# 4 How have countries configured long-term care service delivery to improve efficiency and access to needed services?

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## 4.1 Introduction

As people grow older and their functional status declines, they are generally more likely to need help and support for everyday activities (Costa-Font & Raut, 2022). With ageing populations and increasing demands for long-term care worldwide (Costa-Font & Raut, 2022), questions related to access, affordability and quality of long-term care have become increasingly relevant. In Europe, for example, the European Pillar of Social Rights recognises the right to affordable long-term care services of good quality for all European citizens who need them (European Commission, 2017). In Asia, there is an acute awareness 'of the increasing need to establish and finance long-term care services in response to demographic, economic, and social trends' (UNESCAP, 2022; Asian Development Bank, 2022:v). To achieve these goals amid demographic and socioeconomic changes, governments are prioritising the re-design of care delivery, putting

people at the centre, and promoting coordination of services between health and social care systems.

As outlined in the introduction to this volume, the structure and scope of coverage of long-term care systems vary greatly between countries, reflecting widely diverging local contexts, social norms, demographic trends (ageing first and foremost), economic development and availability of resources. Although providing adequate long-term care is a huge challenge in rapidly ageing developed welfare states, LMICs are facing declining fertility rates and increasing life expectancy and consequently a growing need for long-term care as well as discussed in detail by Hu and Wittenberg in chapter 2. Long-term care has historically been considered a family and close-community responsibility in many countries, with some actions covered by health and/or social protection systems. Recently, long-term care has begun to be provided through stand-alone, separate systems. In many Asian countries, for example, there has been a growing awareness of the need to develop facilitating environments to support older people to age well, and to ensure that families and communities are enabled to care for their older citizens (Asian Development Bank, 2022).

Long-term care systems have been undergoing reform processes for as long as they have existed, and no gold standard model exists. Instead, the growth of formal long-term care in countries at all income levels in the mid-twentieth century presented a wide range of opportunities, closely linked to other elements of the welfare system and a product of historical, political and social factors (Zimmerman, et al., 2022). The Covid-19 pandemic had and continues to have significant implications for the provision of long-term care especially for vulnerable groups. The pandemic accentuated already existing structural challenges, including access, affordability, quality of services, staff shortages and the costs of fragmentation across health and long-term care. It also unveiled new ones, such as insufficient infection prevention and control standards and practices, shortages of personal protective equipment and inadequate testing (European Commission, 2021a; Asian Development Bank, 2022).

The purpose of this chapter is to provide an understanding of different long-term care service delivery models and how these enable access while securing efficient use of resources. The chapter starts with an overview of the key challenges facing international long-term care

systems before discussing how countries have been responding to these challenges by looking at emerging trends in long-term care service delivery. To dive in deeper, the next section reviews the evolution of long-term care service delivery in selected countries, focusing on recent and ongoing developments. It concludes with cross cutting lessons for policy makers looking to improve accessibility and efficiency of long-term care in their countries before finishing with a short conclusion.

## 4.2 Challenges and trends in the delivery of long-term care services

### *Challenges*

Despite pronounced differences between national systems and contexts, countries across the globe face common challenges regarding delivering long-term care.

The first challenge is that countries are undergoing demographic and epidemiological changes, including accelerated population ageing and the growing prevalence of chronic conditions, multimorbidity and functional limitations that increase considerably with age. This can translate into an ever-growing share of the population that now and in the future requires support and care to maintain functionality and a high quality of life, with limited evidence that morbidity is compressed at the end of life as life expectancy increases. The proportion of older individuals needing long-term care has continued to grow in the last two decades (Costa-Font & Raut, 2022). Almost all Western European countries as well as India, Ghana and the Russian Federation amongst others showed an increasing trend in terms of long-term care needs measured in numbers of people requiring assistance for IADLs that facilitate their independent living. To meet these demands, countries are working towards strengthening their long-term care systems across all delivery settings, both in care facilities, at home and in communities, ensuring service design and people-centredness, and boosting capacities to respond to evolving care needs (European Commission, 2019; UNESCAP, 2022).

The second challenge is that the ageing trend in both developed and developing countries is expected to increase the demand for both formal and informal care. Long-term care relies heavily on informal carers and while their numbers are declining, informal carers still provide the largest portion of long-term care (Costa-Font & Raut, 2022). Formal care is

often provided by a range of paid health professionals as either residential care (nursing homes, special housing, assisted living communities, day centres, etc.) or as home care. Informal care, on the other hand, is often provided within the context of a social relationship (close relatives or neighbours) and generally without pay (WHO, 2022a). Informal care can be provided in the user's home and, in many cases, in residential care settings. In many contexts, long-term care is provided as a mix of informal and formal care, and not only one or the other. Even in countries where long-term care systems are well-developed and the service packages are rather generous (e.g., Denmark, Netherlands, Sweden), informal care always has and still accounts for the majority of care provided (European Commission, 2021b; European Commission, 2021a). In addition, changes in family patterns, such as a growing number of single households, increasing participation of women in the labour market and generally more labour mobility, will likely result in declining availability of informal carers and increase the demand for available formal long-term care providers (Spasova, et al., 2018). Adding to this, the attractiveness of the formal care sector for potential workers is undermined by several negative perceptions linked to poor and strenuous working conditions (both physical and mental) and inadequate pay (Eurofound, 2020; European Commission, 2021a; European Commission, 2021b).

A third major challenge, also addressed in chapter 2, is the persistent shortage of health professionals and a workforce with the proper skill mix. WHO has estimated that there will be a global shortfall of ten million health workers by 2030, with more profound decreases in low- and lower middle-income countries and across all health professions (WHO, 2022b). This can severely impact the successful implementation of long-term care policies and the provision and quality of care. As countries are looking for ways to reconfigure the delivery of formal long-term care services, they need to address how to: 1) increase the numbers of formal health professionals and informal caregivers, 2) retain the existing workforce, 3) improve working conditions, and 4) ensure the proper support for informal caregivers. Furthermore, having a long-term care workforce with the size and skills needed to meet the increasing demand for long-term care is a challenging task because of the many and often interrelated factors at play. Such factors include the population's demographic characteristics, economic growth, technology, migration of long-term care professionals, education/training, and retirement policies (Grubanov-Boskovic, et al., 2021). This implies a need for a holistic approach to

workforce planning that integrates and coordinates different policy areas at local, national and international levels (Grubanov-Boskovic, et al., 2021). These complex and often interrelated demand and supply-side factors translate into rising numbers of people requiring and looking for long-term care services, while the number of people providing these services is not rising commensurately but is rather stagnating or even declining. This leads to a growing imbalance between the supply and demand for long-term care services.

## *Trends*

Countries around the globe are grappling with the challenges of ageing, increased demand and workforce shortages to varying degrees. Consequently, countries have been promoting new care delivery models to tackle these, and specific trends have emerged. The most prevalent are presented below.

**Enhancing the integration of long-term care services is a widely used approach to improve their access, affordability and quality**

The provision of long-term care services involves a wide range of service providers including medical and nursing care, personal care services, assistance services, social services and informal carers. Furthermore, different funding schemes are often used, e.g., for social care, health care and long-term care. While collaboration between formal long-term care workers with other professionals and informal caregivers is widespread, the division and coordination of tasks are not always clear-cut and responsibilities sometimes overlap. Due to this fragmentation in provision and funding, long-term care is often poorly coordinated and not delivered in a patient-centred way. One solution is to better integrate services within the spectrum of long-term care and within the wider health system so that people in need of long-term care, who often have complex health needs, have a more seamless, effective and positive care experience. Such care could consist of:

1) a targeted, community-based and proactive approach to care for people who have complex health needs (case management),
2) the collaboration of different professionals in multi- or interdisciplinary teams, working interdependently under a common care plan to address people's long-term care needs, and

3) proactive patient care coordination by a case manager throughout the entire continuum of care, bringing together care professionals and providers around the patient's needs across various settings (WHO, 2021).

Enhancing integrated care has been a widely followed approach, aiming to improve access to long-term care as well as affordability and quality of services (Asian Development Bank, 2022; Costa-Font & Raut, 2022). The successful implementation of policies that aim at strengthening the integration of care is highly dependent on having an adequate workforce in place that has the right training and skill set.

The most commonly applied measures to reinforce the integrated delivery of care tackle sectoral disparities between health care and social care by setting up coordination structures. These aim to improve care management and hence population health and well-being through enhancing communication and cooperation between formal long-term care providers to improve the effectiveness and efficiency of care delivery (see Box 4.1 for examples) (Costa-Font & Raut, 2022).

**Box 4.1. Several countries have been reforming long-term care to become better coordinated and integrated**

In Bulgaria, attempts have been made to establish a revised model of integrated, high-quality social services. An integrated network of home care services for people with disabilities and older people is expected to increase access to long-term care, supporting more than 30,000 people (European Commission, 2021a). In Greece, a government programme established 150 integrated care centres for older people in 2018, which provide them with information and support on home care services and coordinate care services (European Commission, 2021a). In Belgium, twelve projects have been set up at the local level since 2018 to test a range of measures to increase the integration of care and support to improve the care of people with chronic diseases, including older people (European Commission, 2021a). Finland took steps in 2018 to improve the sharing of individual's social welfare information in the national archive with care institutions at the county level, aiming to improve care management through better and more efficient communication (European

**Box 4.1. (cont.)**

Commission and Social Protection Committee, 2021). Despite these developments, it must be noted that throughout the Covid–19 pandemic, many national strategies and emergency response plans across Europe did not explicitly prioritise integrated perspectives on long-term care provision, often leaving long-term care systems under capacity (WHO, 2022a).

In Thailand, a government-led pilot project was launched in 2016, with the aim of establishing a care management system for community-based long-term care. A key aspect of the programme is a care manager who is assigned to older people eligible for long-term care. The care manager is typically a nurse from a community health promotion hospital or primary health centre, who is responsible for assessing the care needs of the older person. Based on this, an individual care plan is developed jointly with a multidisciplinary team. Also, the care manager assigns and supervises the community caregivers who provide social care services based on the older person's care plan; health professionals provide further health and medical services, including preventive services, rehabilitation and assistive devices. The initial target was set at 100,000 beneficiaries in 1,000 out of 7,255 subdistricts. In 2018, the programme budget was increased to B1.159 billion (USD 35.4 million), to enable the project to reach 193,200 people. In that year, 72,000 trained caregivers participated in this project (Asian Development Bank, 2022).

In Canada, there have been several initiatives, such as the Comprehensive Home Option for Integrated Care of the Elderly (CHOICE) programme in Alberta implemented in 1996, to integrate medical and social care through the provision of transportation, day centres, social and health services, and the SIPA programme (Integrated Services for Frail Older Persons), which combines the provision of community services, a multidisciplinary team and case management in Quebec.

The PRISMA (Program of Research to Integrate the Services for the Maintenance of Autonomy) programme also exists in Quebec and uses community primary care services to integrate health and social services, acute and long-term care, and community and residential services such as hospitals and nursing homes. These projects follow the principal objectives of improving the integration of care for frail and older people while pursuing cost savings and efficiency gains for providers, higher quality for clients and better health outcomes (Costa-Font & Raut, 2022).

**Several countries have shifted their long-term care delivery model towards home and community-based care**

There have been developments in most European countries to improve the delivery of long-term care in residential settings and at the same time expand community-based solutions. The aim is to achieve better outcomes for users and their families at lower or comparable costs. On the downside, it potentially puts many long-term care service delivery structures under constant pressure for reform (Ilinca, et al., 2015). In some countries, this has led to a decrease of residential care capacity while simultaneously increasing home care and community-based care (e.g., in the Nordic countries and Netherlands). However, in countries with traditionally low levels of residential care provision for older people and where the family support structure has generally been the main provider of long-term care, there has been an increase in residential care capacity (e.g. Southern and Eastern Europe or the Republic of Korea) (Spasova, et al., 2018; Alders & Schut, 2019), while community-based care has not developed at the same pace or has even been reduced. Although a majority of countries have recognised the importance of de-institutionalisation and many are strategically shifting towards it, progress towards this goal has been mixed.

Older people prefer receiving home care instead of residential care, although many expect such services will not be available when needed (Ilinca & Simmons, 2022). Attempts to de-institutionalise long-term care have often been accompanied by a greater focus on home and community-based care solutions (Spasova, et al., 2018). For example, in some countries home and community-based care solutions have been expanded to enable long-term care users to continue living in their own homes (e.g., Belgium, Canada, Denmark, Japan, Ireland, Netherlands, New Zealand, Norway, Sweden, Poland and Switzerland). This trend, which is often labelled 'ageing in place', is defined as 'remaining living in the community, with some level of independence, rather than in residential care' (Davey et al., 2004: 133; Alders & Schut, 2019). In the Netherlands, for example, since a large-scale reform of long-term care in 2015, the number of beds in residential facilities has been reduced while capacity for ageing in place has been built up (Janssen et al., 2016). Another approach has been to introduce regulatory measures to promote home care by making the eligibility criteria for residential care stricter (Finland, Czech Republic and Hungary). To enable these changes, countries are increasing public funding and

insurance coverage of home and community care. Furthermore, in some countries cash benefits, directed either at service users or providers, aim to incentivise the use of home and community-based care solutions (e.g., Austria, Germany, Netherlands, Sweden, United States and United Kingdom) (Feng, et al., 2020). Additionally, there has been a trend towards protective housing and co-housing/co-living in the Netherlands, neighbourhood developments in Germany, and empowerment-oriented community development in Japan (Inaba, 2016; Johansen & van den Bosch, 2017; WHO, 2020; Rusinovic, et al., 2019).

While most older people prefer to stay in their own homes and receive community-based care (Ilinca & Simmons, 2022), this option does not always exist for all groups of the population. For some people, the informal care resources that are often needed to complement professional care delivery are not available for a range of reasons, for instance, lacking a supportive social network and environment. Furthermore, people with severe limitations in everyday activities may require more intensive support than their social network and home-based services can offer (Oliveira Hashiguchi & Llena-Nozal, 2020). Lastly, the affordability or availability of care services in the community often severely limits the options that older people have. Residential care is the final public safety net in many countries, as community-based care is often subject to high cost sharing.

**Digital technologies are changing the delivery of long-term care, requiring new professional skills**

Since the outbreak of the Covid-19 pandemic, many countries have seen a shift towards accelerating the use of digital technologies in the provision of long-term care. Digital technologies can be enablers in providing long-term care in residential settings, as well as home care and community-based settings. With adequate support for users (e.g., training and capacity building) these technologies can help improve the daily activities and overall quality of life of older people receiving long-term care, their relatives and their professional caregivers (Gallistl, et al., 2021).

Having a robust digital infrastructure in place can facilitate communication between health workers, people receiving long-term care and their families and local communities. Furthermore, digital technologies can improve access to and the delivery of care, for example by enabling remote monitoring by providers, 'smart home' technology to ensure the

safety of users at home, and telecare and telehealth to facilitate exchanges between care users, formal providers and informal caregivers. This plays a key role in improving integration between different long-term care and health care services, resulting in more efficient joint provision of care across levels and care types. Lastly, digital solutions may allow people with long-term care needs to stay in their homes or communities instead of receiving more expensive care in residential facilities.

The shifts towards greater use of digital technologies in the delivery of long-term care is generating a need for new professional roles and skills, affecting both the demand for and the supply of health and care workers. The effect of increased use of these technologies on the health and care workforce remains closely related to a range of ethical (relating to issues such as data privacy, fairness and human oversight of digital and automatised solutions), social (higher ability and acceptance of working with IT devices than working with people) and labour market aspects (i.e. when IT could replace labour or could expand productivity in long-term care occupations, adding to labour-enhancing effects) (Grubanov-Boskovic et al., 2021).

While overall use of digital technologies by healthy older people across the European region has increased significantly in recent years (Seifert, et al., 2020), implementing and using digital tools can be challenging, especially when older people and their caregivers (both formal and informal) lack access to these tools or do not have sufficient digital skills to operate and benefit from them. Hence, a precondition for mainstreaming digital technology use in long-term care is continued investment in digital literacy for care users, their families and the care workforce (Grubanov-Boskovic et al., 2021). It should also be noted that vast differences persist across countries in the European region in terms of connectivity, internet service use, and uptake of digital products and their integration in long-term care, underlining that implementation of information and communication technology (ICT) use in long-term care is strongly context dependent.

**Private providers have been emerging to fill gaps in the public provision of care**

Several countries are experiencing an increasing demand for residential care facilities and a correspondingly insufficient supply of publicly provided formal long-term care. Consequently, private organisations

have been emerging to fill these gaps in the public provision of care for those who can afford it (European Commission, 2021a) (Spasova, et al., 2018). Strategies that countries have been deliberately choosing include: increasingly allowing the private provision of services and the development of private for-profit and not-for-profit institutions (Germany, Sweden, United Kingdom, Netherlands); allowing private for-profit care institutions to qualify for public funding (Belgium, Germany) and public authorities to contract beds in private residential facilities (Malta, Türkiye); and introducing more market mechanisms through cash benefit schemes and personal care budgets, and allowing patients to purchase care from private providers (Malta, Spain, Finland) (Spasova, et al., 2018; European Commission, 2021a). Also, in Ireland, the supply of long-term care services was stimulated by fostering private sector participation through changes in the regulatory framework (European Commission, 2021a).

However, it is important to note that there are disadvantages: an increased risk of difficulties in monitoring and promoting quality, problems of equity (both in terms of service quality and distribution of services), perverse incentives to accept users whose care is expected to be less expensive and reject those whose care is expected to be more costly, and lack of incentives to invest in prevention and rehabilitation. For example, the introduction of a long-term care insurance programme in the Republic of Korea in 2008 rapidly increased the number of private providers, but without an adequate quality management programme (Walker & Wyse, 2021). Another concern is that it may contribute to further fragmentation of service delivery, which creates new challenges for users in navigating a complex system of different providers (Leichsenring, et al., 2015).

## 4.3 Country case studies

In the following section, five country case studies will illustrate the four major trends in long-term care outlined above and place them in the context of the development of long-term care in these countries. The case studies will show that these trends are often overlapping and linked but also that there are notable differences in how these manifest in different countries and contexts. We will focus on Germany, Japan, Norway, Romania and Sweden, which differ in how their long-term care systems are organised, demographic trends, levels of spending on long-term care as well as level of institutionalisation (see Table 4.1).

**Table 4.1.** *Type of long-term care system and key country characteristics*

| Country | Type of long-term care system (year of inception) | Population ages 65+ (% of total population) in 2023* | Long-term care health spending (in current USD per capita) in 2021** | % of long-term care recipients in institutions (65+, % of 65+ population) in 2020*** | % of long-term care recipients at home (65+, % of total population 65+) in 2020*** | Beds in residential long-term care facilities (per 1000 population aged 65+) in 2020*** |
|---|---|---|---|---|---|---|
| Germany | Federally organised long-term care insurance (1995) | 23 | 1,273 | 4.0 | 15.6 | 54.2 (2019) |
| Japan | National long-term care insurance provided by municipalities (2020) | 30 | 880 (2020) | 2.6 | na | 26.4 |
| Norway | National tax-funded long-term care system provided by municipalities (2012) | 19 | 2,644 | 3.8 | 10.8 | 42.1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Romania | National tax- and contribution-funded long-term care system (2000) | 18 | 49 | na | na | na |
| Sweden | National tax-funded long-term care system divided between national, regional and local levels of government (1982) | 20 | 1,736 | 4.0 | 12.8 | 64.8 |

*Notes*:* World Bank (2024)** WHO (2024)*** OECD (2023)

### *Germany: The introduction of long-term care insurance paved the way for privatisation of services and more recent strengthening of long-term care services integration*

Long-term care in Germany is provided within the institutional framework of long-term care insurance. This form of insurance was introduced as the fifth pillar of the social security system in Germany in 1994–5 and runs parallel to the health care system, following the same principles in terms of population coverage, access and choice but with substantially higher cost sharing. Long-term care insurance in Germany is funded by mandatory contributions deducted from the salaries of all employees in the country (currently 3.05–3.4% of annual salary). In 2018, 72.8 million (87.7%) of Germany's population was covered by mandatory social long-term care insurance and about 9.2 million (11.1%) by mandatory private insurance (Blümel, et al., 2020). Statutory and private insurance do not differ in coverage, which under both schemes is limited to a portion of long-term costs, with the rest being paid OOP by beneficiaries and families (WHO, 2020a).

The Federal Ministry of Health, specifically the Department of Long-Term Care, bears the main responsibility for governance of long-term care. Local authorities also contribute to long-term care financing in their role of funders providing social assistance by covering high cost sharing (in particular co-payment for board and lodging in residential care) for families that cannot afford these payments. The role of local authorities is being reinforced through the promotion of neighbourhood development (*Quartiersentwicklung*) and the allocation of care counselling to municipalities. Overall, there is growing interest in improving counselling for people in need of care and their caregivers, in particular by enhancing the coordination of health services and long-term care and by strengthening the role of local authorities (WHO, 2020a).

Eligibility for long-term care in Germany had been traditionally limited to people with 'restricted competencies in daily life'. Following the advice of an expert committee in 2013 to expand this definition to better reflect the needs of an increasingly ageing population, this was modified to those 'with health-related impairments of their independence or abilities and therefore requiring help from others' (WHO, 2020a:23). As a result of new legislation following this, the three previously defined levels of care needs were replaced by

five care grades based on physical, mental and physiological disabilities, paying more attention to retaining autonomy while considering mental disabilities (WHO, 2020a). Following a long-term care needs assessment, beneficiaries can choose among cash benefits, benefits in kind and residential care. They can also choose providers. Needs are generally assessed after an acute episode requiring hospitalisation, and often hospitals include the needs assessment within the management of the patient discharge.

In principle, home care is given priority over residential care, i.e. people are cared for at home as much as possible, notwithstanding their individual right to choose between home care and residential care. Eligible beneficiaries can apply to receive care in a nursing home, which often also offer short-term care, day or night care, as well as respite services for informal caregivers. Beneficiaries who forgo cash benefits and opt for in-kind benefits at their home can receive care provided by ambulatory care providers. Services include nursing and social services, ranging from assistance with household activities to curative care services prescribed by physicians (Federal Ministry of Health, 2020). Beneficiaries may also request additional services such as day care or short-term care. In order to be eligible for service provision, providers have to obtain a utility supply contract with the long-term care insurance fund, based on compliance with staffing, training and various other regulations. Some support is available for caregivers as well (see Box 4.2).

Through the introduction of long-term care insurance in 1994–5, the infrastructure for long-term care delivery changed notably. The previously prevailing provider structure of large not-for-profit organisations was reorganised through a deliberate reliance on private investments in long-term care, which was considered essential to extend supply structures in Germany. This reorganisation led to a marketisation trend and the emergence of new for-profit and not-for-profit providers on the long-term care market, while the number of public service providers decreased considerably, affecting competition, coordination of long-term care services and users' choice (Glendinning & Moran, 2009; WHO, 2020a; Leichsenring et al., 2015). Several small providers of home care have been founded in urban areas; both family businesses and large investors boosted the share of private for-profit providers in residential care from 50.9% in 1999 to 65.4% in 2015 (WHO, 2020a).

**Box 4.2. Services for unpaid caregivers in Germany providing long-term care services at home**

Different services are available to unpaid caregivers providing care for older people at home. First and foremost, unpaid caregivers are covered by statutory pension insurance while providing services to a beneficiary, as long as the care amounts to at least 14 hours per week at the beneficiary's home and the caregiver works less than 30 hours per week or not at all. Employed caregivers who leave their job to care for a family member are also covered by unemployment and accident insurance, with contributions paid by long-term care insurance.

Also, starting in 2012, new schemes have been put in place for those taking care of a family member to be able to reduce their working hours, take a loan to cover forgone salary as well as take up to six months care leave.

For beneficiaries who choose long-term care services in the form of cash benefits, funds can be used to cover a small compensation for informal care work. An increasing number of households are employing live-in caregivers, often immigrants. Respite care is also available to unpaid caregivers who get sick or take holidays (WHO, 2020a).

The Long-Term Care Further Development Act in 2008 gave room for long-term care insurance to establish integrated care arrangements with care providers and other contracting partners, such as family doctors. These integrated care contracts are aligned between health insurers and care providers, as regards service provision and reimbursement for providers (Leichsenring et al., 2015). The financial incentives built into the long-term care insurance model are one of the most powerful tools promoting integration and innovation (WHO, 2022a). Disease management and integrated care initiatives were established at the local level from 2002 onward to improve the quality of care, contain costs and promote coordination and self-management, with considerable uptake.

Multidisciplinary practices with family doctors and specialists aimed at facilitating care integration have also become increasingly common, especially in rural settings. Arrangements often either take the form of family doctors as care providers, referring beneficiaries to specialists within the network, or family doctors facilitating communication with ambulatory care after a patient is discharged from hospital (WHO, 2020). In another example, local advisory centres for long-term care

(*Pflegestützpunkte*) funded by long-term care insurance exist to facilitate coordination across local service providers and services and to provide counselling for people with care needs (WHO, 2022a).

There are important challenges, however. First, the delivery of health and social services is still considered fragmented and poorly coordinated in Germany (WHO, 2020). Major weaknesses include limited information exchange and communication among providers, poor collaboration with other sectors, as well as family doctors not being informed adequately or in a timely fashion about their patients' discharge from hospital care. There are no care pathways or discharge plans for people in need of long-term care. To fill the gap of fragmented service delivery, unpaid caregivers often take on an additional and burdensome role as care coordinators for which they may be ill-equipped. In addition, care integration is often hampered by provider payment mechanisms that result in competition to attract patients. Also, the fact that health care insurance covers the total costs of interventions, while long-term care insurance provides only partial financial coverage, adds to a set-up where insurers and providers have limited incentives to better align delivery services (WHO, 2020).

Second, Germany's long-term care system is faced with an inadequate supply of trained workers. While most long-term care is still provided at home by unpaid caregivers such as spouses, partners or adult children, a professionalisation process has taken place with 355,000 people working in home care and 730,100 practitioners in residential care in 2015 (WHO, 2020). Nevertheless, the increased demand for qualified personnel is becoming noticeable, especially in rural regions. In recent years, various training, qualification and compensation interventions at both the federal and regional levels have been implemented to attempt to improve the situation. However, despite these endeavours, there are concerns related to quantity and quality of the future workforce in long-term care in Germany (WHO, 2020).

### *Japan: A strong focus on community-based integrated long-term care services while building up disability prevention and home care capacity*

Japan is the country with the oldest population in the world. People aged 65 years or older accounted for 30 per cent of the total population in 2023 depending on whether the updated data in Table 4.1 is

incorporated (see Table 4.1). A long-term care insurance system was launched in 2000 to address the needs of growing numbers of older people with impairments and support their independence. The system was established to shift the burden of family caregiving to social solidarity, shifting cost sharing through insurance payments and integrating long-term medical care and welfare programs (Yamada & Arai, 2020). The system is highly decentralised, with the municipalities operating as insurers that collect long-term care insurance contributions, provide insurance benefits and manage the long-term care insurance finances. They are also responsible for assessing eligibility using a 74-item questionnaire based on ADLs (Jin et al., 2022). (A detailed discussion of systems for determining eligibility for long-term care is provided by Carrino et al. in chapter 3 of this volume.)

The long-term care insurance covers in-home services (e.g., home visits/day services and short-stay services/care) and services at facilities, including long-term care welfare facilities (also called special nursing homes), long-term care health facilities (also called geriatric health services facilities), and long-term care medical facilities (also called medical long-term care sanatoriums). There are no cash benefits or other direct benefits for family caregivers. Health care managers are actively involved in care plans and service arrangements. Individuals deemed not eligible for long-term care or support may still use preventive care services (Yamada & Arai, 2020).

Following the adoption of the long-term care insurance system, there was a significant growth in the number of people eligible for long-term care, leading to substantial increases in the government's financial burden. As a result, the Japanese government launched a disability prevention programme in which older persons were assessed for frailty using the so-called 'Kihon' checklist and a strategy with community-specific preventive activities aimed at high-risk individuals. The Kihon checklist, however, proved insufficient to identify individuals at high risk of disability; additionally, engagement in local intervention programs was relatively low (Yamada & Arai, 2020).

Following the unsatisfactory outcomes of the high-risk approach to disability prevention, the government shifted to a community-based strategy. This strategy aims to set up a community-based integrated care system by 2025 that can provide seamless preventive, medical and long-term care, as well as welfare and housing services to all individuals (Yamada & Arai, 2020). Home care will play a key role in this

community-based integrated system, but this will need the development of home medical care, home visit services and nursing care. In terms of disability prevention, central and local governments have been promoting community activities, such as salons, to facilitate group participation and encourage social activities among older people (Yamada & Arai, 2020), which have had positive results in reducing disability incidence and cost (Yamada & Arai, 2017; Saito et al., 2019).

Important challenges remain. First, the long-term care insurance system's capacity to prevent disability is still insufficient and needs further attention. Second, there are not enough geriatricians and physicians who practice geriatrics. A strategy is needed to stimulate and motivate physicians to provide frailty prevention in their daily practice. Third, most physicians still employ a disease-oriented rather than a function-oriented approach for older persons, which needs to be addressed in training and continued professional development (Yamada & Arai, 2020).

### *Norway: A strong focus on de-institutionalisation and integration has resulted in a large proportion of older people receiving care at home*

In Norway, the government formulates the overall care policy for long-term care, while the municipalities are responsible for planning and providing long-term care services (Sogstad et al., 2020). They are financed through general tax revenue, block grants from the government and user charges (Grødem, 2018; Theisen, 2020). Services are provided in nursing homes, sheltered housing and in people's homes (Sogstad et al., 2020). The guiding principle for providing long-term care, no matter the setting, is enabling people to stay in their homes for as long as possible (Sperre Saunes et al., 2020).

The role of Norwegian municipalities in long-term care services has gradually changed since the 1970s (Hagen & Tingvold, 2018; Sogstad et al., 2020), which has led to increasing decentralisation, integration, and de-institutionalisation (Hagen & Tingvold, 2018). In 1988, the responsibility for nursing homes was transferred from regional to municipal authorities (Otnes, 2015). Between 1991 and 1995 the responsibility for the care of persons with developmental disabilities was placed with the municipalities. The aim of the reform, known as the HVPU reform, was to shift care from institutions to home care. As a result, people younger

than 67 years now account for 42 per cent of recipients of home-based care in Norway (Helgheim & Sandbaek, 2021). In 2008, the government introduced 'Care Plan 2015', aiming to gradually expand municipal care services (Helse- og Omsorgsdepartmentet, 2008). As part of the plan, an investment grant scheme for nursing facilities and residential care homes was established, administered by the Norwegian State Housing Bank (Helse- og Omsorgsdepartmentet, 2008; Hagen & Tingvold, 2018). The aim was to encourage the municipalities to increase and improve their existing nursing and care homes, aiming to increase the quality of care (Westberg et al., 2019).

In 2012, the Coordination Reform was implemented, aiming to improve the coordination of care between municipalities and hospitals (Sperre Saunes et al., 2020). Following the reform, the care services landscape evolved, with municipalities increasingly establishing specialised care services for different user groups and their care needs (Sogstad et al., 2020). Examples include municipal acute inpatient units with 24-hour admissions, larger and more specialised short-term care units in nursing homes, and home care teams with particular expertise in dealing with specific patient groups (e.g., people with dementia) or providing specific services (e.g., palliative care and rehabilitation) (Sogstad et al., 2020). With the Coordination Reform, the municipal level was tasked to create more comprehensive and coherent services, which created new demand and required municipalities to build health services to a larger extent than before (Spasova, et al., 2018). Therefore, the transition from hospitals to municipalities has remained burdensome. The reform may have solved some problems but also created new challenges. For example, the ombudsman for users and patients has expressed concern that the reform requires hospitals to discharge patients after treatment when hospital care is concluded and transfer responsibility to the municipality. At the same time, the municipalities may not have the necessary services in place. The transition phase has proven complex, and there have been instances where it resulted in lower quality of care (Spasova, et al., 2018). Evaluations of the effects of the Coordination Reform have shown mixed results. However, the reform has generally supported care delivery at the lowest, most effective level of care and it paved the way for primary care and public health reforms in 2015 (Sperre Saunes et al., 2020).

As a result of the Coordination Reform, there was a shift in tasks between specialised and municipal health services, resulting in shorter

hospital stays and more patients discharged to municipal health services (Utviklingssenter for sykehjem og hjemmetjenester, 2021). Consequently, there is a need for professional restructuring with a higher level and different kinds of expertise, new work methods and new professional approaches (Ministry of Health and Care Services, 2013; Ministry of Health and Care Services, 2020). For example, between September 2014 and January 2015, the municipality of Eidsberg piloted a project on virtual wards, which is not an actual department but a way of organising resources (Eidsberg Municipality, 2015). The virtual wards followed a patient directly to their home after discharge from hospital and consisted of a team of doctors and physiotherapists headed by a nurse with advanced training in geriatric nursing (Ministry of Health and Care Services, 2020).

The government's Care Plan 2015–2020 introduced reablement as a key priority area (Ambugo, et al., 2022; Vabø, et al., 2022), which is also referred to as everyday rehabilitation or rehabilitation for people living at home (Ministry of Health and Care Services, 2020). A broadly used definition of reablement is 'a person-centred, holistic approach that aims to enhance an individual's physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services' (Ambugo et al., 2022:2).

Another key policy area highlighted in the Care Plan 2015–2020 is the need for new architecture and (digital) technology to strengthen current services and prepare for the future care needs of the population. One element of this policy area is the continuation of the Norwegian State Housing Bank's investment grant scheme for nursing facilities and residential care homes. One example of a project for residential care homes and nursing homes is a shared housing facility for people who need 24-hour nursing and care in Trondheim (Ministry of Health and Care Services, 2020). Another element of the policy area is the national programme for the development and implementation of welfare technology. Welfare technology can help people cope with their daily lives and health issues, allow more people to live longer in their own homes despite reduced functionality, and help prevent or postpone admission to an institution (Ministry of Health and Care Services, 2020). Some of the more common technologies are safety alarms, GPS, cooker monitors, electronic calendars, electronic medicine dispensers and various sensors (Tjerbo et al., 2022).

### *Romania: National policy aims to increase community-based provision of long-term care services but lack of resources limits progress and private providers are filling the gap*

Rooted in legislation adopted in 2000 (Law 17/2000 on Social Assistance for Older People), the current structure of the Romanian long-term care system, eligibility criteria, care services and the settings in which they can be provided were established by Law 292/2011 on the Social Assistance Framework (*Legea-cadru a asistenței sociale*). Important service capacity and development progress has been achieved since then. The legislative framework has been completed to include quality and cost standards for long-term care services (European Commission, 2021b). At the same time, the Romanian long-term care system remains severely underfinanced and underdeveloped, both concerning the estimated care needs it aims to respond to and in comparison to other EU countries (European Commission, 2021a). Accessibility, affordability and quality of care services are pressing concerns, while the sustainability of a system facing marked workforce shortages and heavily reliant on informally provided care is threatened by prevalent sociodemographic and population migration trends, as well as by the lack of meaningful support for informal caregivers (Ministry of Labour and Social Justice, 2018). High levels of fragmentation pose an additional challenge, leaving care users and their families to navigate a complex system with very little support.

Long-term care benefits and services are distributed between the health care systems (home health care), the national system for the support of people living with disabilities (51 per cent of beneficiaries are aged 65 and above), and the social assistance for older persons system. Following the adoption of the Framework Law of Decentralisation 195 (*Legea-cadru a descentralizarii*) in 2006, local councils hold responsibility for planning, financing and organising public service provision in their territorial areas. As many local councils lack both the financial resources and the residential capacity to develop care services, chronic underfinancing in long-term care is the norm rather than the exception across Romanian municipalities (WHO, 2020b). In the absence of meaningful accountability and enforcement mechanisms, paralleled by limited and sporadic allocation of central budget financial resources, national authorities have little scope to support a more equitable and coordinated development of care

services. Noteworthy is the launch and progressive expansion of the national community care programme (*Asistență medicală comunitară*), pooling financial resources from national health, social and education budgets and coordinated across all three relevant ministries. In 2021, the community care programme supported 1,800 community care workers and 500 health mediators operating in the most deprived communities, where they often represent the only access to health or long-term care support (WHO, 2022a; Ciurea et al., 2021).

The National Strategy for Promoting Active Ageing 2015–2020 also recognised the development of the national long-term care system as one of its strategic objectives. It emphasised the need to strengthen the community-based provision of long-term care services and accelerate progress on de-institutionalisation. During the implementation period, three national programmes were launched, pooling European financing and national funding from the central budget. They represent the most ambitious investment to date in the development of the delivery network for community-based long-term care services, targeting primarily underserved and deprived communities.

Despite a political commitment to promoting community-based care and these recent positive developments, it is apparent that the pace of progress is insufficient to meet and keep up with expected increases in population care needs. Data collected in 2019 across Europe indicate Romania has the highest share of older individuals in need of long-term care (more than 55 per cent) but the lowest share of older people who are able to access home-based care services – 4.7%, in comparison to over 50 per cent in Denmark and an EU average of over 20 per cent (European Commission, 2021a). Moreover, there is no indication that current policies can put Romania on a pathway toward closing the vast gap between needed and available care, especially in community-based settings. Increases in care service capacity in recent years, while considerable in relative terms, have been largely concentrated among residential care providers. Between 2017 and 2020 the number of residential care facilities for older people virtually doubled, while the number of day care centres grew by one-third and that of home-based care providers by only one-fifth (National Institute of Statistics Romania, 2022). These data highlight the necessity of dramatic increases in formal care services investment in Romania to ensure service capacity grows rapidly; but importantly, such policies must be paired with

targeted legislation and earmarked funding for the specific development of community-based care options.

At the same time, the data point to another complementary and significant marketisation trend in the development of the Romanian long-term care system: highly differentiated growth patterns in terms of type, speed and concentration between privately and publicly owned care services. A decade ago (2012), a comparable number of private and public residential care providers were licensed to operate in Romania, with the bulk of residential care capacity accounted for by publicly owned facilities. In the intervening years, the private residential care market grew at an accelerated pace while public provision remained sluggish in its development. The most recent data at the time of writing (April 2022) indicate a profound restructuring of the residential care sector: 83 per cent of all residential care providers in Romania are privately owned entities, which account for 76 per cent of the total residential care capacity (number of beds/places) (Ministerul Muncii si Solidaritatii Sociale, 2022). In contrast, increases in the number of home-based care providers have been more rapid for publicly owned providers, supported by national investment programs, and comparatively slower for privately owned providers in the face of high operational costs, difficulties in attracting and retaining workers and smaller profit margins. As a result, Romania has failed to meet its goal of de-institutionalising care provision for older people with care needs. It is unclear whether this goal can be achieved without redesigning financing models and incentive structures for private long-term care providers.

Rapid growth in private provision has no doubt helped to alleviate unmet care needs, but it has also led to deepening inequalities in access to care as these options are not uniformly distributed across the country or covered by public insurance. Private provision is highly concentrated in those localities where both the demand for care and the willingness to pay for care services are high and stable. More urbanised and more economically developed counties benefit from this capacity increase, while rural and lower-income counties and communities remain severely underserved. In addition, a highly privatised long-term care provision with an overwhelming representation of for-profit private providers raises significant quality concerns. Despite having revised quality standards and assurance mechanism, Romanian authorities have been struggling to inspect and enforce these standards with regularity, as reflected in a series of scandals about severe abuse and improper conditions,

particularly in residential care centres. Romania's case highlights the crucial role of public authorities in regulating, monitoring and providing adequate incentives for high-quality long-term care delivery, even when provision of care services is primarily delegated to the private sector.

### *Sweden: National policies focus on de-institutionalising and better coordination of long-term care services, while allowing the private sector to offer such services*

The long-term care system for older people in Sweden is a public, tax-financed and comprehensive system regulated through the Swedish Social Services Acts from 1982. The responsibility for long-term care for older people is divided between the national, regional and local levels of governance. The parliament and government set the overall policy targets and directives at the national level, while service provision is split between the regions and municipalities. The regions provide health care and medical treatment. The municipalities provide social care as either residential care (i.e. nursing homes, residential care facilities and group homes for persons with dementia) or home help care and services (Schön & Heap, 2018).

Previously, the county councils were responsible for providing care for older people. However, a community care reform (the Adel reform) in 1992 shifted the responsibility to the municipalities. The aim of the reform was to increase productivity at the hospital level and build a long-term care system based mainly on home care (Stolt & Winblad, 2008). Consequently there has been a reduction in the number of hospital beds, closure of residential facilities, and an increasing number of people being helped at home rather than in institutions (Schön & Heap, 2018). This is in line with the 'ageing in place' policy, which has dominated Swedish long-term care policy in recent years (Schön & Heap, 2018). In the years since the community care reform, Sweden has constantly expanded and strengthened the provision of home-based services, and today Sweden is held up as an example of successful home care for older people (Šiška & Beadle-Brown, 2020). However, home-based services have not increased at such a rate that it has outweighed the reduction in residential care capacity.

The reform also addressed the fragmentation between health and social care by introducing a reimbursement system for delayed hospital discharges and making joint care plans mandatory. Consequently,

collaboration between health professionals and social workers has increased, ensuring appropriate care and smoother transitions for users between different levels of care (Ilinca, et al., 2015).

Two long-term care policy trends that have co-existed in Sweden are marketisation and integration (Bihan & Sopadzhiyan, 2017). Various laws have been particularly important for the marketisation of social services. In 1992, a local government act enabled municipalities to introduce a purchaser-provider split and outsource the provision of care for older people to both for-profit and not-for-profit providers (Erlandsson et al., 2013; Moberg, 2021). Another key piece of legislation is the Act on System Choice in the Public Sector from 2009, which facilitated the introduction of consumer choice models without a process of competitive tendering and procurement (Meagher & Szebehely, 2010; Erlandsson et al., 2013). By 2019, about 159 of 290 municipalities offered a user choice in their home-based care, and 21 offered a choice in their residential care (Moberg, 2021). The Act on Tax Deductions on Household Services and Personal Care, which came into force in 2007, is another example of market policies (Szebehely & Trydegaård, 2012; Erlandsson et al., 2013)

The division of responsibilities between regions and municipalities in Sweden has not proved favourable for good coordination between the different care levels. Therefore, in recent years policies to improve care coordination, especially for older people with complex health problems and severe needs, have been high on the social policy agenda. The TioHundra organisation in Norrtälje municipality is one example of an integrated care model attempting the manage these problems (Agerholm et al., 2021). Founded in 2006 and owned, financed and managed jointly by the Norrtälje municipality (responsible for social care) and Region Stockholm (responsible for health care), TioHundra operates as a single comprehensive health and social care organisation (Agerholm et al., 2021).

Despite these important developments, the interface between health care and municipality care continues to be a problem area (Myndigheten för vård- och omsorgsanalys, 2021). Furthermore, a government investigation recently concluded that people in long-term care do not have access to health care to the same extent as the general population (SOU, 2022). There are thus structural deficiencies in

long-term medical care of older people, such as the shared responsibility between regions and municipalities, which may result in insufficient access to medical competence and equipment, staffing shortages and a lack of trained or licensed staff as well as deficient working conditions for staff (SOU, 2020).

## 4.4 Main lessons

In this section, we distil four overarching lessons that emerge from the review of trends and case studies, shedding light on the dynamic and context-dependent nature of long-term care systems.

### *1. De-institutionalising the care system requires building up community-based care solutions and investing in support services for informal caregivers*

Most older people prefer to stay in their own homes and receive community-based care. This has a dual benefit, in that it can improve access to services while reducing the need for more expensive residential care and therefore contribute to a more efficient system. Indeed, shifting from residential care to home care services has been high on the reform agenda in many European countries, but often fails because home-based care services have been underdeveloped. De-institutionalisation should therefore be accompanied by policies that promote and facilitate community-based care solutions. This implies policies that help build up home care services and local support networks. For instance, in Sweden and Norway, community-based care solutions include policies that promote home care while at the same time making the eligibility criteria for residential care stricter. This requires reallocating public funding and insurance coverage towards home and community care – sometimes with the help of financial incentives as seen for example in Germany. Furthermore, de-institutionalisation should go hand in hand with the development of support services for informal caregivers. For example, in Sweden, the lack of support for informal caregivers has been a barrier to de-institutionalisation. Other countries can learn from this and invest in programmes and services that provide assistance to families and friends taking care of older people and people with disabilities.

These policies should also take a holistic view of the patient and address the issue that some people will not have informal arrangements available, for example because they lack a supportive social network and environment or because they have severe limitations in everyday activities that require more intensive support. Moreover, having a sufficient and well-trained workforce is crucial for successful implementation. Countries should invest in training and education for health care professionals to ensure they have the skills necessary for modern care models that enable more people to live at home.

### 2. *Effective regulation and oversight are crucial to mitigate the potential downsides of privatisation in long-term care*

The case studies highlight various strategies employed in the countries to address the increasing demand for long-term care services through allowing private initiative. These strategies include allowing private provision of long-term care services, enabling private for-profit care institutions to qualify for public funding, contracting beds in commercial long-term care homes, introducing market incentives and personal care budgets, and fostering private sector participation through changes in the regulatory framework. While these approaches aim to meet the growing need for long-term care services, they also come with potential negative effects that must be carefully considered and monitored.

Privatisation in long-term care can pose challenges such as difficulties in monitoring and maintaining quality standards, leading to variations in care quality and increasing the risk of abuse against vulnerable care users. It can also result in equity issues, with access to high-quality care often favouring those who can afford private services. Perverse incentives may arise, where private providers prioritise patients with less expensive care needs over those with more complex and thus costly requirements. Additionally, there is a risk of insufficient investment in preventive and rehabilitative care. Privatisation can lead to service fragmentation, making it harder for users to navigate a complex system with multiple providers. Furthermore, inadequate workforce capacity and access inequalities between urban and rural areas have the potential to deepen disparities in care provision. Effective regulation and oversight are crucial to

mitigate these potential downsides and ensure that privatisation in long-term care aligns with the goals of quality, equity, coordination and patient-centredness in care delivery.

### 3. *Digital solutions have the potential to boost access and efficiency in long-term care when thoughtfully implemented to address unique contextual needs and challenges*

Digital technologies can play a pivotal role in transforming the landscape of long-term care services, with the potential to enhance the quality of care and the overall wellbeing of older people, their families and caregivers. These technologies, when accompanied by proper user support and training, enable improvements in daily activities and quality of life. Robust digital infrastructures facilitate communication between health care workers, long-term care recipients, their families, informal caregivers and local communities. Digital tools can facilitate remote monitoring by providers, enhance safety through 'smart home' technology and enable telecare and telehealth, promoting seamless interaction among care users, formal providers and informal caregivers. This integration strengthens the efficiency of care provision across different long-term care and health care services, ultimately allowing individuals with long-term care needs to remain in their homes or communities, reducing the need for more expensive residential care.

However, the widespread adoption of ICT in long-term care carries the risk of further deepening existing inequalities in access. While the use of digital technologies has grown significantly among healthy older people in Europe, implementation and utilisation of digital tools can be challenging, particularly when individuals lack access or digital literacy. Ensuring the mainstream use of digital technology in long-term care requires continued investment in digital literacy for care users and their families. Furthermore, it creates a demand for new professional roles and skills, necessitating training and capacity building as well as the involvement of professional end users in the development of new systems. This shift also raises ethical concerns related to data privacy, fairness and human oversight of digital and automated solutions. Moreover, disparities persist between European countries in terms of connectivity, internet service use and digital product adoption, highlighting the context-dependent nature of ICT implementation in long-term care.

### 4. *Successfully implementing integrated and well-coordinated long-term care requires a common vision and careful planning*

Several countries have embarked on long-term care reforms to enhance coordination and integration. Initiatives have been taken to establish integrated networks of home care services, care management systems and collaborative programs that bridge medical and social care. Improved coordination and integration of long-term care services offer numerous benefits in terms of access, efficiency and overall quality of care. In many countries, long-term care services encompass a wide array of providers and funding schemes, often leading to fragmentation and overlapping responsibilities. This can result in poorly coordinated care that falls short of being patient-centred. A solution to this challenge is the integration of services within the long-term care spectrum and the broader health care system. Such integration involves targeted community-based care, collaboration among various professionals in interdisciplinary teams, and proactive patient care coordination throughout the continuum of care. This approach aims to provide a more seamless, effective and positive care experience, particularly for individuals with complex health needs.

However, it is important to note that while integration can bring substantial benefits, it also presents challenges and potential negative effects if not executed carefully. This includes issues related to care quality, workforce training, ethical considerations and the need for robust communication and cooperation among providers. Moreover, during crises like the Covid-19 pandemic, integrated perspectives on long-term care provision have sometimes been overlooked, resulting in underperforming long-term care systems. Thus the successful implementation of integration policies requires a common vision across stakeholders, careful planning, adequate workforce preparation and a commitment to addressing the unique needs and challenges of each context.

## 4.5 Conclusion

The landscape of long-term care is evolving rapidly, driven by factors such as ageing populations and a corresponding rise in multimorbidity and demand for support, changing family structures, and shifting societal expectations – all against a background of persistent

workforce shortages. This chapter has shown how these major challenges have given rise to new trends in long-term care provision, i.e. increased integration, the shift from residential care to home-based care, as well as the emergence of the private sector and new digital solutions. The country case studies emphasise the critical importance of recognising the context dependency of long-term care systems and the absence of a one-size-fits-all approach. The evolution of long-term care systems must therefore take into account the unique socio-cultural, economic and demographic circumstances of each country.

Key takeaways for improving long-term care systems include prioritising de-institutionalisation by shifting to community-based care, promoting home care services and supporting informal caregivers, all of which contribute to improved access and health system efficiency. Effective regulation and oversight are crucial when considering privatisation in long-term care to ensure quality, equity and coordination. Implementing IT digital solutions in long-term care can enhance communication, monitoring and care coordination, thereby streamlining access to services and increasing overall health system efficiency, but this requires addressing digital literacy, ethical concerns and disparities. Coordination and integration of long-term care services can improve access by reducing fragmentation and it enhances quality, contributing to health system efficiency. However, challenges related to care quality, workforce training and ethics must be managed carefully to achieve these goals. Successful long-term care reform necessitates a common vision, planning, workforce preparation and stakeholder commitment to address the unique needs and challenges of each context, ultimately leading to improved access and efficiency within the entire health system.

## 4.6 References

Agerholm, J., de Leon, A. P., Schön, P., Burström, B. (2021). Impact of integrated care on the rate of hospitalization for ambulatory care sensitive conditions among older adults in Stockholm County: an interrupted time series analysis. *International Journal of Integrated Care*, 21(2), 22.

Alders, P., Schut, F. T. (2019). Trends in ageing and ageing-in-place and the future market for institutional care: scenarios and policy implications. *Health Economics, Policy and Law*, 14(1), 82–100.

Ambugo, E. A., Dar, I., Bikova, M. S., Førland, O., Tjerbo, T. (2022). A qualitative study on promoting reablement among older people living at home in Norway: opportunities and constraints. *BMC Health Services Research*, 22, 1–13.

Asian Development Bank (2022). *The road to better long-term care in Asia and the Pacific*. Manila: Asian Development Bank. doi: http://dx.doi.org/10.22617/TCS220199-2WHO Global Health Expenditures Database

Blümel, M., Spranger, A., Achstetter K., Maresso, A., Busse, R. (2020). *Germany: health system review*. Copenhagen: WHO Regional Office for Europe.

Ciurea, D., Faracasanu, D., Motea, O., Onofrei, L. (2021). *Community healthcare. Community's nurses' opinion on working conditions, professional activity and training needs*. Bucharest: United Nations Children's Fund/Romanian Center for Health Policy and Services Foundation.

Costa-Font, J., Raut, N. (2022). *Global report on long-term care financing for the World Health Organization*. London: London School of Economics and Political Science (LSE).

Davey, J., de Joux, V., Nana, G., Arcus, M. (2004). Accommodation options for older people in Aotearoa/New Zealand. Wellington: Centre for Housing Research Aotearoa New Zealand (CHRANZ). https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=f42bb8e783c2795e7d0a54a203340bb9c169b8e7.

Erlandsson, S., Storm, P., Stranz, A., Szebehely, M., Trydegård, G. B. (2013). *Marketising trends in Swedish eldercare: competition, choice and calls for stricter regulation*. In: Meagher, G., Szebehely, M., eds. *Marketisation in Nordic eldercare: a research report on legislation, oversight, extent and consequences*. Stockholm: Stockholm University (Stockholm Studies in Social Work 30): 23–84.

Eurofound (2020). *Long-term care workforce: employment and working conditions*. Luxembourg: Publications Office of the European Union.

European Commission (2017). *Commission recommendation on the European Pillar of Social Rights*. No. 2017/761, 26 April 2017. Brussels: European Commission.

European Commission (2019). *Joint report on health care and long-term care systems & fiscal sustainability – country documents 2019 update*. Luxembourg: European Union (Institutional Paper 105).

European Commission (2021a). *Long-term care report. Trends, challenges and opportunities in an ageing society. Volume I*. Luxembourg: Publications Office of the European Union.

European Commission (2021b). *Long-term care report. Trends, challenges and opportunities in an ageing society. Volume II, country profiles*. Luxembourg: Publications Office of the European Union.

European Commission and Social Protection Committee (2021). *2021 pension adequacy report – current and future income adequacy in old age in the EU. Volume 1*. Luxembourg: Publications Office of the European Union. https://data.europa.eu/doi/10.2767/013455

Federal Ministry of Health (2020). *Long-term care guide. Everything you need to know about long-term care*. Berlin: Federal Ministry of Health.

Feng, Z., Glinskaya, E., Chen, H., Gong, S., Qiu, Y., Xu, J., et al. (2020). Long-term care system for older adults in China: policy landscape, challenges, and future prospects. *The Lancet*, 396(10259), 1362–72.

Gallistl, V., Seifert, A., Kolland, F. (2021). Covid-19 as a 'digital push?' Research experiences from long-term care and recommendations for the post-pandemic era. *Frontiers in Public Health*, 9, 660064.

Glendinning, C., Moran, N. (2009). *Reforming long-term care: recent lessons from other countries*. York: Social Policy Research Unit, University of York.

Grødem, A. S. (2018). *ESPN thematic report on challenges in long term care – Norway*. Brussels: European Commission.

Grubanov-Boskovic, S., Ghio, D., Goujon, A., Kalantaryan, S., Belmonte, M., Scipioni, M., et al. (2021). *Health and long-term care workforce: demographic challenges and the potential contribution of migration and digital technology*. Luxembourg: Publications Office of the European Union.

Hagen, T. P., Tingvold, L. (2018). Planning future care services: analyses of investments in Norwegian municipalities. *Scandinavian Journal of Public Health*, 46(4), 495–502.

Helgheim, B. I., Sandbaek, B. (2021). Who is doing what in home care services? *International Journal of Environmental Research and Public Health*, 18(19), 10504. https://doi.org/10.3390/ijerph181910504.

Helse- og Omsorgsdepartementet (2008). *Særtrykk av St.prp. nr. 1 (2007–2008) Programkategori 10.60. Omsorgsplan 2015 [Reprint of St.prp. nr. 1 (2007–2008) Programme category 10.60. Care plan 2015]*. Oslo: Ministry of Health and Care Services.

Ilinca, S., Leichsenring, K., Rodrigues, R. (2015). *From care in homes to care at home: European experiences with (de)institutionalisation in long-term care*. Vienna: European Centre for Social Welfare Policy and Research.

Ilinca, S., Simmons, C. (2022). *The time to care about care: responding to changing attitudes, expectations and preferences on long-term care in Europe*. Vienna: InCARE (Policy Brief No.2).

Inaba, M. (2016). Aging and elder care in Japan: a call for empowerment-oriented community development. *Journal of Gerontological Social Work*, 59(7–8), 587–603. doi: 10.1080/01634372.2016.1258023.

Janssen, D., Jongen, W., Schröder-Bäck, P. (2016). Exploring the impact of austerity-driven policy reforms on the quality of the long-term care provision for older people in Belgium and the Netherlands. *Journal of Aging Studies*, 38, 92–104. doi: 10.1016/j.jaging.2016.05.003. Epub 2016 Jul 1. PMID: 27531456.

Jin, X., Iwagami, M., Sakata, N., Mori, T., Uda, K., Tamiya, N. (2022). Regional variation in long-term care spending in Japan. *BMC Public Health*, 22, 1810. https://doi.org/10.1186/s12889-022-14194-6

Johansen, F., van den Bosch, S. (2017). The scaling-up of Neighbourhood Care: from experiment towards a transformative movement in healthcare. *Futures*, 89, 60–73.

Le Bihan, B., Sopadzhiyan, A. (2019). The development of integration in the elderly care sector: a qualitative analysis of national policies and local initiatives in France and Sweden. *Ageing & Society*, 39(5), 1022–1049.

Leichsenring, K., Rodrigues, R., Winkelmann, J., Falk, R. (2015). *Integrated care, choice and competition. Challenges and strategies of care coordination in the context of market-oriented governance in Germany and Sweden*. Vienna: European Centre for Social Welfare Policy and Research.

Meagher, G., Szebehely, M. (2010). *Private financing of elder care in Sweden: arguments for and against*. Stockholm: Institute for Futures Studies.

Ministerul Muncii si Solidaritatii Sociale – Situatia serviciilor sociale licentiate 26 04 2022 *[The situation of licensed social services 26 04 2022]* (Information bulletin). Bucharest: Ministry of Labour and Social Solidarity Available at https://www.mmuncii.ro/j33/index.php/ro/2014-domenii/familie/politici-familiale-incluziune-%C8%99i-asisten%C8%9B%C4%83-social%C4%83/acreditare-furnizori-%C8%99i-servicii-sociale/.

Ministry of Health and Care Services (2013). *Meld. St. 29 (2012–2013) Morgendagens omsorg [Report. St. 29 (2012–2013) Tomorrow's Care]*. Oslo: Ministry of Health and Care Services: c*hapters 1–3*.

Ministry of Health and Care Services (2020). *Omsorg 2020 – Regjeringens plan for omsorgsfeltet 2015–2020 [Care 2020 – The government's plan for the area of care 2015–2020]*. Oslo: Ministry of Health and Care Services.

Moberg, L. (2021). User choice and the changing notion of social citizenship in Swedish elderly care. *Nordic Social Work Research*, 13(1), 1–16.

Myndigheten för vård- och omsorgsanalys (2021). *Den nordiska äldreomsorgen. En jämförande kartläggning av struktur, organisation och innehåll [Nordic elderly care. A comparative survey of structure,*

*organisation and content]*. Stockholm: Swedish Agency for Health and Care Services Analysis (https://www.vardanalys.se/rapporter/den-nordiska-aldreomsorgen/, accessed 20 December 2023).

National Institute of Statistics Romania (2022). Tempo Database (indicator code: TEMPO_ASS113F) [online database]. Bucharest: National Institute of Statistics. (http://statistici.insse.ro/shop/?page=catD&lang=en&category_id=23, accessed 25 May 2022).

OECD (2023). OECD Health Statistics 2023 [online database]. Paris: OECD Publishing (https://www.oecd.org/els/health-systems/health-data.htm, accessed 30 November 2023).

Oliveira Hashiguchi, T. C., Llena-Nozal, A. (2020). *The effectiveness of social protection for long-term care in old age: Is social protection reducing the risk of poverty associated with care needs?* Paris: OECD Publishing (OECD Health Working Papers, No. 117).

Otnes, B. (2015). Utviklingen i pleie-og omsorgstjenestene 1994–2013 [Developments in the care and nursing services 1994–2013]. *Tidsskrift for omsorgsforskning [Journal of Care Research]*, 1(1), 48–61.

Rusinovic, K., van Bochove, M., van de Sande, J. (2019). Senior co-housing in the Netherlands: benefits and drawbacks for its residents. *International Journal of Environmental Research and Public Health*, 16(19), 1–12.

Saito, J., Haseda, M., Amemiya, A., Takagi, D., Kondo, K., Kondo, N. (2019). Community-based care for healthy ageing: lessons from Japan. *Bulletin of the World Health Organization*, 97:570–4.

Saunes, I. S., Karanikolos, M., Sagan, A. (2020). Norway: health system review. *Health systems in transition*, 22(1), 1–163.

Schön, P., Heap, J. (2018). *ESPN thematic report on challenges in long term care – Sweden*. Brussels: European Commission.

Seifert, A., Batsis, J. A., Smith, A. C. (2020). Telemedicine in Long-Term Care Facilities During and Beyond Covid-19: Challenges Caused by the Digital Divide. *Frontiers in Public Health*, 8, 601595.

Šiška, J., Beadle-Brown, J. (2020). *Transition from institutional care to community-based services in 27 EU member states: final report. Research report for the European Expert Group on Transition from Institutional to Community-based Care*. S.l.: ResearchGate.

Sogstad, M., Hellesø, R., Skinner, M. S. (2020). The development of a new care service landscape in Norway. *Health Services Insights*, 13, 1–7.

SOU (2020). *Äldreomsorgen under pandemin [Elderly care during the pandemic]*. Stockholm: Regeringskansliet. (https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/2020/12/sou-202080/, accessed 20 December 2023).

SOU (2022). *Nästa steg. Ökad kvalitet och jämlikhet i vård och omsorg för äldre personer. Statens offentliga utredningar [Next steps. Improved quality*

*and equality in health and social care for older people. Government public inquiries]*. Stockholm: Regeringskansliet. (https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/2022/06/sou-202241/, accessed 20 December 2023).

Spasova, S., Baeten, R., Coster, S., Ghailani, D., Peña-Casas, R., Vanhercke, B. (2018). *Challenges in long-term care in Europe. A study of national policies*. Brussels: European Commission Publications Office.

Stolt, R., Winblad, U. (2009). Mechanisms behind privatization: a case study of private growth in Swedish elderly care. *Social science & medicine*, 68 (5), 903–911.

Theisen, T. (2020). Municipalities' decision to care: at home or in a nursing home. *International Advances in Economic Research*, 26(4), 327–342.

Tjerbo, T., Førland, O., Sørvoll, J., Hagen, T. P., Fosse, R. M., Ambugo, E. A., et al. (2022). *Resultatevaluering av Omsorg 2020–regjeringens plan for omsorgsfeltet 2015–2020 [Outcome evaluation of Care 2020 – the government's plan for the area of care 2015–2020]*. Oslo: University of Oslo, Health Economics Research Programme (HERO Online Working Paper Series 2022:2).

UNESCAP (2022). *Asia-Pacific report on population ageing 2022: trends, policies and good practices regarding older persons and population ageing*. s.l.: United Nations, Economic and Social Commission for Asia and the Pacific (ST/ESCAP/3041).

Utviklingssenter for sykehjem og hjemmetjenester (2021). *Virtuell avdeling – et nytt trinn i omsorgstrappen? Systematisk geriatrisk vurdering av skrøpelige eldre etter utskrivelse fra sykehus, helsehus og korttidsavdeling til eget hjem [Virtual ward – a new step in the care staircase? Systematic geriatric assessment of frail elderly people after discharge from hospital, health centre and short-term ward to their own home]*. Østfold: Indre Østfold Kommune [Inner Østfold Municipality].

Vabø, M., Zechner, M., Stranz, A., Graff, L., Sigurðardóttir, S. H. (2022). Is Nordic elder care facing a (new) collaborative turn? *Social Policy & Administration*, 56(4), 1–14.

Walker, W. M., Wyse, M. (2021). *Leadership and governance of long-term care systems in Asia and the Pacific*. Manila: Asian Development Bank. https://www.adb.org/publications/long-term-care-systems-lessons-asia-pacific.

Westberg, N. B., Skjeflo, S. W., Hveem, E. B., Pedersen, S., Øien, H., Sørvoll, J., et al. (2019). *Evaluering av investeringstilskudd til omsorgsboliger og sykehjem [Evaluation of investment grants for care homes and nursing homes]*. Oslo: Memon Economics (Menon-publikasjon Nr. 43/2019).

WHO (2020a). *Country case study on the integrated delivery of long-term care: Germany*. Copenhagen: WHO Regional Office for Europe.

WHO (2020b). *Country case study on the integrated delivery of long-term care: Romania*. Copenhagen: WHO Regional Office for Europe.
WHO (2021). *Framework for countries to achieve an integrated continuum of long-term care*. Geneva: World Health Organization.
WHO, 2022a. *Rebuilding for sustainability and resilience: strengthening the integrated delivery of long-term care in the European Region*. Copenhagen: WHO Regional Office for Europe.
WHO, 2022b. *Working for health. 2022–2030 action plan*. Geneva: World Health Organization.
WHO (2024). Global Health Expenditure Database [online database]. Geneva: World Health Organization. (https://apps.who.int/nha/database, accessed December 2024)
World Bank (2024). Population ages 65 and above [online database]. Washington, DC: World Bank Group. (https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS?end=2023&locations=1W&start=2017, accessed December 2024)
Yamada, M., Arai, H. (2017). Self-management group exercise extends healthy life expectancy in frail community-dwelling older adults. *International Journal of Environmental Research and Public Health*, 14, 531.
Yamada, M., Arai, H. (2020). Long-term care system in Japan. *Annals of Geriatric Medicine and Research*, 24(3), 174–180. doi: 10.4235/agmr.20.0037. Epub 2020 Aug 24. PMID: 32829572; PMCID: PMC7533196.
Zimmerman, S., Cesari, M., Gaugler, J. E., Gleckman, H., Grabowski, D. C., Katz, P. R., et al. (2022). The inevitability of reimagining long-term care. *The Journal of Post-Acute and Long-Term Care Medicine*, 23(2), 187–189.