

Trends in Long-Term Care Financing In Selected Countries

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Good morning, Senator Breaux and Members of the Committee. My name is Carol O'Shaughnessy, Specialist in Social Legislation at the Congressional Research Service. Thank you for the opportunity to testify. This morning I will present an overview of trends in long-term care financing in selected countries.

Population Aging Is a Worldwide Phenomenon

The world's elderly population is increasing dramatically. In many Western European countries and in Japan, the elderly population already represents over 15% of the total population. While the United States, Canada, and Australia are relatively young by world standards, with the elderly population hovering around 13% of total population, a large growth rate will occur later. From 2000 to 2030, the U.S. elderly population is estimated to increase by just over 100%. Many European nations and Japan will experience a growth rate of more than 50% over that period.

The aging of societies over coming decades has commanded the attention of policymakers worldwide and will have dramatic implications for pension plans, labor markets, and health and long-term care systems. Lowered fertility rates and increased longevity will continue to affect the share of population that the elderly represent in many industrialized countries for some time to come. While growth in elderly populations is well recognized in the industrial nations of Europe and North America, developing countries are also experiencing rapid growth in their older populations – predicted to increase by two- to four-fold by 2030.

The industrial nations of Europe have the highest proportions of elderly populations, and growth of that population will continue well into this century. In 2000, of 11 Western European countries, in only one – Italy – did older persons constitute 18% or more of the total population. However, by 2015, in nine of these 11 countries, older persons are estimated to be 18% or more of the total population.¹ Moreover, Japan is experiencing extremely rapid growth in its elderly population that exceeds that of many European nations and North America. By 2015, one-quarter of Japan's total population will be age 65 or older.

¹ Austria, Belgium, Denmark, France, Germany, Greece, Italy, Sweden, and the United Kingdom.

Table 1. Estimate of Persons Aged 65 and Older, and 80 and Older, as a Percent of Total Population, 2000, 2015, and 2030, Selected Countries

Country	2000		2015		2030	
	Percent 65 and older	Percent 80 and older	Percent 65 and older	Percent 80 and older	Percent 65 and older	Percent 80 and older
Australia	12.4	3.0	15.8	4.1	21.1	6.0
Austria	15.4	3.4	18.8	4.9	25.2	7.0
Canada	12.7	3.1	16.1	4.3	22.9	6.2
France	16.0	3.7	18.8	5.8	24.0	7.5
Germany	16.2	3.5	20.2	5.4	25.8	7.2
Japan	17.0	3.7	24.9	7.0	28.3	11.1
Russia	12.6	2.0	13.8	3.1	20.5	4.1
Sweden	17.3	5.0	21.4	5.7	25.1	8.6
United Kingdom	15.7	4.0	18.4	4.9	23.5	7.0
United States	12.6	3.3	14.7	3.8	20.0	5.3

Source: U.S. Bureau of the Census and U.S. Department of Health and Human Services. *An Aging World*, November 2001.

Many Nations Are Focusing on the Economic and Social Challenges Presented by Population Aging. Reform of Long-Term Care Financing and Service Delivery Is a Key Component of Review

These demographic factors will have immense impact on public and private spending for pension, social welfare, health and long-term care systems in many nations in the future. As the United States and other countries prepare for an aging society, policymakers worldwide are planning or have already taken steps to change their long-term care financing and service delivery systems. Although countries differ in their approach, many have recognized that provision of long-term care is one of three pillars of social support for the elderly, along with retirement income and medical care.

Comparisons among countries is challenging because of the different economic and political circumstances of each country and the nature of the social contract that each country shares with its citizens. For example, two countries that have instituted long-term care reforms, Germany and Japan, have certain characteristics that differ from other nations. Germany has more than a century-long tradition of public responsibility for the health care of its citizens. Unlike many other countries today, Japan has a long tradition of filial responsibility for older family members.

A landmark study prepared by the Organisation for Economic Co-operation and Development (OECD) for its 29 member nations,² *Maintaining Prosperity in an Ageing Society*, focused attention on a number of complex and interrelated challenges posed by aging populations. The study indicated that comprehensive reform to address the economic and social implications of these demographic factors on care systems will be necessary.³ OECD noted that for many societies there is a limited window of opportunity to put reforms in place before experiencing the full impact of rapidly aging populations.

Along with the impact that population aging has on pensions, labor markets, and health care, OECD focused attention on the need to reform long-term care systems. OECD pointed to the need to develop medical technology to reduce physical dependency and chronic disease in old age as well as the need to improve integration of health and social services for older persons. OECD recommended that frailty in very old age should be treated as a normal part of the aging process and that reforms should result in:

- treating long-term care as a normal risk of life, with the burden of financing shared by the working-age and older populations;
- providing coverage against catastrophic costs, while insuring a balanced access to home help and institutions;
- encouraging a multiple-pillar system of delivery, with more emphasis on supporting people in their own home or in similar home-like settings and less in publicly subsidized nursing homes [and]
- harmonizing long-term care policy with health reforms in order to support the best mix of health and caregiving elements.⁴

A key challenge, according to OECD, is to develop a system that can provide chronic care and improve the balance between care in community settings and institutional care, between family and formal care systems, and between medical and social services. As in the United States, many countries have found this balance difficult to accomplish.

Although there are scarce comparable multi-national data regarding total long-term care spending, OECD estimated that public spending for long-term care is a small, but growing, proportion of the Gross Domestic Product (GDP) of many nations. Estimates indicate that public spending for long-term care services in selected countries in 2000 was less than 1% of GDP, and ranged from .6% of GDP in the United States, to almost 3% in Sweden. (See Table 2.) Projections of future spending is affected by many variables, including assumptions about economic growth, fiscal constraints, and disability rates of elderly populations; however, the data are illustrative of the growing financial implications of long-term care in many countries.

² The OECD consists of 29 countries, including the 15 European Union (EU) countries of Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom. It also includes six non-EU European countries (the Czech Republic, Hungary, Norway, Poland, Switzerland, and Turkey); two Asian countries (Japan and South Korea); three Oceanic countries (Australia, Iceland, and New Zealand) and three North American countries (Canada, Mexico, and the United States).

³ Organisation for Economic Co-operation and Development (OECD), *Maintaining Prosperity in an Ageing Society*, Paris, 1998.

⁴ OECD, *Reforms for an Ageing Society*, Paris, 2000. p. 66.

Table 2. OECD Projections of Publicly Financed Long-Term Care as a Percent of GDP, Selected Countries

(Data assume that past trends in disability rates and institutionalization rates continue)

Country	1996	2000	2010	2020
Australia	0.81	0.82	0.88	0.99
Canada	0.71	0.74	0.81	0.93
Germany	0.71	0.72	0.78	0.90
Japan	0.75	0.83	1.10	1.40
Sweden	2.86	2.71	2.59	2.88
United Kingdom	1.05	1.06	1.08	1.22
United States	0.66	0.64	0.59	0.61

Source: OECD Economic Studies No. 30, *Is the Health of Older Persons in OECD Countries Improving Fast Enough to Compensate for Population Ageing?* By S. Jacobzone, E. Cambois, and J.M. Robine. OECD, 2000. Estimates were based, in part, on projections of the number of disabled elderly persons and of working age population, the cost of long-term care in each country (institutional and home care) in a baseline year, and institutionalization rates. Some countries, including the United States, have experienced decreased rates of disability among the elderly. The authors attribute the decline in the percent long-term care is of GDP in the United States to steeper declines in the disability rates in the United States as compared to other countries, among other things. The United States percent of GDP for long-term care would rise over the period if no change in disability and institutionalization rates is assumed.

Some Nations Have Enacted Major Reforms in Long-Term Care Financing

During the 1990s, a number of nations enacted major legislation to redesign their systems of long-term care for the frail elderly.

- In 1994, Germany created an employer-mandated insurance program where employer and employee share equally in a 1.7% levy on wages to pay for long-term care services.
- Japan enacted major legislation to establish a public long-term care insurance system, which was implemented in April 2000.
- In 1990, the United Kingdom enacted major legislation to transfer funds from the central government to local governmental authorities to be used for home and community-based services and to correct a financial bias that favors institutional care. More recently, in 1999, the Royal Commission on Long-Term Care made far-reaching recommendations to the British Parliament regarding changes in the current system, including elimination of means-tested programs for personal care assistance that lead to impoverishment of frail older persons. It also recommended establishment of a national family caregiver assistance program.
- In the 1990s, Australia enacted measures to support family caregiving, including providing financial support and respite care for caregivers.
- In 1993, Austria enacted legislation to assist families using a combination of cash benefits and social services, with eligibility based on multi-level need categories.

Reviews of various countries have found some similarities in the goals of reform. These include the following:

- Policymakers of all industrialized countries are attempting to find the right balance between public and private responsibility for long-term care.
- Many countries are striving to create greater incentives for home and community-based care, and in some cases, to correct incentives that favor institutional care. In some cases, the desire to control costs of institutional care has propelled policymakers to expand home and community-based care.
- Countries are striving to integrate the delivery systems for acute and long-term care.
- Countries recognize the important role of unpaid care provided by families and friends to assist older persons with functional and/or cognitive disabilities. The role of women in providing unpaid care is especially salient.
- A key feature of reform designs is to avoid creating disincentives to family support. Increasing assistance to family caregivers is an important part of redesign efforts in many countries.
- A number of countries are developing systems that allow consumers greater choice among the types of services and service providers.
- In many countries, responsibilities for administration are generally decentralized, divided among federal and local (or provincial) authorities. Local governmental agencies or insurance plans (in the case of Germany) are responsible for assessment of an individual's need for service and development of a care plan according to services available.
- In some countries, eligibility for services is based on need, not ability to pay. On the other hand, some reform programs require individuals to pay for a portion of the cost of their care through fixed or variable cost-sharing schedules, based on income.

The following presents a summary of recent reforms of long-term care systems in Germany, Japan, and the United Kingdom.

GERMANY⁵

Demographic Trends. Changing demographics were an influential factor in establishing a long-term care insurance system for Germany's aging population. In 1980, 9.4 million people in the Federal Republic of Germany were 65 years of age or older. By 2000, the number 65+ in Germany had grown by 44% to over 13 million. This rapid growth is partially attributed to the reunification of the German Democratic Republic (East Germany) and the Federal Republic of Germany (West Germany).

⁵ This section of testimony is taken from CRS Report RL30549, *Long-Term Care for the Elderly: The Experience of Four Nations*, by Mayra M. De La Garza and Carol O'Shaughnessy, April 27, 2000.

The younger generation in Germany is decreasing, both in absolute terms and as a proportion of the total population. In 1997, the number of people under 15 years of age totaled 13.1 million (16% of the total population), a slight decrease compared to prior years. The Federal Statistical Office of Germany calculates that in a few years there will be more people aged 65 years and over than those 15 years and under.

Projections about the growing older population and a desire to expand home and community-based care led to a major redesign of the German long-term care system. The redesign was enacted into law in 1994. The law established a mandatory universal social insurance program for long-term care financed through equal employer and employee contributions.⁶ The program is separate from the general health insurance program.

Before the enactment of a social insurance approach, long-term care services for the chronically ill were covered under the federal welfare law, and financed at the local level. Under the welfare program, eligibility for services was means-tested and determined by assessing a person's income and assets. Services included cash support and/or in-kind benefits.

The new long-term care social insurance program is considered a capped entitlement program with maximum per-person benefits. It provides nearly universal coverage and, unlike the prior welfare program, eligibility is not related to a person's income and assets. For persons covered by the statutory health insurance program administered through the sickness funds (insurers), long-term care insurance is compulsory and is also administered by the sickness funds. Privately insured persons, i.e., self-employed persons, are required to purchase private long-term care insurance. While the long-term care insurance program covers institutional care, the insurance system favors home care over institutional care. Non-professional caregivers receive training and compensation for their caregiving efforts, and providers of institutional care are compensated on a per-resident, per-month basis.

The most recent data we have (November 2000) indicates that the number of persons with long-term care insurance totaled 80 million or 97% of the total population. At the end of 2000, 1.9 million, or 2.4% of the total insured population, had been beneficiaries of the insurance, with 70% requiring home care and 30% requiring institutional care.

Eligibility. The long-term care insurance program provides benefits and services to anyone requiring assistance with the "regular tasks" of daily life on a long-term basis (estimated at 6 months or longer).⁷ Under the public long-term care insurance program,

⁶ The German Bundestag (Lower House) approved a draft bill addressing social provisions for long-term care on April 22, 1994. One week later, the Bundesrat (Upper House) consented to the bill. On January 1, 1995, long-term care insurance was established as an independent branch of the social insurance system and gradually phased in. The long-term care insurance program has provided benefits for home care since April 1, 1995, and for long-term institutional care since July 1, 1996.

⁷ Section 14(4) of Volume 11 of the Code of Social Law defines regular tasks as *personal hygiene* – washing, bathing, cleaning teeth, combing hair, shaving, emptying bowels and bladder; *food* – preparing or administering food; *mobility* – getting in and out of bed, dressing and undressing, walking, standing, climbing stairs, leaving and returning to one's home; and *household tasks* – shopping,

(continued...)

the medical service department of each health insurance fund is responsible for assessment of individuals in their own homes to determine eligibility and the extent of need for long-term care services.⁸ Each person in need of assistance is assigned to one of three levels of care based on need for care. Each level of care is associated with a maximum insurance allowance, i.e., level of cash and services a person may receive. The entitlements provide for both home care services and nursing home costs. National guidelines and pre-determined benefits are intended to ensure uniformity of assessment and equality of treatment.

While the long-term care insurance program is focused on the elderly, it also provides for the younger disabled population in need of nursing care. These persons receive a flat-rate allowance to help cover treatment costs. The goal is to help disabled people live in the community rather than be compelled to live in nursing homes. German law emphasizes integration of persons with disabilities into the community and the workplace by promoting their employment. German law requires that at least 6% of the workforce of government and private employers (with more than 16 employees) be persons with disabilities. If the employment quota for the disabled is not met, the employers must pay a fee which ultimately subsidizes costs for those who do employ disabled persons.

Services. Germany began phasing in its long-term care insurance program in 1995. Home care benefits were provided beginning April 1, 1995. In July 1996, the second phase began, providing for institutional care. Anyone paying into the long-term care insurance fund can receive full benefits immediately. Home care services are designed to supplement family care. The plan pays for care in institutions, but not for room and board expenses.

The insurance plan in Germany provides both cash and services so that beneficiaries may receive a nursing allowance, a home care allowance, and/or payment of full institutional care. There are no restrictions as to the combination of cash and services received, so that recipients may choose from an array of services, ranging from comprehensive services and minimal amounts of cash, to receiving all benefits in the form of cash and buying privately delivered services. Although cash has been the predominant choice of long-term care clients, recent trends show the number of people choosing only cash is declining. More people seem to prefer tailored individual home care services or combination packages that provide both in kind and cash benefits. The majority of people in need of long-term care desire to live at home or in familiar surroundings for as long as possible.

Benefits for caregivers are also covered. The plan provides free nursing care courses for relatives and other caregivers. In addition, the plan gives statutory pension and accident insurance benefits to primary informal caregivers.

Financing. The public long-term care insurance plan is financed entirely through equal employer and employee contributions. Assistance received, however, is not related to amount paid in to the insurance fund or to a person's financial situation. What began as

⁷ (...continued)

cooking, cleaning the home or apartment, washing-up, changing and washing bed linen and clothing, or heating of the home.

⁸ Section 18 of the Code of Social Law XI.

a 1% contribution rate in 1995 rose to a rate of 1.7% of wage income with the implementation of the second phase of the program in 1996. The increase was planned and the tax rate has remained stable. Contributions are split evenly between the employer and employee. They are directly deducted from wages and transferred to the health insurance fund. Cost sharing by recipients is a key element. When costs of care exceed benefit levels, the difference must be paid by the person requiring care or his/her family. If the individual or family cannot afford additional costs, the welfare system finances the additional costs.

Japan

Demographic Trends. The Japanese tradition of filial duty has characterized the country's system of care for many years. While most elderly remain in their own homes, many reside with their eldest sons. In 1998, approximately half of elderly persons lived with their children. Once a Japanese older person begins to live with his/her child, the daughter-in-law becomes the main provider of care, often spending years tending to the nursing and daily needs of her "patient."

While children of aging parents carry the responsibility of providing care for the senior population, this Japanese tradition is being affected by a number of social and demographic factors. These include: a rapidly growing elderly population, lower fertility rates, decreasing youth population, and greater life expectancy. In addition, Japanese women are now entering the labor force in larger numbers and are increasingly leaving behind the roles of housewife and caregiver.

Japan's public long-term care insurance system was implemented beginning in April 2000. It provides comprehensive in-home and institutional benefits for persons aged 40 and over who need long-term care services. Its purpose is to provide comprehensive and high-quality long-term care services, including in-home care and institutional services. The goals of this new system are to:

- allow users to choose freely from diversified services;
- offer integrated welfare and medical services;
- provide more efficient medical services for long-term care; and
- separate traditional medical insurance from provision of long-term care services.

Services offered through the insurance system were expected to rectify the overuse of expensive long-term stays in hospitals, a practice referred to as "social hospitalization." "Social hospitalization" (or "social admissions") refers to the practice of hospitalizing those in need of long-term care due to the shortage of community care and nursing homes. In Japan, almost 6% of the elderly population are institutionalized (compared to about 5% in the United States).

Eligibility. A "certification" or assessment process administered by the Long-Term Care Certification Committee in each municipality assesses a person's eligibility based on his/her mental and physical condition. Standards for certification for care are objectively determined nationwide.

Under this system, people age 65 and older are the "primary insured." This group was estimated to be 22 million in FY2000. The "secondary insured" are those between the ages

of 40 and 64, estimated to be 43 million people in FY2000. These two age groups are categorized as “primary” and “secondary” because of differences in methods of assessment and collection of premiums for each.

People between the ages of 40 and 64 may receive in-home and institutional care based on age-related factors leading to early onset of senility, cerebrovascular disorders, and other illnesses associated with aging. Those 65 and over who require long-term care or support because they are bedridden, physically weak, or have dementia may receive care under this system. Those who require support due to physical conditions are provided in-home services to prevent institutional care. The degree of family support available is not a factor in eligibility determinations.

Services. After determining an individual’s needs, a care planning organization allows the insured person to select his/her preferred services from a variety of home care services, and creates a service plan. The goal is to allow users to choose the services they want.

With the new insurance system, frail persons in need of physical support may receive approximately ¥62,000 (US \$500 in 2002) per month in home benefits while those requiring more intensive care (for example, those who are bedridden or have dementia) may receive an amount up to almost six times that amount per month, depending on the level of care needed. Benefits for institutional care are fixed for each type of institution, and depend on the level of care required.

In-home services include:

- Home-visit/day care (home help),
- Home-visit nursing services,
- Home-visit rehabilitation,
- Commuting assistance for rehabilitation,
- In-home medical care management guidance,
- Commuting assistance for care (day service),
- Short stays in facilities,
- Communal living facilities with care-takers (group homes),
- Long-term care at fee-charging homes for the elderly,
- Rental service for welfare equipment, and
- Funds for home improvement and adaptation.

Institutional care services include:

- Special nursing homes for the elderly,
- Health services facilities for the elderly, and
- Sanatorium-type wards.

Financing. Financial support for the long-term care insurance program is provided by the national government, prefectures,⁹ medical care insurers, premiums paid by the insured, and copayments paid by service recipients. Public subsidies pay one half of the

⁹ Japan is divided into 47 prefectures, which are administered by governors and assemblies. A prefecture is further subdivided into minor civil divisions, including the city, town, and village, which have their own mayors, or chiefs, and assemblies.

total benefit expenditures, with the national, prefectural and municipal governments contributing 25%, 12.5%, and 12.5%, respectively. To keep a balance between service users and non-users, and to raise awareness of service costs, beneficiaries pay a 10% coinsurance amount for long-term care services. Moreover, recipients are responsible for their own meal costs at long-term care facilities.

“Primary” insured users (age 65 and older) pay fixed insurance premiums based on income, as determined by each municipality. Premiums are deducted from pensions. The medical insurance systems of the “secondary” insured users (aged 40 to 64) determine premiums for long-term care, based on a national standard. A portion of these premiums for this group are paid by employers. These premiums are collected together with the medical insurance premium by the medical insurer.

United Kingdom

Demographic Trends. The number of people aged 65 years or over increased from 7.3 million people (13.2% of the total UK population) in 1971, to 9.3 million (15.7% of the total) in 2000, a growth of 27%.

Recognition of the demographic trends and dissatisfaction voiced by many U.K. policymakers with the current long-term care system led to a major policy review in 1997. The Royal Commission on Long-Term Care was appointed by the Secretary of State for Health to analyze the current system and to make recommendations for improvement. The Commission was to examine options “for a sustainable system of funding of Long-Term Care for the elderly, both in their own homes and in other settings.” The Royal Commission presented its findings and recommendations in a report to Parliament in March 1999 (*With Respect to Old Age, A Report by the Royal Commission on Long Term Care*).

While a major reform enacted in 1990 was designed to improve the system of care, the Royal Commission concluded that the “current system is failing.” Reasons included insufficient home care and assistance to caregivers, lack of progress in correcting the institutional care bias, poor quality of institutional care, and lack of a client-based focus. Among the Commission’s conclusions were the following:

- “Long-term care is a risk that is best covered by some kind of risk pooling – to rely on income or savings, as most people effectively have to do now, is not efficient or fair due to the nature of the risk and the size of the sums required;
- Private insurance will not deliver what is required at an acceptable cost, nor does the industry want to provide that degree of coverage;
- The most efficient way of pooling risk ... across all generations, is through services underwritten by general taxation, based on need rather than wealth [with some cost sharing];
- ... more care (should be given) to people in their own homes. Therefore the role of housing will be increasingly important in the provision of long-term care;

- More services should be offered to people who have an informal carer [caregiver].”¹⁰

The Royal Commission found that, despite attempts to lessen the bias toward institutional care in favor of home care envisioned by the 1990 Health and Community Care Act, more effort is needed. The Commission indicated that its proposals to provide personal care services, free of charge, would lead to expansion of home care services. It also recommended that more support be given to families and others who provide unpaid, informal care, and proposed that a national caregiver support program be established.

The Royal Commission recommended the continuation of the current pay-as-you-go model to finance long-term care. While the Commission considered other methods, it recommended no major changes in taxation. As discussed above, the Commission recommended changes so that individuals would be required to contribute toward the cost of their care. Policymakers have debated legislation that would enact a number of the Commission’s recommendations.

Table 3 compares major components of three countries’ systems.

¹⁰ A Report by the Royal Commission on Long Term Care. *With Respect to Old Age: Long Term Care—Rights and Responsibilities*. Presented to Parliament by Command of Her Majesty. March 1999. p. xviii-xix. See also, Roll, Jo. Social Policy Section. House of Commons. *Royal Commission on Long-Term Care*, February 17, 2000.

Table 3. Comparison of Selected Country Characteristics and Long-Term Care Systems

population % 65+	Germany	Japan	U.K.
United States 12.6% (2000) 14.7% (2015) 20.0% (2030)	16.2% (2000) 20.2% (2015) 25.8% (2030)	17.0% (2000) 24.9% (2015) 28.3% (2030)	15.7% (2000) 18.4% (2015) 23.5% (2030)
Financing	employer mandated insurance; 1.7% of wages, shared equally by employer and employees; cost-sharing based on income.	public long-term care insurance plan; public subsidies; insurance premiums and copayments paid by beneficiaries	pay-as-you-go taxation; individual contributions toward cost of care; tax credits for caregivers
Eligibility	assessment of need for care by medical service department of health insurance fund; benefits granted on basis of care requirement and not financial resources	assessment of need for care by municipalities	assessment of need by local authorities; requires individuals to contribute toward the cost of care based on a fee schedule (called a "means test")
Services and benefits	pre-determined benefits according to three levels of care/need; beneficiaries able to choose a mix of cash or services	12 at-home care programs to choose from, three institutional care services; maximum benefits at fixed yen amounts based on care needs	wide range of institutional and home care services in varying amounts
Problems	low fertility rate and growing elderly population	rapid growth in elderly population and decrease in number of potential caregivers; decline in family care	bias toward institutional care; lack of uniform application of eligibility criteria; uneven quality and access

Source: CRS Report RL30549, *Long-Term Care for the Elderly: The Experience of Four Nations*, by Mayra M. De La Garza and Carol O'Shaughnessy. April 27, 2000.

Summary

Projections of growing elderly populations and the institutional bias in long-term care systems have served as an impetus for policymakers in many industrialized nations to review their systems of long-term care financing and delivery. Areas of reform have included programs to assist family caregivers, expansion of home care programs, and financing methods to spread the costs of long-term care between public sources and private financing (through insurance plans, as in Germany, and/or fixed or sliding fee cost-sharing on the part of those persons needing care), among other things. Policymakers are attempting to find the right balance between public and private responsibility for long-term care while at the same time striving to create greater incentives for home and community-based services that most older people want.