USA. In 2020, Medicaid accounted for 42% of spending on LTC and covered 6% of people aged 65 years and older.

Eight states adopted the Community First Choice program, which offers a 6% increase in Medicaid federal matching payments to encourage states to shift spending from institutional to home-based care for eligible individuals. However, the programme faced challenges in adoption and implementation. Factors that influenced the adoption of the programme across states included their readiness to implement home-based care, the strength of existing home- and community-based services, the availability of direct care workers to provide care at home and in the community, and the availability of affordable and accessible housing for nursing home residents to allow them to receive care in noninstitutional settings. States also had concerns about navigating the complex processes to access the Medicaid funding, budgetary concerns related to high demand from beneficiaries, and the ability of states to meet the federal matching requirement. The challenges may have become more severe as a result of the COVID-19 pandemic. Other factors influencing the adoption of the programme included the importance of LTC to state leadership.

Sources: Beauregard & Miller (10), US Department of Health and Human Services (11).

Delivering LTC in communities and at home requires investments in human resources and enabling systems. There must be an adequate supply of health and social caregivers for people with different needs for services and service intensity. Health and social care workers need additional time and remuneration to make home or community visits. Systems must be in place to monitor, measure and ensure the quality of care, particularly for adults with complex medical needs. There must be clear guidelines to identify adults whose care needs can safely be provided at home and, when necessary, triggers to initiate the transition to a facility that can provide a higher level of personal support or medical care. Guidance and investments must also be in place to identify how to manage care in remote regions where medical referrals may be difficult or referral facilities do not provide appropriate care (7).

Offering community-based choices about the location of palliative and end-of-life care may reduce pressure on hospitals and better address individual preferences; however, this shift requires high investments to ensure that health and social needs are met.

As illustrated in Fig. 2, there were steep declines in the ratio of beds to the number of older persons in residential facilities in Finland and Norway. This could be explained in part by policies that shift end-of-life care to alternative settings closer to individuals’ homes (5). The location of care at the end of life matters to individuals as well as policy-makers. Between
16.7% and 24.5% of total medical expenditures are estimated to occur within 3 years of the end of life in high-income settings, regardless of a person’s age and cause of death (12). End-of-life care is not limited to older persons; however, persons aged 80 years and older constitute about half of deaths in high-income settings (3). The Organisation for Economic Co-operation and Development reports that about half of people in high-income settings receive end-of-life care at hospitals, and this figure is more than 70% in Japan and the Republic of Korea. The same report concludes that many older people prefer to receive end-of-life or palliative care at home or in alternative social settings, and that there is an unmet need for palliative care for managing pain.

Offering choices about the location of end-of-life and palliative care can reduce pressures on hospitals and institutions. Generally, countries that spend more on formal LTC infrastructure for older persons can offer such alternatives. This suggests that health expenditures dedicated to palliative and end-of-life care may be reduced in settings where there has been an expansion of LTC services that corresponds with individuals’ and families’ preferences (13). However, providing high-quality end-of-life care at home and in the community requires substantial investments in systems that ensure access to appropriate pain management, treatments that minimize the onset of secondary conditions, and social and emotional support (14).

Integrating long-term care services into financing and delivery systems for health or social services may promote access among beneficiaries who might otherwise face difficulties in navigating systems to meet their care needs

A common issue in countries with established LTC programmes is coordinating care in situations in which health and social services are delivered separately. Older persons may face challenges in trying to navigate the different agencies or programmes providing necessary services. Mandatory public LTC insurance programmes, while ensuring predictable sources of revenue, may result in poor coordination and fragmentation across the health and social sectors. Generally, where multiple LTC programmes exist, weak coordination and integration may reduce financial sustainability and increase cost-shifting – that is, shifting beneficiaries to other programs in order to save costs (15). This may be particularly relevant where different programmes are delivered at different administrative levels of government. Given that many older people require both health and social care, such poor coordination disrupts the continuity of care and introduces complexity in care management.

Some countries, such as Denmark, integrate the delivery of LTC services into the health system, which may improve the coordination of services. However, this may also result in higher costs, given the reliance on the health workforce to deliver social and non-medical care. In other settings (e.g. Belgium, France, Italy, Portugal and Spain), some components of medical LTC services – such as skilled nursing, medical care delivered at home and nursing home care – are integrated into the health care system while personal and social services are part of the social service system (16). Such approaches may provide better integrated health care.
The World Health Organization has put forward a series of strategies for delivering integrated LTC. For service delivery, this includes implementing evidence-based care pathways; ensuring quality standards for providing LTC across different settings; creating pathways for integrated and person-centred care; and developing strategies for coordination and communication among providers including sharing information between clinicians about patient care (17). Electronic health records can also lead to better clinical decision-making by enabling information about people receiving LTC to be shared among providers in an interoperable format (18).

In providing long-term care, governments can choose to deliver care directly or purchase care from private non-profit or for-profit organizations; however, when purchasing services, governments remain responsible for decisions about policy and implementation

Among established LTC systems, services are predominantly financed by public resources. Many governments provide LTC services directly through public facilities, for example in Denmark, Finland, Norway and Sweden. In other settings, services can be purchased from nongovernmental organizations. In Malaysia, for example, there is a legacy of residential nursing facilities operating alongside a large private sector (Box 3).

**Box 3. Malaysia’s legacy of residential care for older persons**

Before independence, Malaysia had a long history of charitable, private residential facilities for older persons that had been established to support unmarried male labourers from China and India who did not have any next of kin in the country. In the 1960s, the Malaysian government took over several of these homes, and they became a component of its social welfare strategy to provide institutional care for older persons without family caregivers. Today’s public institutions represent this legacy and serve fewer than 2400 older people, which is a fraction of the country’s total older population. These facilities offer a safe living environment, religious guidance, counselling, physiotherapy, recreational activities and some medical treatment. Public residential homes are funded by the national or state government, without charge to residents. To meet the increasing demand, more than 1000 private care homes are operated by nongovernmental, religious and private for-profit entities, of which some one third are registered and licensed.

**Source:** Cheng et al. (16).

In countries such as Germany, Japan and the USA, government ownership of LTC providers is uncommon. In these cases, the government functions as a third-party payer or insurer to reimburse non-profit or for-profit organizations for publicly covered services. The theory underlying purchasing is that competing providers may offer choices and care options to beneficiaries at a lower cost (19). However, care quality is a concern, particularly among for-profit organizations that focus primarily on profit-seeking rather than the needs of their clients.
Where governments purchase services from private sector providers, they remain responsible for implementation decisions including enrolling and accrediting eligible providers; establishing beneficiary eligibility; setting reimbursement rates; monitoring compliance with quality, administrative and fiscal standards; and paying providers for services. Purchasing LTC services also involves potentially high costs, such as for setting up contractual arrangements and quality standards, monitoring providers’ performance and ensuring regulatory compliance. Such costs may offset the efficiency gains from purchasing services from private providers.

**Some countries offer cash subsidies to beneficiaries so they can purchase personal or health long-term care services; however, the impact of cash subsidies is unclear, and concerns exist that such subsidies pressure women to remain in traditional informal caregiving roles**

Some countries provide vouchers or cash subsidies to beneficiaries to purchase needed LTC services – whether personal, health or medical – from either professional or informal caregivers. In theory, cash subsidies enable choice and allow beneficiaries to purchase the nursing and personal care that they need while enabling them to stay in their home (20). Such programmes have been implemented across high-income settings and appeal to those advocating for consumer choice, broader LTC markets and cost control, and for reducing the reliance on institutional care (21).

There are wide variations in critical implementation details of cash subsidies for LTC, including the level of cash benefits, eligibility requirements, the levels of acceptance and uptake, as well as whether they are subject to income caps or delivered to targeted recipients. In some settings, beneficiaries can choose between cash subsidies or care available through formal service delivery systems; however, the amount of the cash allowance tends to be lower than the value of the care available. Typically, cash subsidies do not cover the full cost of the caregiving needed. Many countries apply restrictions on how beneficiaries may use cash subsidies. In low- and middle-income countries (LMICs), cash subsidies have been provided as part of poverty alleviation programmes or pensions, and the amount of support that can be dedicated to LTC is relatively low (16). Box 4 describes the cash subsidy programme in Serbia.

**Box 4. Cash subsidies in Serbia’s long-term care system**

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

**Source:** Stokic & Bajec (22).
Because of these key implementation issues, cash subsidies are usually insufficient to impact the utilization of community-based services and residential care (23). Trade-offs are necessary because subsidies from the public sector effectively reduce the government’s fiscal space to finance and deliver LTC services (7). Cash subsidy programmes may boost the informal or grey market for domestic workers (as occurs in Austria, Germany and Italy) rather than generate demand for formal services and foster professionalism in the provision of those services (16). In this situation, informal caregivers are left without the protections offered under labour laws and without other social benefits, such as a pension, health insurance or paid sick leave.

If poorly designed and implemented, subsidies may undermine coverage and quality goals. This is particularly true in settings with weak quality regulations, such as in many LMICs, where purchasing low-quality LTC services in unregulated environments may result in suboptimal outcomes (24). Cash subsidies may also promote gender inequities by encouraging caregivers, who are mostly women, to remain in traditional informal caregiving roles rather than enter the formal labour force (25). The successful use of such subsidies also requires personal wherewithal and social and institutional support, including, for example, individual awareness of needs for services and sufficient cognitive capacity for decision-making or support from family members, or a combination of these (26). Therefore, such programmes require further evaluation of their impact, including the required institutional and governance structures necessary for success and the potential unintended effects, particularly on women as informal caregivers.

**Implications for low- and middle-income settings**

Countries invest in LTC systems and facilities, allocate patients and provide incentives across different delivery settings to balance the aims of financial protection, financial sustainability and coverage for beneficiaries with wide variations in needs. Skilled nursing facilities remain a major expenditure for many developed LTC systems; however, countries are shifting service provision from institutions to the community and home, with the aims of reducing costs and responding to patients’ preferences. It is unclear, however, whether providing services in the community or at home reduces costs, given the significant investments needed to provide quality services in the community, including the human resources, quality monitoring and systems for referral for needed care. This is particularly true for community- and home-based palliative and end-of-life care, which require more intensive caregiving services. Integrating health and social services and implementing strategies for patient coordination across LTC service providers may improve access. Some countries offer cash subsidies to provide incentives for beneficiaries to purchase needed personal or health services in their communities. While this may appear to be a simple solution, the impact of cash subsidies depends on critical design issues, a beneficiary’s skills in using subsidies, and the institutional and social environments – including the availability of caregivers and quality regulations. Subsidies may undermine LTC outcomes, where purchasing low-quality LTC services in unregulated environments can result in suboptimal outcomes. Concerns exist that subsidies pressure women to
remain in traditional informal caregiving roles and thus negatively impact the overall economy and that of the household. In LMICs with LTC activities, there is limited evidence to inform policies about LTC resource allocation and its alignments with service delivery policies. Such information could be collected by routinely tracking expenditures by types of providers and care categories.

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