DISCUSSION PAPER

ELDERCARE POLICIES IN EAST ASIA AND EUROPE:

Mapping Policy Changes and Variations and Their Implications

No. 19, December 2017

ITO PENG AND SUE YEANDLE
PROGRESS OF THE WORLD'S WOMEN 2018

UN WOMEN

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SUMMARY

Adequate and dignified care provision for frail elderly populations is becoming an urgent policy issue not only in high-income countries but also in many middle- and low-income ones. The growing demand for eldercare in many countries is driven by rapid demographic ageing as well as by changes in family patterns and gender relations, greater distanciation between generations and institutional and ideational changes in relation to political economy and the meanings and practices of care. This report documents and analyses varieties of eldercare policies, and their readjustments, in East Asia and Europe. It analyses changing social, economic and political contexts and their implications for eldercare and eldercare policies in 10 selected countries and territories – China, Japan, Republic of Korea, Singapore and Taiwan Province of China in East Asia and Finland, France, Germany, Spain and the United Kingdom in Europe – that all have in common severe care deficits that will only amplify in the future, given their rapid population ageing, low fertility, rising female employment and increased mobility and distanciation of families. The first two sections of the report describe broad social, economic and political contexts and trace the trajectory of eldercare policies, noting reforms and developments at first the regional level and then the level of country or area. The third section examines the impacts and implications of these changing eldercare arrangements and policies for women and families. The two regions are sites of intense eldercare policy reforms, as governments across both regions try to manage the imperatives to address increasing public demand for care, maintain fiscal control over social and health-care expenditures and respond to changes caused by population ageing and mobility. This has resulted in significant cross-national and cross-regional policy learning, innovations and experimentations, as governments adopt and adjust policy models from other locales to meet their needs. Policymakers in all the areas considered continue to find these developments challenging, with some elderly people and their families, especially women, inadequately supported. The paper argues that despite active policy learning, significant variations remain both within each region and between the two regions, underscoring the importance of local histories, institutions and cultures in shaping policy diversity.

RÉSUMÉ

La question des soins de santé adaptés et dignes pour les personnes âgées fragiles est en train de revêtir un caractère d'urgence dans les pays à revenus élevés mais également dans de nombreux pays à bas et moyens revenus. La demande croissante de soins de santé pour les personnes âgées dans de nombreux pays est stimulée par le vieillissement rapide de la population ainsi que par les recompositions familiales et l'évolution des relations de genre, les écarts croissants entre les générations et des mutations institutionnelles et idéologiques en lien avec l'économie politique et les significations et les pratiques en matière de soins. Ce rapport documente et analyse diverses politiques en matière de soins de santé pour les personnes âgées ainsi que leurs rééquilibrages en Asie de l'est et en Europe. Il analyse les contextes sociaux, économiques et politiques fluctuants et leurs implications sur les soins de santé et les politiques en matière de soins de santé pour les personnes âgées dans 10 pays et territoires sélectionnés - la Chine, le Japon, la République de Corée, Singapour et la province chinoise de Taiwan en Asie de l'Est et la Finlande. La France, l'Allemagne, l'Espagne et le Royaume-Uni en Europe – qui ont tous en commun des déficits graves en matière de soins de santé, lesquels ne feront que s'aggraver à l'avenir compte tenu du vieillissement rapide des populations, des taux de fertilité bas, de l'augmentation de la main d'œuvre féminine, la mobilité croissante et la distance géographique entre les familles. Les deux premières sections du rapport décrivent les contextes sociaux, économiques et politiques et retracent l'évolution des politiques en matière de soins de santé pour les

personnes âgées, en indiquant les réformes et les mutations aux niveaux des régions, pays et territoires. La troisième section examine les conséquences et implications de ces dispositifs et politiques de soins de santé fluctuants pour les personnes âgées pour les femmes et les familles. Ces deux régions sont des hauts lieux de réformes des politiques en matière de soins de santé étant donné que les gouvernements des deux régions s'emploient à faire face à l'urgence d'accroître la demande publique de soins, de maintenir le contrôle budgétaire sur les dépenses sociales et médicales et de répondre aux mutations causées par le vieillissement et la mobilité de la population. Ces démarches donnent lieu à des apprentissages transnationaux et transrégionaux importants en termes de politiques, d'innovations et d'expérimentations, car les gouvernements adoptent et adaptent les modèles politiques d'autres systèmes pour répondre à leurs besoins. Les décideurs politiques de tous les territoires examinés continuent de considérer ces évolutions comme des défis car les personnes âgées et leurs familles, surtout les femmes, ne sont pas suffisamment soutenues. Ce document estime que, malgré des adaptations politiques importantes, des variantes importantes subsistent dans chaque région et entre les deux régions, ce qui souligne l'importance de l'histoire, des institutions et de la culture locales dans le façonnage de la diversité politique.

RESUMEN

La necesidad de establecer políticas públicas de cuidados dignos y adecuados para la población adulta mayor es cada vez más urgente no solo en los países de ingresos altos, sino también en muchos otros de ingresos medios y bajos. La creciente demanda de cuidados para personas adultas mayores en numerosos países se ve impulsada por el rápido envejecimiento demográfico y los cambios en las estructuras familiares y las relaciones de género, así como por un mayor distanciamiento entre generaciones, modificaciones institucionales y conceptuales en relación con la economía política y los significados y las prácticas de cuidados. El presente informe documenta y analiza las diversas políticas de cuidados de personas adultas mayores y sus readecuaciones en Asia Oriental y Europa. Examina los cambiantes contextos sociales, económicos y políticos y las consecuencias para los cuidados de personas adultas mayores y para las políticas al respecto en diez países y territorio China, Japón, la República de Corea, Singapur y la provincia china de Taiwán, en Asia Oriental, y Alemania, España, Finlandia, Francia y el Reino Unido, en Europa. Estos países comparten un grave déficit de cuidados, que se acrecentará debido al rápido envejecimiento de la población, la baja tasa de fecundidad, el aumento del empleo entre las mujeres y el creciente desplazamiento y distanciamiento de las familias. Las primeras dos secciones del informe describen los contextos sociales, económicos y políticos en general y recorren la historia de las políticas de cuidados de personas adultas mayores, señalando reformas y avances primero a escala regional y, a continuación, a nivel de país o de zona. La tercera sección examina los resultados y las consecuencias que tienen los cambiantes mecanismos y las políticas de cuidados de personas adultas mayores para las mujeres y las familias. Las dos regiones contemplan intensas reformas a las políticas de cuidados de personas adultas mayores: los Gobiernos en ambas regiones intentan administrar las exigencias actuales para abordar la creciente demanda de cuidados por parte de la sociedad, mantener el control fiscal sobre el gasto social y la atención de la salud y responder a los cambios generados por el envejecimiento y desplazamiento de la población. Esta realidad propició el aprendizaje entre los distintos países y regiones en lo relativo a las políticas empleadas, las innovaciones y las experimentaciones, a medida que los Gobiernos adoptaban y ajustaban modelos de otros lugares a las necesidades locales. Las personas encargadas de la formulación de políticas en estas zonas continúan enfrentando desafíos en esta área, ya que algunas personas adultas mayores y sus familias, especialmente las mujeres, no cuentan con el apoyo necesario. El informe sostiene que, pese al activo aprendizaje sobre políticas, existen aún importantes variaciones al interior de ambas regiones y entre ellas, lo que enfatiza la importancia de las historias, instituciones y culturas locales para la formulación de políticas que tengan como eje la diversidad.

1. INTRODUCTION:

Adequate and dignified care provision for frail elderly populations is becoming an urgent policy issue not only in high-income countries but also in many middle- and low-income ones. There is, of course, a demographic dimension to this urgency, given falling fertility rates, increasing life expectancy and ageing populations, although the average trends on all three dimensions are highly differentiated even within the same locality (by class, race, ethnicity/race and other aspects of diversity). Moreover, demographic ageing often has a female face, not only because women tend to live longer than men but also because most women tend to marry/cohabit with men older than themselves. They thus care for them as part of their 'wifely duties' and often live alone in late old age when they need care themselves.

But there is more to eldercare than demography because family patterns and structures are rapidly changing and diversifying: for example, nuclearization of families where hitherto extended families have been the norm, with shrinking family size such that younger family members can no longer physically or emotionally care for multiple elderly family members even if they wanted to (for example, in China); greater distanciation between generations in the context of migration and mobility (both domestic and transnational); and greater complexity in family relationships, where families have been affected by separation/divorce, re-partnering and the formation of new families.[1] Ideational changes also play their part: for example, reluctance on the part of the younger generation, especially women, to adopt gender roles of providing care for elderly parents in the traditional manner and/or on the part of the older generation to be a 'burden' on their children (especially in the case of East Asia, and a view also expressed by some elderly Europeans).[2] Some of these social and normative trends may be tied to changing intergenerational power dynamics as the capacity or the desire of older generations to claim care, based in some societies on notions of filial piety, may be diminished as a result of full embedding of modern ideals (e.g., Japan and the Republic of Korea) or, as in the case of China, because land-based livelihoods are de-centred and younger generations seek off-farm options.[3] Together with concerns that, for many, longer lives may also mean living longer with increased frailty, disability and poor health, these changes in family structures, living arrangements and intergenerational contracts are impacting on the perceived or real need for non-familial care provision and hence the urgency of public policy responses.[4]

This report documents and analyses varieties of eldercare policies, and their readjustments, in East Asia and Europe. The two regions warrant in-depth and comparative research, first because of their advanced ageing demographies. Europe is currently the most aged, while East Asia is the most rapidly ageing region in the world; by 2040 they will become the two most aged regions, with over 25 per cent of their total populations over the age of 65.[5] Second, the two regions are also sites of intense eldercare policy reforms as governments try to manage the imperatives to address increasing public demands for care on the one hand and maintain fiscal control over social and health-care expenditures on the other. This has resulted in significant cross-national and cross-regional policy learning, innovations and experimentations as governments

1. UNPD undated; UNDESA 2015; Olah 2015; Raymo et al. 2015.
2. Raymo et al. 2015; EC undated b.
3. MOHLW 2009b; Cheung and Kwan 2009; Chou 2011.
4. Chou 2011; Du 2013; Pellikan and Westerhout 2005.
5. UNDESA 2016; see also Table 2-2 in this report.

adopt and adjust policy models from other locales to meet their needs. Third, despite active policy learning, significant variations remain, both between the two regions and within each region. This underscores the importance of local histories, institutions and cultures in shaping policy diversity.

The first two sections of the report describe broad social, economic and political contexts and trace the trajectory of eldercare policies, noting reforms and developments at first the regional level and then the of the country or area. The third section examines the impacts and implications of these changing eldercare arrangements and policies for women and families. The following questions are posed: how is eldercare being de/re-familialized (or not)? How and why is it being marketized? How do migrant care workers fit into this picture? Are the new forms of provision 'crowding-out' family care or merely meeting new and expanding demand for eldercare? And, more broadly, how do these developments influence or contribute to altered family and gender relations and play out in contexts of social and economic inequality? The analysis focuses primarily on national institutional and policy approaches to eldercare in East Asia and Europe. Eldercare is a hugely complex and multi-dimensional issue that not only touches on social and economic contexts and policies but also encompasses a wide range of physical, emotional and cognitive dimensions, such as age-related frailty, physical and mental health conditions and various forms of care dependency or needs. Individual care needs and the modalities of care services are also very diverse and complex, ranging from intensive round-the-clock nursing care to companionship and simple home help services. Ideally, a comprehensive analysis of eldercare would include all these aspects; however, this is beyond the scope of the present paper.

The paper analyses changing social, economic and political contexts and their implications for eldercare and eldercare policies in 10 selected countries and territories across East Asia and Europe: China, Japan, Republic of Korea (hereafter, Korea), Singapore and Taiwan Province of China; and Finland, France, Germany, Spain and the United Kingdom. They all have in common severe care deficits that will only amplify in the future, given their rapid population ageing, low fertility, rising female employment and increased mobility and distantiation of families.[6] Their governments have become much more aware of the need to reconcile families' work and care responsibilities, both to meet family and care needs and in the national economic interest. As it becomes clear that historical ways of dealing with care – in all cases, relying primarily on the family to care for its members – are no longer sustainable, these governments have begun to search for and to experiment with alternatives to existing eldercare systems, often looking at the policies and programmes of other countries for cross-national learning.[7] To date, policy responses have varied greatly, from minimal response (implicitly assuming that family members will continue to provide care for frail elderly persons, either directly or indirectly by employing others to do this work), to more active strategic responses (for example, through new forms of support for family/friend carers, or alternatively trying to re-culture citizens with Confucian filial piety, as in the case of China), to explicit 'out-sourcing' and marketization of eldercare. In all cases, there has been active policy learning as countries assess, adopt and adjust new eldercare models in light of their social, economic and cultural contexts.[8]

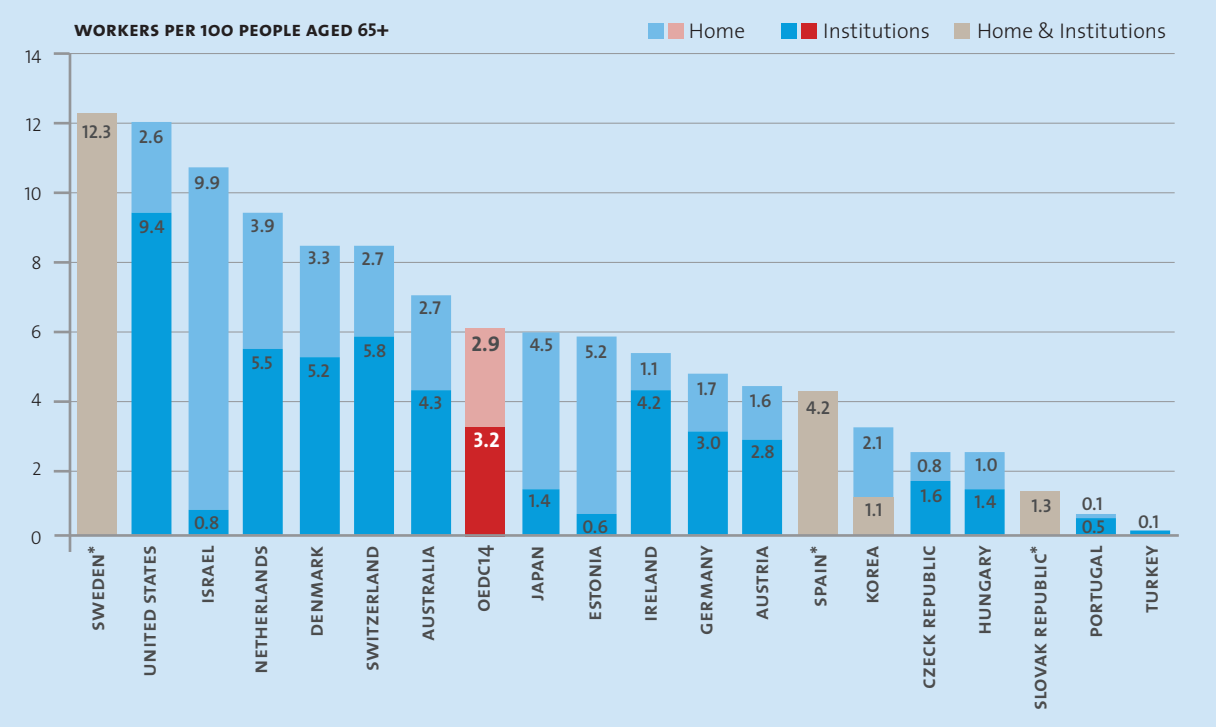
6. EC 2013; Raymos et al. 2015; UNDESA 2015.
7. National responses include assessing rates of poor health/disability in older age and adopting various measures to reduce these. OECD (2015) data for 2013 show that in the European States considered, about half of men's years 65+ were lived in good health, but only one third to two fifths for women (who also tend to live longer). East Asia has achieved some of the largest gains in life expectancy rates in the world: 84 years for Hong Kong in 2015, with China, Japan, Korea, Singapore and Taiwan Province of China all having life expectancy of over 80 years (OECD 2016), however, many of these people may be living for longer periods in poor health. While there are very few comparable data, an OECD health survey (based on 2013 data) shows only 25 per cent of Japanese and 19 per cent of Koreans over the age of 65 report having good or very good health. In both cases, women's self-reported health status is poorer than men's, at 24 per cent for women as compared to 27 per cent for men reporting being in good or very good health in Japan, and 15 and 25 per cent, respectively, for Korea. These figures are significantly lower than the OECD-34 average of 47 per cent for men and 41 per cent for women (OECD 2015). (Note, however, that consideration of public health/health promotion measures is beyond the remit of the present paper.)
8. EU 2014; Peng and Wong 2008; Kwon 2009.

The trajectories of eldercare policy reform are far from straightforward, however. Whereas international policy learning has led to increased socialization of eldercare in some places – for example, through long-term care insurance (LTCI) in Germany, Japan and Korea – in other countries the process has instead led to progressive re-familialization of eldercare responsibility, as in the cases of China and, to some extent, Finland.[9] Europe and East Asia have both seen increased marketization of eldercare in recent decades as many governments attempt to privatize systems that were hitherto publicly funded or to further reinforce the private market role in the provision of care.[10]

To date, policy responses have varied greatly (Table 1-1), from minimal response (implicitly assuming that family members will continue to provide care for frail elderly persons, either directly or indirectly by employing others to do this work), to more active strategic responses (for example, through new forms of support for family/friend carers, or alternatively trying to re-culture citizens with Confucian filial piety, as in the case of China), to explicit 'out-sourcing' and marketization of eldercare.[11]

FIGURE 1.1

Long-term care workers per 100 people aged 65 and over, 2013 (or nearest year)



Source: OECD 2015. * In Sweden, Spain and the Slovak Republic, it is not possible to distinguish LTC workers in institutions and at home. *OECD Health Statistics 2015*, http://dx.doi.org/10.1787/health-data-en. Statlink: http://dx.doi.org/10.1787/888933281433

9. Du 2013; Jolanki et al. 2013.
10. Szebehely and Meagher 2013; Eurofound 2015; Feng et al. 2011; Feng et al. 2012.
11. Comparable national data on care workers per 100 people aged 65+, for some countries, show one aspect of this variation, although figures are not available for all the case studies (Figure 1-1). Please note that the data on Figure 1-1 indicates only those who are formally employed in "care work" and does not include those employed informally by families or those undertaking care work under different occupational categories such as domestic workers (in Singapore) or caregivers (in Taiwan Province of China).

TABLE 1-1

National eldercare support arrangements in selected countries and areas: Asia

	Japan	Korea (Rep. of)	Taiwan Province of China	China	Singapore
General approach (private market vs. regulated institution)	Regulated institutional model	Regulated institutional model	Mix	Mix	Liberal market model
% public expenditure on LTC	2.1% (OECD 2015)	0.7% (OECD 2015)	0.2%	0.1%	N/A
# or % foreign CWs	2,945: EPA CWs + nurses	67,357 (estimated number)	224,356 (2015 Dec)	N/A	231,500 (2015 Dec)
Eldercare policies	• **Universal LTCI:** people 65+ with assessed care needs and 40–64 with age-related disabilities (e.g., Alzheimers); compulsory LTCI contributions age 40+ • Community-based and residential services • Co-payment 20%	• **Universal LTCI:** people 65+ and age-related LTC (e.g., dementia) for <65s • Publicly funded but mainly privately delivered; most providers private for-profit; Government regulates care quantity and quality • Co-payment 30%	• **Senior Allowance** NTD$3,500 pcm for citizens over 65 • **LTC Ten-Year Plan:** covers home, day and family care, rehab., respite, transport services; subsidies to users of eldercare services (NT$180/ph)	• Community/family still supply most LTC • Retirees from state-owned enterprises and public institutions have OAP, med/health, housing and other support services • **Public nursing homes** are mostly filled and/or overflowing	• **Central Provident Fund (CPF)** • **ElderShield:** compulsory CPF account for citizens 40+ • **Annual tax relief for adult children** caring for parents: S$11,000/year for co-resident parent with daily living needs; S$4,500 for physically independent non co-res. parent

* As the four national systems within the UK differ in significant ways, that for England (by far the largest by population), is described here.
** P. 164, Fig. 5.12, based on official Department of Communities and local government data.

TABLE 1-1 (CONT.)

National eldercare support arrangements in selected countries: Europe

	Finland	France	Germany	Spain	United Kingdom*
General approach (private market vs. regulated institution)	Regulated institutional model, some privatization of delivery	Regulated institutional model, with private market elements	Regulated institutional model, mostly privatized service delivery	Quasi universal, state guaranteed, from 2007	Regulated institutional model, most via 'independent' (for- and not-for-profit) providers
% public expenditure on LTC	2.2% (OECD 2015)	1.9% (OECD 2015)	1.0% (OECD 2015)	0.7% (OECD 2015)	1.2% (Luchinskaya 2017)**
# or % foreign CWs	Low (see text)	16% foreign born (2009)	18% of all CW (est.) (see text)	29% foreign born (2008)	17% England; 52% London
Eldercare policies	• Tax- funded, universal, needs-tested support, via municipalities: residential care / supported housing; home care; support for informal care • Trend to ageing in place • Informal Care Allowance (family carers, contract with municipality) • Vouchers/tax credits offered in lieu of services	• Compulsory, corporatist health insurance • Residential/home-based support (municipalities) • Benefits incl. APA (Pers. Allowance for Autonomy) paid to people 60+ with assessed care needs; no means-test, but more affluent users make income-based co-payments • Extensive use of cash benefits	• Compulsory LTCI for most (see text) • LTCI benefits often taken as cash, incl. to support family care • Quality assured, highly privatized care market • 2.5 million social LTCI beneficiaries (2013) • System being adjusted to increase dementia support	• Tax-funded, means- tested, with co-payments • Decentralized, role for regions in admin./ funding • Guaranteed min. protection of assessed needs • 2012 reforms reduced funding and cash allowance for family care, cut social security contrib. for CWs in home • Dependency insurance: regulated, voluntary, some tax breaks	• Free to access, tax-funded health care (NHS) • Universal (low) state OAP • Attendance Allowance (needs tested, unregulated) • Means- and needs-tested home /residential care through local authorities, mainly via independent providers • Residential/home and community based services • Growing private pay market due to means testing; many users now pay 100% of costs

* As the four national systems within the UK differ in significant ways, that for England (by far the largest by population), is described here.

** P. 164, Fig. 5.12, based on official Department of Communities and local government data.

In Europe, marketization of eldercare has proceeded in different ways. In Nordic countries such as Finland, Norway and Sweden, local governments are increasingly outsourcing eldercare to private or semi-private care providers,[12] while in Italy and the United Kingdom care allowances and personal budgets have allowed some families and elderly people to purchase care through the market.[13] In Austria and Germany, LTCI gives the option of either cash allowances or services. In some countries, the existence of a cash option allows people to purchase private care – often provided by 'cheap' migrant care workers from Eastern Europe or other parts of the world at lower cost than formal services – and in so doing creates a grey market.[14] In France, conditional care allowances have been used as a policy tool to activate local employment (for the unemployed and those deemed economically 'inactive').

A diverse approach to marketization of eldercare is evident in East Asia as well. Because the social and economic changes have been so rapid and dramatic, and because the absolute volume of care needed is so large, East Asian countries have had to change the way it is provided. Today, significant outsourcing of care, from the family to the market or public sector, is taking place, often facilitated by the state through different policy levers. Both Japan and Korea have introduced LTCI. In both countries, however, private sector care providers play an important role in eldercare delivery. In Japan, strict government regulation has led to a quasi-market situation whereby eldercare is delivered through both public and private for- and not-for-profit sectors, while in Korea looser regulation has resulted in private market providers playing a larger role.[15] Taiwan Province of China passed the first of two laws in 2015 that may pave the way for LTCI. In the meantime, Taiwanese families are actively utilizing the Foreign Live-in Caregiver Programme, a special government-sponsored programme that recruits foreign migrant caregivers to provide eldercare in private homes.[16]

A similar approach to eldercare is also evident in Singapore, where the Government explicitly encourages – and has redoubled its commitment to supporting – families to employ foreign domestic workers to provide eldercare by offering tax incentives.[17] In China, eldercare is becoming rapidly privatized as the Government offers public grants to entice the private sector to develop and provide eldercare services. For many, the expansion of publicly supported and privately delivered (and mainly institutional) eldercare has contributed more to the process of re-familialization than de-familialization. Moreover, partly because of the sheer enormity of managing and coordinating its huge, socially and economically diverse populations, and partly because of the disarticulation of its previously bifurcated social security system that divided urban and rural residents after the 1979 economic reform, Chinese eldercare policy remains undeveloped, disjointed and unclear.[18] Increasingly, in response to the rising demand for care, big cities such as Shanghai have started implementing publicly paid home care services for elderly people on low incomes. A large proportion of those working in the home care services in Shanghai are female migrants from neighbouring rural provinces.[19] The Government, in turn, is using large city governments as policy 'pilots' before implementing new policies at the national level. Policy innovation and learning in China thus may be happening through local to national level policy transfers.

12. Meagher and Szebehely 2013.
13. Ungerson and Yeandle 2007.
14. da Roit and Le Bihan 2010.
15. Peng 2017.
16. Lan 2002; Lin and Bélanger 2012.
17. Yeoh and Huang 2009.
18. Feng et al. 2012.
19. Hong 2017.

2.
REGIONAL ANALYSIS

2.1
East Asia

The five East Asian case studies comprise hugely diverse social, economic and political settings. They range from some of the world's richest post-industrial economies (Japan and Singapore) to middle-income (Korea and Taiwan Province of China) and rapidly transitioning (China) economies. Politically the group represents both established (Japan) and recently consolidated democracies (Korea and Taiwan Province of China),[20] a mix of authoritarian and democratic (Singapore) and a communist capitalist (China) state. The demographic differences among the five case studies cannot be ignored either: China has the world's largest national population (1.38 billion), while Singapore has one of the smallest (5.66 million), with Korea and Taiwan Province of China in mid-range at 50 and 23 million, respectively. The Japanese population – currently at around 127 million – is the oldest in the world and has begun to decline absolutely since 2007 due to low fertility.

Despite these differences, the five East Asian welfare states share in common several features that differentiate them from most of the Western welfare states. First, they are 'familialistic' in the sense that the state – even the Communist Chinese state – has traditionally relied on the family to look after elderly people, the ideational root of which is commonly explained by their historically shared Confucian doctrine, which upholds filial piety as one of the virtues.[21] Second, they have all experienced substantial and rapid social, economic and family changes since the 1990s, making eldercare an urgent family and policy imperative.

Like most Western countries, all the East Asian countries and areas have been experiencing fertility decline and population ageing for some time; but unlike other regions, total fertility rates in East Asia are significantly lower and the pace of population ageing is much faster. Today, total fertility rates in the five case studies range from 1.03 in Taiwan Province of China to 1.59 in China, all well below the replacement ratio, and below the Organisation for Economic Co-operation and Development (OECD) average of 1.5 (Table 2-1). Although the proportions of people aged 65 and over in China, Singapore, Korea and Taiwan Province of China are currently still quite low (9.6 per cent, 11.7 per cent, 13.1 per cent and 12.2 per cent, respectively), the figure is already very high in Japan (26.3 per cent) and expected to increase sharply in all five countries and areas over the next two decades (Table 2-2). By 2035, all of them, except China, will have an elderly population comprising over 26 per cent of the whole; and by 2060, all five will have a third or more of their populations over the age of 65 (in Taiwan Province of China the 65+ population is projected to make up almost 41 per cent of the population). In Japan, the proportion has risen from 14.4 per cent in 1995 to 26.3 per cent in 2015 and is projected to reach 31.9 per cent by 2035 and 36.7 per cent by 2060 (Table 2-2). This has, unsurprisingly, pushed old-age dependency ratios up, from 15.0 in 1985 to 43.3 in 2015, and these are estimated to further increase to 57.0 by 2035 and 72.4 by 2060; in China, the figures are 7.9 to 13.0, 32.7 and 61.1, respectively[22] (Table 2-3).[23]

20. The democratization process in Taiwan Province of China began in 1988 following the death of President Chian Ching-kuo and culminated in 1996 with the first direct presidential election. Prior to that Taiwan Province of China was ruled under the mili-tary government headed by the Nationalist government (KMT) after it took over the country in 1949. Korea achieved democracy in 1987 with the first direct presidential election. Prior to this, like Taiwan Province of China, Korea had been under military dictatorship since 1948.
21. Mediterranean countries (Greece, Italy, Portugal and Spain) share similar familialistic orientations, in their case explained by Christian traditions (especially through the Catholic and Orthodox churches) rather than Confucianism.
22. UNDESA 2016.
23. Old-age dependency ratio is calculated here as ratio of population 65+ per 100 population 15–64.

TABLE 2-1

Total fertility rates in East Asia and Europe

	1990– 1995	2015– 2020	2025– 2030	2035–2040	2045–2050	2055–2060
China	2.00	1.59	1.66	1.70	1.74	1.76
Japan	1.48	1.46	1.57	1.64	1.69	1.73
Korea (Rep. of)	1.70	1.33	1.45	1.54	1.60	1.65
Taiwan Province of China	1.79	1.03	1.15	1.31	1.45	1.55
Singapore	1.73	1.26	1.31	1.35	1.38	1.41
Finland	1.82	1.77	1.79	1.81	1.82	1.83
United Kingdom	1.78	1.91	1.90	1.89	1.89	1.89
Spain	1.28	1.38	1.48	1.55	1.61	1.65
France	1.71	1.99	1.98	1.97	1.96	1.96
Germany	1.30	1.44	1.51	1.57	1.62	1.65

Source: UNPD 2016.

TABLE 2-2

Percentage population 65+ in East Asia and Europe

	1995	2015	2035	2060
China	5.9	9.6	21.3	32.9
Japan	14.4	26.3	31.9	36.7
Korea (Rep. of)	5.9	13.1	27.4	37.1
Taiwan Province of China	7.4	12.2	27.5	40.8
Singapore	6.3	11.7	26.7	36.3
Finland	14.2	20.5	26.2	27.6
United Kingdom	15.9	17.8	23.1	26.0
Spain	15.1	18.8	28.8	34.6
France	15.1	19.1	25.1	26.4
Germany	15.4	21.2	30.8	33.1

Source: UNPD 2016.

TABLE 2-3

Old age dependency ratio in East Asia and Europe

	1985	2015	2035	2060
China	7.9	13.0	32.7	61.1
Japan	15.0	43.3	57.0	72.4
Korea (Rep. of)	6.6	18.0	46.1	73.0
Taiwan Province of China	7.5	16.4	44.7	83.1
Singapore	7.5	16.1	43.7	68.5
Finland	18.3	32.4	45.1	48.6
United Kingdom	23.0	27.6	38.4	45.2
Spain	18.2	28.3	48.4	65.7
France	19.1	30.6	43.3	46.2
Germany	20.8	32.2	54.7	61.6

Source: UNPD 2016.

Population ageing in these East Asian countries and areas is further complicated by rising life expectancy. Back in 1960, children born in China (the country, of the five, with the lowest life expectancy) had an average life expectancy of just 44 years, and for those at age 65 the life expectancy was another eight years; whereas in Japan (the country with the highest life expectancy), newborn children (born in the same period) could expect to live on average almost 66 years and, if they reached age 65, for another 13 years. By 2015, however, the average life expectancy of a newborn child in China had risen by over 30 years, to 77 years, and average additional life expectancy at age 65 was about 16 years. By 2035, the average life expectancy rates for 0- and 65-year-olds in China are expected to increase to 81 and 19 years, and by 2060, to 84 and 22 years. In Japan, the average life expectancy of a newborn child in 2015 was 84 years (15 years longer than in 1960), and at age 65, 22 years (nine years longer than in 1960); the figures are expected to rise to 87 and 24 years, respectively, by 2035, and 89 and 26 years by 2060)[24] (Table 2-4). This means that a significant proportion of today's and tomorrow's elderly people in East Asia will continue to live through their 80s and 90s; the implication for long-term care (LTC) needs is clear.

24. UNDESA 2016.

TABLE 2-4

Average life expectancies at 0, 65 and 85, 1955–2060

	Age	1955–1960	1975–1980	1995–2000	2015–2020	2035–2040	2055–2060
China	0	44.04	65.19	70.59	76.50	80.55	84.38
	65	8.13	12.59	14.15	16.15	18.79	21.61
	85	2.57	3.88	4.58	5.44	6.43	7.62
Japan	0	66.25	75.32	80.47	84.09	86.85	89.26
	65	12.88	15.83	19.57	22.16	24.17	26.02
	85	4.05	4.75	6.53	7.71	8.65	9.61
Korea (Rep. of)	0	51.23	64.94	74.93	82.76	86.26	89.01
	65	11.94	12.90	16.03	20.79	23.10	25.17
	85	4.48	4.06	5.05	6.90	7.86	8.91
Taiwan Province of China	0	62.91	70.78	75.18	80.26	83.87	86.48
	65	12.75	13.71	16.57	19.95	22.43	24.37
	85	3.91	4.90	5.49	7.11	8.35	9.42
Singapore	0	63.95	71.05	77.68	83.70	86.95	89.57
	65	11.91	13.50	17.00	21.65	24.15	26.34
	85	4.05	4.71	6.05	8.83	10.30	11.67
Finland	0	68.03	72.55	77.05	81.48	84.67	87.15
	65	12.73	14.65	17.20	20.27	22.35	24.13
	85	3.82	4.72	5.35	6.46	7.42	8.42
United Kingdom	0	70.54	72.94	77.09	81.25	84.37	86.78
	65	13.62	14.72	16.82	19.90	22.13	23.97
	85	4.26	4.87	5.62	6.72	7.70	8.66
Spain	0	67.51	74.14	78.49	83.22	86.03	88.48
	65	13.78	15.63	18.35	21.24	23.25	25.13
	85	4.28	4.80	5.89	6.85	7.95	9.06
France	0	69.20	73.51	78.29	82.85	85.75	88.27
	65	14.07	15.84	18.73	21.70	23.56	25.32
	85	4.20	5.01	6.07	7.29	8.22	9.26
Germany	0	68.91	72.31	77.22	81.54	84.78	87.35
	65	13.45	14.42	17.25	19.97	22.21	24.15
	85	3.92	4.35	5.43	6.33	7.36	8.42

Source: UNPD 2016.

Average family size has also declined in all five East Asian countries and areas,[25] as have co-residency rates for adult children and elderly parents. By 2014, the majority of people aged 65+ in China, Japan, Korea and Taiwan Province of China were no longer living with their adult children; in some cases, such co-residence has fallen sharply – for example, in Korea, from 80.5 per cent in 1980 to 27.3 per cent in 2011 (Table 2-5). Singapore stands out as the exception within the group, largely owing to active government campaigns and generous tax support to incentivize co-residency between elderly people and their children. Married women's employment rates in the region have also risen, such that today more married women are working than not.[26] These changes have highlighted, and will continue to alert governments and policymakers to, old age social security and eldercare issues. In the meantime, social and structural changes have also helped reshape people's understanding of, and national policies and practices in relation to, eldercare. As families struggle to balance work and care responsibilities, the notion of filial piety is being redefined, and family care is increasingly being subcontracted and outsourced to non-family care providers. This sets new norms that are more accepting of non-familial care provisions. As East Asian governments see their national economic interest in mobilizing women's human resources, they are also beginning to respond more actively to the family's need to reconcile work and care responsibilities. These new social, economic and political contexts have thus set the stage for active policy learning and experimentation.

TABLE 2-5

Proportion of people aged 65+ living with children

	1980	1990	2000	2008	2010	2014
Japan	69.0	59.7	49.1	44.1	42.2	40.6
Korea	80.5	68	49.1	29.8	27.3 (2011)	N/A
Taiwan Province of China	82.0	61.88	58.05	N/A	52.06	N/A
China	73.0 (1982)	68.7	59.9	57.0 (2005)	N/A	N/A
Singapore	N/A	N/A	66.8	N/A	61.3	55.4

Sources: **Japan:** Cabinet Office 2016. **Korea:** Data for 2010 and 2011 based on KOSIS undated, where the indicator is % 65+ living with children; data for 1980 and 2000 based on Kim 2008, where the indicator is % 60+ living with children. **Taiwan Province of China:** Personal communications with Accounting and Statistics Department, Ministry of Interior. Data include those who are co-residing with son-/daughter-in-law and adopted children. **Singapore:** MSF 2015. **China:** 1982 and 2005 figures based on Wong and Leung 2012; other data based on National Bureau of Statistics 2016.

25. Average household sizes in China, Japan, Korea, Singapore and Taiwan Province of China in 2014 were 2.97, 2.4, 2.7, 3.3 and 2.8, respectively (UNDESA 2016.).
26. China is the only exception to this, as married women's employment there declined after the economic reform, from 73 per cent in 1990 to 64 per cent in 2014 (World Bank 2016). Nevertheless, the majority of married women were in employment in 2016.

Although the five East Asian welfare states share similar social and demographic contexts and a common gender ideology that defines care as a female responsibility, they have adopted very different policies towards eldercare. The recent increase in women's employment and changes in family structures and gender relations have led to significant modification of traditional Confucian practices and to greater acceptance of outsourcing familial responsibility by either socializing it or privately outsourcing it by hiring live-in domestic and care workers within private homes. The diverse approaches to eldercare policies seen in these case studies may be explained partly by the differences in national historical and institutional contexts. In countries where eldercare is largely outsourced via publicly provided or funded care services, such as Japan and Korea, the use of migrant care workers is less common, whereas in places where eldercare is largely outsourced through the private market, internal or foreign migrant workers have increasingly come to fill the niche of live-in domestic and care workers.

The spectrum of eldercare policies evident across the region range from supporting eldercare services through the expansion of public eldercare systems such as LTCI to supporting private familial care responsibilities by enabling families to purchase care in the private market. The Japanese and Korean Governments, for example, have both universalized eldercare by implementing a new and compulsory universal LTCI to support the family and to supplement the existing, and increasingly fiscally squeezed, national health insurance. These LTCI schemes provide publicly funded and publicly and/or privately provided eldercare services.[27] In contrast, the Singaporean Government has eschewed the public eldercare provision approach and instead is actively promoting a private market means to eldercare through a combination of the ElderShield programme (a government-employer sponsored individual savings plan), tax support for adult child-elderly parent co-residence[28] and tax and immigration policy support to enable families to employ foreign live-in domestic/care workers.[29] In China and Taiwan Province of China, a mix of social care and private market approaches is evident as the two Governments experiment with public eldercare service programmes while at the same time supporting private market provision of eldercare.[30] There is also significant cross-national and cross-regional policy learning among these East Asian welfare states, with policymakers, experts and government bureaucrats communicating, studying and adopting policy ideas and models from each other as well as from Europe and North America.

2.2
Europe

The five countries examined here include some of Europe's wealthiest countries, each of which has a well-established welfare system that includes arrangements for supporting elderly people.[31] All five countries are current members of the European Union (EU); as such they have been linked and have had some common policies and legal frameworks for over 20 years. France and Germany were EU founding members in 1958; the UK joined in 1973 (but is expected to leave in 2019 following its 2016 referendum on EU membership). Spain joined the EU in 1986 and Finland in 1995. Among the features they share in their economic and political systems, the free movement of labour is particularly important. They also have reciprocal arrangements that enable nationals of one EU member State to draw their national state's retirement pension while living elsewhere in Europe as well as special arrangements permitting EU citizens to access each other's health and welfare systems.

Health and social policy have remained the responsibility of national governments throughout this period, but under the open method of coordination (OMC) EU member States cooperate on issues relevant to 'social inclusion' and 'social solidarity', including health, pensions and LTC.[32] In 2016, their stated aim with regard

27. Peng forthcoming; Kwon 2008; Inamori 2017.
28. Adult child-elderly parent co-residence is defined here as the co-residency rate of people over the age of 65 with their adult children.
29. Yeoh and Huang 2012.
30. Feng et al. 2011; Feng et al. 2012; Zhang et al. 2006.
31. EU 2014.
32. See http://europa.eu/legislation_summaries/glossary/open_method_coordination_en.htm.

to LTC was to close "the gap between the supply and demand for LTC by exploring how to extend or restore older people's autonomy and capacity to live independently".[33] Through the OMC, EU member States share information about their policies and plans and voluntarily seek to cooperate in developing policy. Relevant documents include the EU's brochure, 'Long-term Care in the EU' ;[34] a major EC staff working document on LTC, published in 2013;[35] and the joint report on LTC produced by the EU Social Protection Committee and the European Commission, published in 2014.[36] The latter includes detailed country profiles, from which some details of the five countries considered in this paper are drawn.

Although all five European countries considered here are today governed through a parliamentary democracy, their political histories are very different. Spain's comparatively recent history includes 40 years of dictatorship (1936-1975) when it had no established welfare state; and after the Second World War (WWII), Germany was divided, also for around 40 years (1949–1990), into two states: West (the Federal Republic of Germany) and East (the German Democratic Republic). The former rapidly became a successful capitalist economy with a strong male breadwinner welfare state,[37] while the latter was a communist state within the Soviet bloc until its collapse in the late 1980s. Each of these countries has taken a distinctive path to reach its current LTC arrangements for elderly people.

With unification in 1990, Germany became Europe's largest State by population, with 81 million people in 2015; at this date, France and the UK were the EU's next most populous countries, each with some 64 million people; Spain had a population of 46 million; and Finland, one of the EU's smaller member States, had 5.5 million. These population sizes are expected to change significantly in coming decades due to the combined effects of their different fertility rates and life expectancy and migration patterns. By 2060, the UK is projected to have the largest population (80 million, 25 per cent larger than in 2013 – an outcome of both high economic and family migration and, for Europe, a relatively high birth rate), with the populations of Finland and France each growing by about 15 per cent. The German and Spanish populations are expected to decline (in Germany to 71 million, down 13 per cent, and in Spain to 46 million, down 5 per cent).[38]

Europe is ageing, with life expectancy at birth across the EU projected to increase by almost 20 years over the century 1960–2060 for men (from 66 to 85 years) and by almost as much for women (from 72 to 89 years). At age 65, life expectancy is set to continue rising (by 4.8 years between 2013 and 2060 for men, and by 4.6 years for women), giving average remaining lifespans on reaching age 65 of 22.4 years for men and 25.6 years for women. The five European countries considered here are at the higher level in these projections; by 2060, women and men at age 65 are projected to have on average a further 24 years of life in Finland, the UK and Germany and a further 25 years in France and Spain (Table 2-4). These countries will therefore have growing numbers of very old people, with people aged 65+ expected to reach 26-28 per cent of the population in Finland, France and the UK, 33 per cent in Germany and 35 per cent in Spain by 2060 (Table 2-2). As in East Asia, these increases are expected to lead to significant growth in the numbers of elderly adults needing care and support.

In these European countries, labour force participation rates among the 55–64 age group – which some decades ago showed a strong tendency, among men, towards early exit from the labour force and had quite low participation rates for women (except in Finland) – are expected to rise across the decades to 2060, a trend already evident in the UK in 2011.[39] This is important, as 55–64 is the age group in which Europeans are most likely to have a parent or spouse with care needs. For women, the expected increase in labour force participation in this age group is very striking; in four of the countries (but not in Finland, where female participation rates are already high) large increases are predicted (+40 per cent in Spain,

33. EC undated a.
34. EU 2008.
35. EC 2013.
36. EU 2014.
37. Lewis 1992.
38. EC 2015; UNDESA 2016.
39. Yeandle and Buckner 2017.

+15 per cent in France and the UK and +14 per cent in Germany).[40] For men, the increase is expected to be +12 per cent and +15 per cent, respectively, in France and Spain, with more modest increases in the UK (+5 per cent) and in Finland and Germany (both about +2 per cent). EU analysis suggests this development will add to tensions in managing work and care responsibilities unless plans are made to improve support for workers in this situation and to improve the quality and availability of eldercare.[41]

Spain and Germany both currently have very low fertility rates at 1.38 and 1.44, respectively, in 2015–2020; these rates are projected to increase slightly by 2035–2040 (to around 1.6) and to then remain more or less stable through to 2060 (Table 2-1). Finland and the UK also have current (2015–2020) fertility rates below replacement level (1.77 and 1.91, respectively). France is the only country of the five considered here to be close to replacement level fertility (at 1.99). Fertility rates in Finland, France and the UK are expected to change only slightly by 2060 (Table 2-1).[42] These are countries where quite large minorities of women now have no children, in part accounting for the low fertility figures. Among women born in 1965, the percentage still childless at age 50 (in 2015) was especially high in Germany (28 per cent) and had reached 20 per cent in both Finland and the UK, although it was considerably lower in Spain (13 per cent) and France (10 per cent).[43]

As discussed later in the paper, these developments pose challenges for the future care of elderly people across Europe, which – despite the provision of services for elderly people in most of Western Europe and in the Nordic States – has continued to rely significantly on family care (mainly provided by middle-aged women, usually daughters or daughters-in-law, but also care by spouses, especially, but not exclusively, wives). This is particularly true in Germany and Spain, is a significant factor in France and the UK and is far from irrelevant in Finland. Demographic projections indicate, however, that through changes in family life, labour force participation, education levels and social attitudes, the availability of middle-aged women to provide unpaid home-based care for elderly people is (in all five countries) set to decline. This is occurring just as the number of elderly people needing assistance in late old age is set to rise and as practice in European health-care systems is reducing the length of hospital stays and expecting to treat many more conditions, for longer, in the community, with patients living in their own homes.

The population of Europe is also set to alter through changes in net migration into the EU from countries outside its membership. These are projected to be significant (+55 million people) in the period 2013–2060, albeit distributed very differently across European States. The UK, Germany and Spain are expected to be major receiving countries (projections to 2060 suggest net migration of +9.2 million for the UK, +7.0 million for Germany and +6.5 million for Spain). Each has traditional sources of migration related to its historic past and is attractive to both family and economic migrants. Within the EU, there is free movement of population and labour with, for example, 1.3 million Britons estimated to live in another EU State and some 3.3 million non-UK EU nationals living in the UK, a situation that could change when, as is now expected, the UK leaves the EU.[44] In some EU States, legal (and in some cases illegal) migration is known to be a significant source of caring labour in both institutional and home settings, as reported in the country descriptions that follow.

These trends in life expectancy, fertility and migration are combining to change the age structures of the EU population as a whole and of its member States. The old-age dependency ratio for the entire EU is expected to increase sharply, from around 28 per cent in 2013 to 50 per cent in 2060.[45] This development will be pronounced in all five countries considered here, with large increases in the ratio in the UK (28 per cent to 45 per cent), France (31 per cent to 46 per cent) and Finland (32 per cent to 49 per cent) and particularly sharp rises in Germany (32 per cent to 62 per cent) and Spain (28 per cent to 66 per cent (Table 2-3). Among the

40. EC 2015.
41. EU 2014.
42. EC 2015; UNDESA 2016.
43. Olah 2015.
44. UNPD undated.
45. EC 2015.

population aged 80+, too, particularly large increases (about +150 per cent over the period to 2060) are expected in Spain and the UK, with the latter also expected to see the largest increase, among the five countries, in its population aged 65+.[46]

Elderly people in the five European countries considered here typically live alone in old age or in couple households. Among those aged 85–89, for example, over half (51 per cent) of elderly people in Spain currently live alone; the figures for the UK, Finland and Germany are even higher (65 per cent, 67 per cent and 69 per cent respectively).[47] At this age, only a small minority (2.8 per cent in Germany, 3.2 per cent in the UK, 5.6 per cent in Finland and 11.7 per cent in Spain) live in a household with three or more persons, suggesting that co-residence with family of another generation is unusual and very low.[48]

The five countries have similarities with regard to some aspects of demography, culture and economy – with cultures in which the values of the Christian church, in various different forms, have historically been dominant and have affected many aspects of family life – and all are capitalist market economies. All are also open societies, permitting a free press and exhibiting increasingly liberal social attitudes regarding, for example, sexuality, personal morality and freedom of expression. They are nevertheless also countries with important socio-political differences that have led to the formation of rather different welfare states, social policies and arrangements for the support of dependent family members, with the result that "European care regimes greatly vary in the organisation, provision and financing of care", particularly with regard to the "respective roles of state, family, market and non-profit actors in providing care to people in need".[49]

The welfare states in all five European countries chosen here have made significant changes to the design and operation of their systems in recent years; some of these are still playing out, with further changes likely. Scholars have categorized their welfare states in a variety of ways,[50] producing various typologies of their LTC arrangements,[51] although no universally accepted typology has emerged. Of particular relevance here, Bettio and Verashcaghina (2010) observe that comparative analysis of European care regimes reveals a number of trends: towards home care and away from institutionalized care; towards private services (including through more use of cash transfers); and the emergence of services intended to support and complement, without replacing, family care.

The next section considers the arrangements for LTC of elderly people in each of the 10 selected case studies.

46. Ibid.
47. Comparable data for France are not available.
48. UNDESA 2016.
49. Salis 2015: 522.
50. See, for example, Antonnen and Sipila 1996; Bettio and Platenga 2004.
51. E.g. Kraus et al. 2010.

3.

CASE STUDY ANALYSIS

3.1

Japan: Regulated social insurance approach

In Japan, eldercare has historically been considered a family responsibility. In response to the rapidly ageing population and concomitant rise in care needs, however, in 1989 the Government introduced a public eldercare system (the Gold Plan). By 1985, the proportion of the population aged 65 and over had reached 10.2 per cent, up from 7.0 per cent in 1970.[52] The Gold Plan was designed as a means-tested supplementary public service for the family. It provided community-based eldercare for frail elderly people, delivered through local governments.[53] Although the Government's initial motivation for the Gold Plan was to contain the rising cost of medical and hospital care for the old – and in particular social hospitalization –that had followed implementation of Free Medical Care for the Aged in 1973, the Plan also helped establish local and national infrastructures for community-based intermediary care facilities and services to assist elderly people and their families, including care homes and assisted living, short stay and day-care centres, and home-care services.[54]

As population ageing accelerated in the 1990s – and the Government came under increasing pressure to address the growing public demand for eldercare, while at the same time controlling health-care spending – Japanese policy bureaucrats began to explore a more comprehensive approach to eldercare. By the 1990s, it was clear that the 'traditional Japanese household structure' no longer applied to most families and that traditional ways of dealing with care – wives, daughters and daughters-in-law – were unsustainable. The proportion of people aged 65 and over living with their adult children had declined to 40.6 per cent in 2014, from 69.0 per cent in 1980 (Table 2-5). The change that caused policymakers most concern was the decline in the proportion of people aged 65 and over living in three-generation households, which dropped from 50.1 per cent in 1980 to 13.2 per cent in 2014.[55]

Inspired by Germany's LTCI (introduced in 1995), the Japanese Government began developing its own LTCI. Japanese policy bureaucrats were motivated to consider LTCI as a way to provide universal care to meet the real and anticipated growing demand for eldercare, but equally importantly they also saw in LTCI a new revenue channel dedicated to eldercare and a mechanism to reduce social hospitalization and soaring national health-care costs.[56] The public expenditure on LTC relative to GDP in Japan was 2.1 per cent in 2013 (0.8 per cent in health LTC; 1.3 per cent in social LTC), which was slightly lower than in Finland (2.2 per cent) but higher than in France (1.9 per cent), the OECD-22 average (1.7 per cent), Germany (1.0 per cent) and Spain or Korea (both 0.7 per cent) (Figure 3-1). Given the rate of population ageing, the Government estimates that public LTC expenditure will rise to 3.2 per cent of GDP by 2025.[57]

Significant cross-national policy learning took place throughout the 1990s as the Government sent policy experts to study LTCI and community care models in Europe, including the UK, and sponsored conferences and workshops to promote public debate on eldercare models.[58] The Japanese LTCI legislation was introduced in 1997 and implemented in 2000,

52. UNDESA 2016.
53. Peng 2002.
54. Japan had established a universal health-care system by 1961.
55. Cabinet Office 2016.
56. Campbell 1996; Peng 2002.
57. OECD 2015; Sato 2015.
58. Peng 2002.

replacing the Gold Plan.[59] The LTCI is a compulsory social insurance levied on all citizens over the age of 40. It provides universal LTC to people over the age of 65 and to those between the ages of 40 to 64 with age-related disabilities, such as dementia. The LTCI covers a wide range of domiciliary, community-based and institutional care services. While the Japanese LTCI is modelled on the German LTCI, in assessment/delivery and practice it uses a single-entry assessment (meaning that all applicants for LTCI services must in the first instance be tested for the level of care they need through a standardized care assessment) and care management model whereby case managers are responsible for creating and managing individual LTC plans.[60] Unlike the German LTCI, Japan's LTCI also has a built-in redistributive function: it is financed by social insurance premiums (45 per cent), general taxation (45 per cent) and co-payments (10 per cent), and services are provided solely on the basis of care needs rather than means-tested.

The Japanese LTCI system is highly regulated. The LTCI law stipulates that only publicly certified eldercare institutions, professionals, home helps and care workers can provide care within the LTCI system. All fees for LTCI services are set by the state, and only local governments, quasi-public welfare corporations, non-profit organizations, hospitals and for-profit companies licensed and supervised by a prefectural government are allowed to provide care.[61] The system thus operates on a quasi-market model. Additionally, unlike the Austrian, German and Korean LTCI systems, Japanese LTCI provides only services (i.e., no cash allowance is payable), a concession to the feminist lobby that argued cash allowances would reinforce women's unpaid familial eldercare obligations within the home.[62]

All the care workers (*kaigofukushi-shi*) working within the LTCI system must have recognized training and pass a national certification examination. Certification training for care workers in Japan is lengthier and more difficult than, for example, in Korea, where the institutional regulations for LTCI are not as stringent. As OECD/EC (2013a) points out, "Japan is one of a few OECD countries imposing high skill requirements for LTC workers. The training duration for a certified care worker in Japan is a minimum of 130 hours (to become an entry-level care worker), compared to two weeks for a home health aide in the United States. Japan also offers financial incentives for providers to provide care workers with continuous training opportunities."

This quality assurance system through a certification requirement creates an institutional entry barrier for uncertified care workers and discourages their employment. The reliance on foreign care workers in Japan is extremely low, partly because of this entry barrier (foreign care workers must also pass the care worker licensing examination, in Japanese) and partly because of public and policy resistance to opening immigration.[63] Wages for eldercare workers are low compared to average industrial wages, though not absolutely so. Nevertheless, lower than average wages and the low occupational status of eldercare workers, particularly those in home care, have resulted in high labour turnover and a serious labour shortage in the sector.[64] Although the total number of certified care workers increased more than five-fold between 2000 and 2013 – from about 211,000 to 1.19 million – only 660,000 (55 per cent) were actually working as care workers within the LTCI system in 2013,[65] with many others working in other parts of the social welfare sector. Given the increased demand for care workers on the one hand and the shortage of such workers on the other, the Government anticipates an eldercare worker shortage of 377,000 by 2025.[66]

In light of the severe labour shortage in the eldercare sector, in 2008 the Government began accepting up to 1,000 foreign nurses and 1,000 foreign care workers annually from Indonesia, the Philippines and Viet Nam to work in eldercare institutions through

59. Ibid.; Campbell and Ikegami 2000.
60. OECD/EU 2013a.
61. Shimizutani 2014.
62. Peng 2002.
63. Ogawa 2012; Ohno 2012; Peng 2016.
64. MOHLW 2009a.
65. MOHLW 2014.
66. According to the MOHLW's estimate, a total of 2.53 million eldercare workers will be needed by 2025, but there will be only 2.15 million care workers available, resulting in a shortage of 377,000 eldercare workers (MOHLW 2016b).

bilateral economic partnership agreements (EPAs). This is not an immigration policy, according to the Government, as EPAs are actually trade agreements that happen to include special labour mobility. EPA nurses and care workers are vetted by the recruiting institutions (eldercare centres and hospitals) in Japan following strict government requirements. Institutions employing EPA nurses and care workers must pay wages equivalent to their domestic counterparts (as nursing and care worker interns) and ensure basic social security and labour rights. EPA nurses and care workers are obliged to write and pass the certification examination in Japanese after three to four years of employment in order to qualify for longer-term stay. Difficulty in passing this examination has seriously discouraged potential applicants. Between 2008 and 2015, only 1,464 EPA nurses applied to work in Japan. Among these 994 were accepted, while 2,887 EPA care workers applied, with 2,069 accepted.[67]

LTCI has made the outsourcing of eldercare much more common and acceptable and has also raised the public's expectations of a greater state role (and responsibilities) in eldercare in Japan. The demand for public eldercare has grown dramatically since the introduction of LTCI. The number of elderly people receiving LTC increased from 1.49 million (6.8 per cent of the 65+ population) in 2000 to 5.12 million (15.5 per cent of the 65+ population) in 2015.[68] A national opinion survey by the Ministry of Health, Labor and Welfare found that more people between the ages of 40 and 65 now identify using home helpers and other LTCI services in their own homes, rather than having children provide care, as the ideal care model for their ageing parents.[69] The proportion of people expecting to live with their children or to have their children take care of them in old age also dropped, from 46.1 per cent in 1983 to 18.0 per cent in 2008.[70]

Although LTCI has relieved care pressure on families in Japan, it is important to bear in mind that a significant proportion of eldercare is still provided by family members, particularly wives, daughters and daughters-in-law. To be sure, LTCI was never intended to replace eldercare provided by family members but rather to lessen the amount of eldercare they need to supply. To this end, the Government has been gradually reforming its standard employment regulations since the 1990s by expanding the Childcare and Long-term Care Leave policy (*Ikuji – Kaigo Kyugyoho*). In 1995, it passed the *Childcare and Long-term Care Leave Law* within the standard *Employment Act*, granting workers in standard full-time employment with childcare and/or family responsibilities the right to take up to three months of unpaid care leave and/or to reduce their work time. The legislation was reformed in 1999 by adding a 40 per cent wage replacement, to be paid through the employment insurance system. The government has been expanding and adding supplements to this legislation since 2000. The most recent reform (enacted in 2016) entitles all workers, including contract workers (but not daily workers), with a minimum of one-year's continuous employment with the same employer, to up to six months of family care leave to be taken continuously or in separate time segments (up to three times).[71] At the same time, the income replacement rate for both parental and care leave was raised from 40 per cent to 67 per cent of the employee's usual wage.[72]

3.2

Republic of Korea: Semi-regulated social insurance approach

As in Japan, eldercare has traditionally been considered a family responsibility in Korea. However, changes in social and family structures in recent decades, and political democratization since 1987, have significantly influenced the country's social policies, including eldercare. First, the proportion of people aged 65 and over living with their adult children plummeted from 80.5 per cent in 1980 to 27.3 per cent in 2011 (Table 2-5).[73] The combination of a decline in adult child-elderly parent co-residence (particularly in the rural areas), an

67. MOHLW 2016.
68. Ibid.
69. MOHLW 2010.
70. MOHLW 2009b.
71. MOHLW 2016c; Ikeda 2017.
72. Inamori 2017.
73. Kim 2008; KOSIS undated.

ageing population and post-democratization welfare state expansion has contributed to the rapid development of eldercare since 2003. As in Taiwan Province of China, much of the post-democratization period Korean politics converged on the issue of social welfare as presidential contenders and political parties competed – and continue to compete – to out-do each other to champion social welfare expansion.[74] The political competition over social welfare and eldercare was further exacerbated by the speed of ageing.

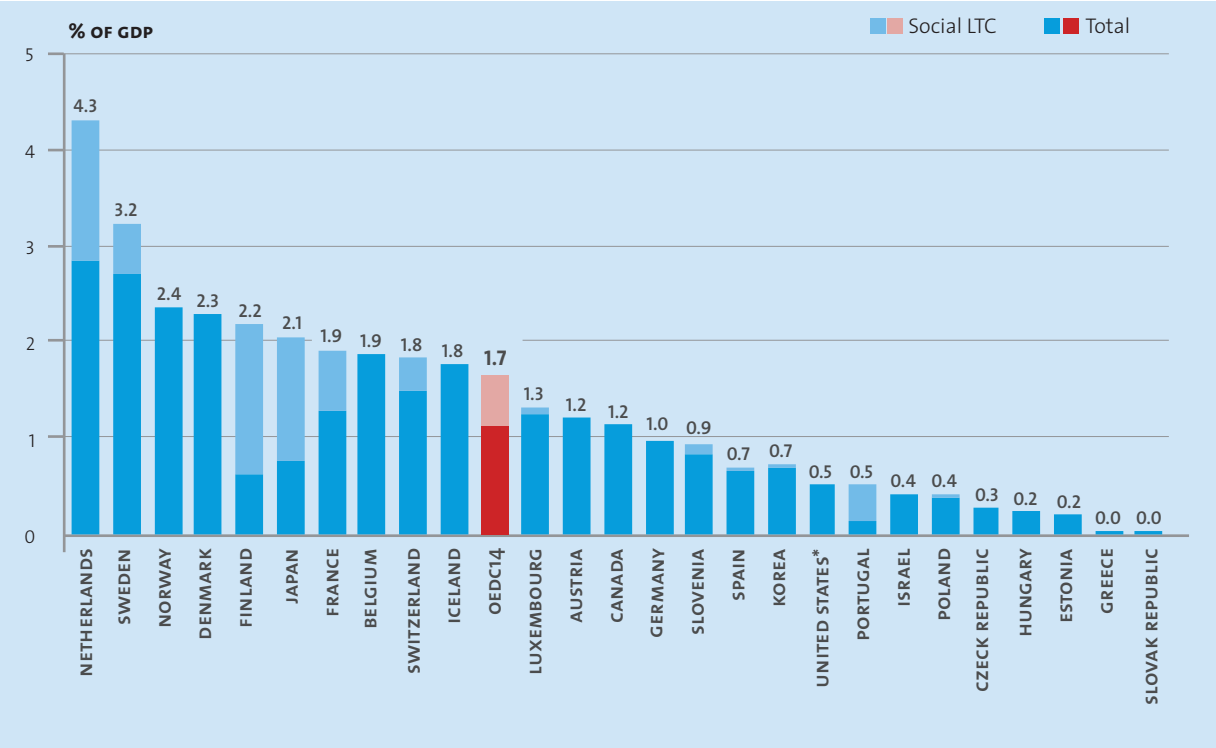
Following Germany and Japan's LTCI examples, the Korean Government established a universal LTCI scheme in 2008. Modelled on the Japanese LTCI scheme, it is financed through compulsory insurance premiums (50 per cent), general tax subsidies (30 per cent) and co-payments (20 per cent).[75] The programme covers the LTC needs of people over the age of 65 and the age-related care needs (such as dementia) of those under age 65. As in Japan, individual care needs are assessed by standard procedures, and the amount of care funded by LTCI is determined by the degree of disability. The Korean LTCI scheme also covers a range of institutional, community and home-based care. LTCI clients can access care from any registered service provider, who is subsequently reimbursed by the National Health Insurance Corporation. Care service providers can be publicly or privately run for-profit or not-for-profit organizations. In 2008, when the LTCI was implemented, Korea spent 0.3 per cent of its GDP on LTC; by 2013, this had doubled to 0.7 per cent.[76]

Given that the proportion of the Korean population aged 65+ was barely 10 per cent in 2008, compared to 21.6 per cent in Japan, 20.0 per cent in Germany, 17.9 per cent in Spain and 16.0 per cent in the UK, Korea's low public expenditure on LTC is not surprising. What is surprising, however, is the annual growth rate of public LTC expenditure in the country. Indeed, OECD indicators show that, in real terms, this increased by 36.1 per cent between 2005 and 2013, by far the fastest among OECD-22 nations.[77] A large part of this rapid expansion can be accounted for by the implementation of LTCI.

74. Estevez-Abe and Kim 2014; Kwon 2003; Peng and Wong 2008, 2010; Wong 2004.
75. Kwon 2008.
76. OECD 2011, 2015.
77. OECD 2015; see Figures 3-1 and 3-2 for OECD comparisons.

FIGURE 3-1

Long-term care public expenditure (health and social components), as share of GDP, 2013 (or nearest year)

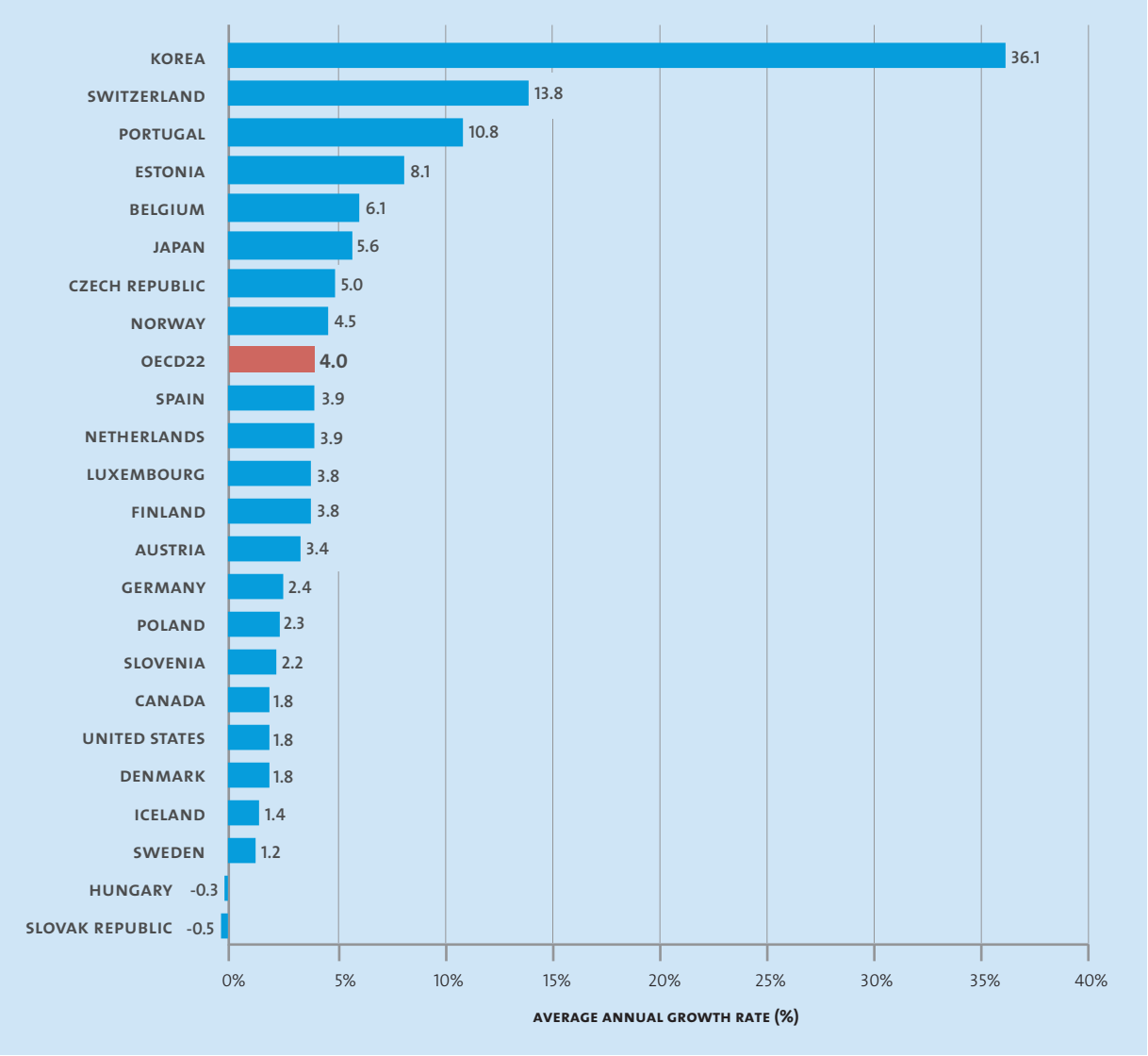


Source: OECD 2015.

Note: The OECD average only includes the eleven countries that report health and social LTC. *Figures for the United States refer only to institutional care. Source: *OECD Health Statistics 2015*, http://dx.doi.org/10.1787/health-data-en.
Statlink http://dx.doi.org/10.1787/888933281455

FIGURE 3-2

Annual growth rate in public expenditure on long-term care (health and social), in real terms, 2005-2013 (or nearest year)



Source: OECD 2015.

Note: The OECD average excludes Korea (due to the extremely high growth rate). Source: *OECD Health Statistics 2015*, http://dx.doi.org/10.1787/health-data-en. Statlink http://dx.doi.org/10.1787/888933281455

The demand for, and public expectations of, social care for the elderly has also increased substantially. The number of LTCI recipients rose from 230,000 (3 per cent of the 65+ population) in 2008 to 314,240 (6.5 per cent) in 2010.[78] The 2012 Korean social survey found that only 33 per cent of respondents thought the family should be mainly responsible for the support and care of the elderly, a significant drop from 1998, when 90 per cent thought this. Similarly, 49 per cent of survey respondents agreed that "the family, government and society" should all be responsible for the care of the elderly in 2012, whereas in 2002 only 18 per cent had thought this.[79] As in Japan, LTCI in Korea is not meant to replace the family's eldercare responsibility; rather, it is meant to help reduce the total amount of eldercare families need to provide. Hence, the Government has also expanded its care leave policy within the basic employment legislation to include family care leave, which currently entitles workers to up to 90 days of leave per year that can be used in different time periods.

The Government, however, faces some serious challenges as it tries to institutionalize and regulate its LTCI system. Unlike Japan, where the eldercare system has been developing since the 1980s, Korea's LTCI was established with almost no pre-existing community-based care system or institutional infrastructure for eldercare. The combination of limited supplies of LTC institutions and care providers, and political concerns over the resultant surge in expenditure as a public eldercare system infrastructure was established, led the Government to open up LTCI service delivery to private sector care providers. This has led to the relaxation of regulations for service provision and a rapid expansion of private eldercare services,[80] which has compromised the quality assurance of the LTCI system. Within three years, between 2006 and 2009, the number of residential eldercare facilities nearly trebled, from 815 to 2,016, while in-home service provider organizations grew more than 12-fold, from 1,045 to 12,935, most of them privately run.[81] Although care workers (*yoyangbahosa*) must be certified to work in the LTCI system, the certification requirement is more lenient than in Japan. In rural and remote areas where eldercare services are limited, the government now allows a cash payment option for the care of the elderly.[82] Approximately 35 per cent of LTCI recipients receive a cash allowance (family care allowance) rather than services.

Today, Korea's LTCI is by and large a publicly funded and privately delivered system. Although the Government regulates the quantity and quality of care through care assessment, training, certification and licensing of care workers and service delivery agencies, the relaxation of state regulation over the care market and somewhat lenient care worker certification system, combined with widespread use of the cash payment option, raise questions about the quality of the care provided to the elderly and the state's capacity to effectively regulate and police the large number of private sector service providers. A similar concern is also raised with the case of China, as will be discussed later.

The co-payment fee for eldercare is also higher in Korea than in Japan. The Japanese Government has recently raised the LTCI co-payment fee from 10 per cent to 20 per cent for higher-income households, whereas co-payment in the Korean scheme was set, from the beginning, at 30 per cent. Many low- and middle-income elderly people were thus unable to access the scheme or had to limit their use of LTCI services. Private for-profit LTC institutions often employ low-wage nursing aides (*gambyoin* – unlicensed care workers) to provide supplementary eldercare outside the LTCI system. Families often use the cash allowance to purchase private services – often provided by female migrant co-ethnic Korean Chinese (*Joseonjok*) – at a lower price. Korea's large informal market[83] and the availability of co-ethnic migrant workers willing to provide care services at a low wage supports the secondary care market.

78. KNHIS 2014.
79. Statistics Korea 2013; KWDI 2013.
80. Rhee et al. 2015.
81. Ibid.
82. Ibid.
83. The OECD (2009) estimates that informal employment makes up approximately 28 per cent of non-agricultural employment in Korea.

Based on its institutional arrangements and financing structures, Korea's care regime therefore looks more like those of Austria and Germany, where the combination of a care worker qualification system within the LTCI arrangements (albeit in Korea not at a very high level), a cash allowance option and a prominent role played by the private for-profit sector has resulted in what Simonazzi (2009) refers to as a "dualistic market". In Korea, the existence of a large *Joseonjok* diasporic population with special long-stay work visas also ensures a ready supply of low-wage workers for the informal care market, thus creating further incentives and pressures to use migrant care workers.[84]

3.3

Singapore: Liberal private market approach

Unlike Japan and Korea, where the Governments have opted, or at least have attempted, to socialize eldercare through LTCI, the Singaporean Government has instead tried to reinforce private (and market) solutions through a combination of negative and positive incentives. On the one hand, the *Maintenance of Parent Act* mandates adult children to provide financial and other forms of support to their parents over the age of 60; on the other, the Government also offers individual savings schemes, tax relief and subsidies for families to co-reside and to purchase care in the private market.

ElderShield is the main government-sponsored private disability insurance plan available for elderly people with LTC needs in Singapore. The plan provides cash support for out-of-pocket expenses incurred for LTC services for up to 72 months. Although it is a part of Medisave, a national (individual) savings scheme dedicated to post-retirement medical expenses within the Central Providence Fund, ElderShield is not compulsory. The insurance premium can be quite high. In 2016, the monthly premium ranged from SG$175 for 40-year-old men to SG$2,380 at age 64. The premium is higher for women at all ages. This means the publicly sponsored disability insurance plan is mainly accessible to middle- and higher-income households. Yet, even so, coverage is limited to 72 months.

The preference for a private market solution to eldercare in Singapore is reflected in very low public expenditure on LTC. In 2010, the Government spent approximately 0.1 per cent of GDP on this.[85]

To promote intergenerational family support, the Government provides tax relief for adult children with elderly parents: SG$9,000 per year if they are co-residing with a healthy parent (SG$14,000 per year if a parent is disabled), and SG$5,500 if not co-residing but providing some form of care and assistance (SG$9,000 if the parent is disabled).[86] The National Council of Social Service funds non-profit organizations to provide community-based support such as preventative care, neighbourhood links and day activity centres, all for a fee.[87] Elderly people on very low incomes only (and their families) can apply for means-tested subsidies to cover the cost of these government-funded intermediary LTC services. Despite tax relief and other incentives to encourage intergenerational support, de-familialization and distanciation processes are evident in Singapore as well. Although it has the highest adult child-elderly parent co-residence rate of all the five East Asian countries and areas compared in this report, at 55.4 per cent in 2014, this is nevertheless a noticeable drop from 2000, when the figure was 68.7 per cent.[88]

As an extension of its private market solution to eldercare, the Singaporean Government also encourages families to employ foreign domestic workers (FDWs) – mostly from the neighbouring countries of Indonesia and the Philippines – through tax concessions. Families hiring FDWs to care for a child or an elderly or disabled person are entitled to a concession levy rate of SG$60 per month for each FDW – less than a quarter of the regular FDW levy of SG$265 per month.[89] The Government has also fully instituted the

84. There are estimated over 700,000 Joseonjok living in Korea.

85. Government of Singapore 2010.
86. Inland Revenue Authority of Singapore 2016.
87. Inter-Ministerial Committee 1999; Mehta and Vasoo 2000; Teo et al. 2006.
88. MSF 2015.
89. Ministry of Manpower 2016.

system for families to recruit and employ live-in FDWs, including a dedicated section for FDWs within the Ministry of Manpower. The combination of tax relief and concessions has helped maintain a relatively high level of adult child-elderly parent co-residence and an extensive use of live-in FDWs to care for elderly people in private homes. Currently most of the approximately 220,000 registered FDWs in Singapore are providing care for the elderly.[90] A 2012 national survey of Singaporeans aged 75 and over found that approximately 50 per cent were dependent on FDWs for their daily care.[91] Another survey, conducted in the same year, also found that "49 per cent of Singaporean families hire foreign domestic workers (FDWs) to provide care to their elders, aided by government discounts on FDWs, making this a prevalent 'care solution'", and that "50 per cent of FDWs do not have experience/formal training in caring for older persons".[92]

The implications of Singapore's compulsory and non-compulsory national savings schemes, tax relief for families supporting their elderly parents and tax concessions for live-in FDWs are clear. These policies have not only led to strongly familialistic policy outcomes and high use of FDWs but also raise questions about social and economic fairness. Although national savings schemes provide some support for elderly people in need of care, they have little or no redistributive capacity. Individual savings are dependent on individual incomes, so low-income households are less able to save for their future financial and care needs compared to high-income households. Similarly, tax relief for parental care and tax concessions for FDWs will be more likely to benefit middle- to high-income households than low-income families, as those with low-income will be unable to afford a FDW in the first place and tax relief only benefits households with income above the prevailing taxable income threshold. Further, and despite a gender wage gap in Singapore that is considerably lower than in other East and Southeast Asian countries, Singaporean women still earn on average only 81 per cent of the male wage for similar work.[93] The long-term cumulative result of women's lower earning means they will be unable to save as much as men for their retirement and care needs in old age. Additionally, the higher premium rate for the ElderShield for women means that women will have to pay more for their eldercare insurance even though they earn less than men. Indeed, Central Providence Fund statistics show that "[i]n 2013, the median CPF savings for women aged 51 to 54 was about $90,000, and for males, $130,000", with women's only 69 per cent of the male average.[94]

90. This number of foreign domestic workers is remarkable, considering the total population of Singapore is only 5.66 million. This is equivalent to approximately one foreign domestic worker per every five households (Peng 2017).
91. Huang et al. 2012; Ostbye et al. 2013.
92. UNESCAP 2015: 13.

3.4

Taiwan Province of China: Mixed public and private market approach

The Taiwanese Government's approach to eldercare has been, hitherto, largely private (i.e., family and market oriented). For example, the Foreign Live-in Caregiver Programme, introduced in 1992, grants families an exclusive channel to recruit and hire such caregivers for frail elderly people. Currently some 240,000 registered foreign live-in caregivers, mostly from Indonesia and the Philippines – 99 per cent of them women – are working there. Approximately 13 per cent of people aged 65+ (and 20 per cent of those over age 80) were being cared for primarily by foreign live-in caregivers in 2009.[95]

As caregiving and domestic work are not considered to be formal employment, foreign live-in caregivers are not covered under the Labour Standard Law in Taiwan Province of China. Although the Ministry of Labour provides guidelines for employers hiring foreign workers – including conditions for admitting foreign live-in caregivers, work permit period and renewals, guidelines on recruitment agencies, and work and wage conditions – employers are not bound to sign a standard contract, nor do they necessarily follow regulations. Regular minimum wage legislation for Taiwanese citizens thus

93. World Economic Forum 2016.
94. Liang-Lin 2015.
95. Lin and Belanger 2012.

does not apply to foreign live-in caregivers; however, under pressure from the Indonesian Government, the largest sending country for such caregivers in Taiwan Province of China, and from civil society groups within the country, the Taiwanese Government agreed to ensure a minimum monthly wage for new incoming foreign live-in caregivers of NT$17,000, starting in 2015, which is almost 85 per cent of the NT$20,008 minimum monthly wage applicable to Taiwanese workers.[96]

Although eldercare policy in Taiwan Province of China shares a similar familialistic and private market orientation with Singapore, the Taiwanese Government, unlike that of Singapore, is not, and cannot afford to be, completely committed to a free market solution to eldercare because of vocal and active civil society mobilization creating pressure for public eldercare. This, combined with a highly competitive national electoral system, makes policymakers very sensitive to public and media discourses and voter preferences. The Government thus began a tentative policy reform process to expand social care along LTCI lines in 2007: the 10-year Long-term Care Plan (LTCP).[97] As in Korea, the newly consolidated democracy has engendered intense political contestation around social welfare, resulting in steady welfare expansion since the 1990s.[98] The LTCP came about partly in response to the growing public demand for eldercare and partly in anticipation of the presidential election the following year. Taiwan Province of China's historical ties and policy affinity with Japan and Korea have also fostered constant cross-national policy learning and transfers among the three.[99] Thus, despite the widespread use of foreign live-in caregivers, there has been growing pressure from both within and outside the Government to establish a public eldercare system such as LTCI. Like Korea, there was no coherent eldercare policy until the 1990s, implicitly assuming that elderly people would be cared for by their families in their homes. Indeed, the adult child-elderly parent co-residence rate in Taiwan Province of China has been higher than in other East Asian countries and areas, only surpassed by Singapore. Even so, the proportion has been falling steadily, from 80.5 per cent in 1980 to 54.2 per cent in 2010[100] (Table 2-5).

Local governments provide some needs-based eldercare services to seniors without any family members. Subsidies for low- and lower-middle-income families to help families with eldercare expenses were made available with the introduction of the *Senior Citizens Welfare Act* in 1980. As eldercare needs grew, the Government implemented the Foreign Live-in Caregiver (1992), Living Allowance for Lower-middle Income Elderly (1993) and Medical Care for Lower-middle Income Elders (1997) Programmes. Both the latter are means-tested social income supports to help poorer elderly people offset living expenses and the costs of care. Given that the adult child-elderly parent co-residence rate in Taiwan Province of China is still relatively high, this social income support may reinforce women's unpaid care work, whether as wives, adult daughters or daughters-in-law, especially among poorer families.

The LTCP applies a multi-pronged approach to develop quality, universal and integrated community-based care, including home care, day care and family care, rehabilitation, respite care and transportation services for "senior citizens age 65 and over, physically and mentally handicapped people age 50 and over, aborigines age 55 and over, and elderly people who have lost capabilities and are living alone".[101] The Plan led to the creation of interdepartmental groups within the Government to work on LTC, the expansion of LTC facilities and training schemes, the mobilization of non-governmental organizations (NGOs) in providing eldercare, and an infusion of fiscal resources in developing the eldercare system. The proportion of elderly people receiving care through the LTCP rose from 2.3 per cent to 33.2 per cent between 2008 and 2015.[102]

The second phase of the national LTC strategy was rolled out in 2012 with the establishment of the Long-term Care Service Network, which aimed to build LTC infrastructure across the territory and to equalize disparities between urban and rural areas. This has led

96. China Post 2015.
97. Executive Yuan 2007.
98. Peng and Wong 2008, 2010; Wong 2004.
99. Korea and Taiwan Province of China were under Japanese colonial rule from 1910 to 1945 and 1895 to 1945, respectively.
100. Ministry of Interior 2016.
101. Executive Yuan 2017.
102. Ibid.

to the establishment of intermediary care facilities, such as day-care centres, integrated service stations and hospitals with medium-term care services for elderly and disabled people in 22 municipalities, 63 counties and 368 townships across the territory. To address the labour shortages in eldercare services, the Legislative Yuan (Taiwanese Legislature) passed the *Long-term Care Services Act* in May 2015 that will set the regulations for LTC workers' professional status and licence and certification requirements by 2017. The Ministry of Education is currently developing training programmes for LTC professionals. In the same year (2015), the Ministry of Health and Welfare also introduced a Long-Term Care Quantity Promoting Plan to further develop home care and community care facilities and extend services to disabled people over the age of 50.

Thus far, the LTCP reform seems to suggest a shift to a more regulated public eldercare programme. In the meantime, the Government has been debating another – and much more controversial – piece of LTC legislation: the *Long-Term Care Insurance Act*. The passage of this Act would determine the final direction of the public eldercare system in the territory. However it has proved highly contentious, not only because it represents a significant departure from the existing private market approach to eldercare and has fiscal implications, but also because of strong opposition, ironically from NGO groups representing families of disabled and frail elderly people, many of whom are beneficiaries of the Foreign Live-in Caregiver Programme.[103] The proposed Act will provide universal LTC to elderly and all disabled adults requiring LTC either through social insurance or general taxation. As many disabled people now rely on foreign live-in caregivers, there is much reluctance by these care receivers and their families to lose their right to private care services, even though they strongly support increased public provision of eldercare. At the same time, the existence of nearly a quarter of a million foreign live-in caregivers currently working in private homes also creates an institutional barrier to establishing a regulated public eldercare system provided within the community – in contrast to Japan, where the highly regulated LTCI system has been an institutional barrier to accepting foreign care workers. LTCI reform in Taiwan Province of China is therefore likely to face considerable political and institutional challenges.

103. Wang and Chen 2017.

3.5

China: Post-communist private market approach

During the Maoist era (1949–1978), basic social security for individuals and families in urban China was negotiated through the state/work unit/citizen tripartite system and in the rural areas through the state/commune/citizen system. This dual-track system ensured full employment, basic social security and welfare, and social care for children, elderly people and others in need of care.[104] During this time the Government adhered to the idea of women's and men's equal contributions to the national economy accorded by the Chinese civil law, and it vigorously promoted socialization of childcare and eldercare to help reduce the family's care burden and liberate women to participate in the labour market.[105] Indeed, as recently as 1990, Chinese women's total labour force participation rate was 73 per cent, noticeably higher than in other East Asian countries.[106] For elderly urban workers, work units provided old age pensions, medical and health-care services, housing and other support services after retirement. Community-based care was available, but families were mainly responsible for the day-to-day care of the elderly at home. In the rural areas, family was the main form of old age security even during the Maoist era. For people with 'Three No's' (*san wu*), public programmes and relief in the form of the 'Five Guarantees' (*wu bao*) were made available by village communes.[107]

104. Zhang and MacLean 2012; Du and Dong 2013; Cook and Dong 2011.
105. Liu et al. 2009.
106. Dasgupta et al. 2015.
107. Liu et al. 2009. The Three No's refers to people with no families, no work employment or prospect of employment, and no means of livelihood. The Five Guarantee policy was introduced in 1956 to ensure those who are widowed or disabled and families without any source of income five basic guarantees of: food, clothing, fuel, education for children and funeral arrangements (Liu et al. 2009).

Chinese family policies, however, changed dramatically after 1979. The post-Mao Reform Era (1979 to now) saw a rapid transition to the market economy with the dissolution and privatization of state-owned enterprises and public institutions. Employers were discharged of social welfare obligations such as housing, childcare, and other social support for the family, causing re-familialization of care obligations.[108] The communist Government also actively promoted the re-culturation of Confucian filial piety through education and the mass media,[109] and by re-invoking an old constitutional law that made families legally responsible for the care of their elderly members. In rural areas, the commune system was replaced by the Household Responsibility System in 1978.[110] The Constitution and the Law on the Protection of the Rights and Interests of Older People's Care required families to look after their elderly relatives.[111]

These policy changes – against the backdrop of strong norms about women's full employment inculcated under the communist regime, economic imperatives for women to work and huge out-migration of young people from rural regions to cities – have left a growing number of elderly 'empty nesters' with little to fall back on, as public eldercare services are not available while their children are either too time-pressed, or too far away, to provide adequate care. To encourage and to legally enforce filial piety, a Family Support Agreement (*jiangting shanyang xieyi*) – a voluntary maintenance support contract between adult children and their parents – was introduced in rural communities in the mid-1980s. The promotion of the Agreements by regional and local governments was so vigorous that by 2005 more than 13 million rural families had signed them.[112] To date, very little data exist to show their effectiveness; however, available studies indicate a substantial increase in family disputes over support in recent years, suggesting that adult children may not always be willing or able to look after their ageing parents.[113] The Government is aware of this and, unsurprisingly, eldercare has become a serious social policy concern in recent years at both the local and national levels.

Like the other four East Asian countries and areas, China is also experiencing rapid population ageing, largely owing to its One-Child Policy implemented in 1979. Today the so-called '4-2-1' family structure – meaning the average middle-aged couple now has to care for four parents and one child, while in the future one child may have to care for two ageing parents and four aged grandparents – is one of the most pressing social policy concerns for the current Government. A recent Beijing survey claims that "72.9 per cent of families have old people to take care of, and 72.1 per cent think caring for old people has affected their work, and things will be worse if an old person falls ill and needs to be hospitalized for a long time".[114] Today's younger generation of Chinese face a moral and structural dilemma: they are not as able or willing as their parents to provide care for their elders, yet they cannot choose to abandon them, nor can they reduce their job obligations and become caregivers.[115] In addition, a huge migration of working-age people from rural to urban areas has significantly reduced the family's capacity to provide care. There was a 253 million-strong 'floating' population in China in 2014, more than double the 2000 figure of 121 million.[116] In 2005, only 57 per cent of elderly people were living with their adult children, compared with 73 per cent in 1982.[117] Elderly Chinese are also not as willing to live with their adult children. A recent China General Social Survey found that only 26.8 per cent of survey respondents expressed interest in living with their children in their old age.[118]

The Government has introduced a number of policy changes, including expanding basic health insurance for both urban employees and rural workers and residents, implementing the rural pension scheme

108. Zhang and MacLean 2012; Liu et al. 2009; Du and Dong 2013.
109. Cheung and Kwan 2009.
110. Chou 2011; Xu 2001.
111. Wong and Leung 2012; Chou 2011; Cheung and Kwan 2009.
112. Chou 2011.
113. Ibid.
114. Liu et al. 2009: 33.
115. Zhan 2004.
116. National Bureau of Statistics 2016.
117. Wong and Leung 2012.
118. China Labour Bulletin 2016.

pilot programme and developing community-based eldercare services and institutional care facilities.[119] The Government began developing a series of community-based eldercare service projects across the country through a public-private partnership scheme in the early 2000s. For example, it launched a three-year, 10 billion CNY (US$1.2 billion) Starlight Project in 2001 to develop eldercare services, activity centres and homes for the aged across the country, particularly in smaller cities and towns that were experiencing rapid out-migration of younger people.[120] By 2005, it had invested over 13.4 billion CNY (US$2.1 billion) and established 32,000 seniors' centres nationwide through co-financing among the Ministry of Civil Affairs, provincial welfare foundations, local governments and welfare lotteries.

Many critics, however, argue that despite the initial government investment, the project failed, in the end, to deliver needed services to the growing number of elderly empty nesters with care needs, largely because of the "dwindling financial support from the government [over time], raising questions about the viability of similar initiatives".[121] Many of the resources were initially put into building care facilities, and the amount of services provided was inadequate in relation to demand. The Government has also directed local and provincial governments to provide community-based personal care and home help dispatch services for the elderly. For people with the 'Three No's', government-run eldercare institutions are being developed in urban and rural areas.[122] A large amount of public funding has also been pumped into the private sector to build and provide institutional eldercare services following a public-private partnership model. This has fuelled a rapid expansion of private eldercare institutions across the country.[123] Unfortunately, this too has not resulted in reduced eldercare pressure for the family; on the contrary, the combination of welfare state infrastructure for eldercare – the new system being built is strongly biased towards market-based provision and economic privatization – has instead resulted in more unequal access.

As in the case of LTCI in Korea, the lack of pre-existing social and institutional infrastructure for eldercare (other than the family), combined with a sudden surge of institutional imperatives to provide care and constrained resources, has led the state to enlist the private sector in developing the eldercare system. The privatization of eldercare services – particularly in the form of residential eldercare – has made it more difficult and expensive for low- and middle-income elderly households to access care and for the Government to regulate the care market. Most crucially, there are simply not enough public nursing homes to meet demand. Currently, about 40,000 nursing homes accommodate approximately 2.66 million residents, most paying fees privately,[124] accounting for barely 1.9 per cent of all the people over age 65. In the city of Nanjing, for example, the proportion of state-owned eldercare institutions had dropped from 60 per cent in the 1990s to less than 23 per cent in 2000.[125] Finally, despite the expansion of private eldercare institutions, the majority of elderly people are still dependent on community and family for their LTC needs, with only about 4 per cent of such needs in China currently being met by institutions.[126]

It may be argued that China's eldercare system is still at a "preliminary development stage".[127] While local governments have begun providing some eldercare services, they are woefully inadequate and locally disparate. In lieu of adequate care services, many urban families have come to increasingly rely on migrant domestic helpers from nearby rural areas to provide home-based care.[128] Domestic help (*baomu* or *jiazhengfuwuyuan*) is now officially recognized by the Government as an occupational category; however, the work is associated with low wages and low status and is accorded little legal protection and limited social security and benefits.[129] Most domestic

119. Feng et al. 2012.
120. China Daily 2003.
121. Feng et al. 2012: 2768.
122. Ibid.
123. Ibid.; Feng et al. 2011; Wu et al. 2008.
124. Qiu and Liang 2011; Glass at al. 2013.
125. Feng et al. 2011.
126. Feng et al. 2011; Glass et al. 2013.
127. Wang and Wu 2017.
128. Hong 2015.
129. Wang and Wu 2017.

helpers perform what is commonly known as '3-C work' – cleaning, cooking and caring. Large wealthy municipalities, such as Beijing and Shanghai, have begun providing domestic help services to low-income elderly people living alone. The Shanghai government, for example, implemented a local domestic help service programme in 2006, providing and paying for home-based care for elderly people living alone. Shanghai's wealth, and large and growing economy, serves as an immense magnet for migrant workers from nearby poorer regions. The number of migrant domestic workers in Shanghai grew from 300,000 in 2009 to 490,000 in 2013.[130] Over 80 per cent of those working in Shanghai's domestic help service programme are migrant workers, almost all of them women.[131] The success of the Shanghai programme has been noted by the Central Government as it monitors local policy experiments for their potential to be scaled up.[132]

As its population begins to age at a rapid rate, the Chinese Government has begun to put more effort into developing the eldercare service infrastructure. It faces several challenges in this process. First, there is a potent economic privatization force that is running counter to tentative welfare expansions in eldercare. Experts agree that the outcomes of large government-funded public-private partnership projects to develop community-based eldercare service centres across the country in the early-2000s, such as the Starlight Senior Centres, have not only been poor and costly but have also failed to make care accessible for low- and middle-income families.[133] Second, the pre-existing eldercare infrastructure is hugely inadequate at both local and national levels. Adding to this, large social and economic disparities and regional diversities also make national policy coordination difficult.

Yet, the Government is mindful of the political imperative to address social policy issues, including growing social and economic inequality, increasing economic insecurity, urban-rural disparity, demographic ageing and a lack of social security for most citizens. There has been growing social unrest across the country over the last few years, much of it attributed to socio-economic inequality and economic insecurity. For example, the incidence of organized labour unrest rose from an average of 15 incidents per month in 2011 to 252 in 2015.[134] This does not even include the incidence of local social unrest and other forms of protest arising on a daily basis. As the Chinese population continues to age, and the family's capacity to care for elderly members declines, the Government will have to find a way to provide eldercare. It will have to identify a new solution to balance its desire for economic growth with the imperatives of supporting its ageing population and reducing social unrest.

3.6

Germany: Regulated social insurance approach

With its historical development of an insurance-based, Bismarkian welfare system, Germany is often typified as a conservative welfare regime and has long held subsidiarity – and family responsibility – to be an important principle of its welfare and social arrangements. Its Constitution guarantees 'living in dignity'.[135] Its decision to introduce compulsory social LTCI, widely debated through the 1980s and implemented in 1995, has influenced developments in other countries, including some in East Asia such as the Japanese and Korean systems already discussed. LTCI has now been a core feature of the German eldercare system for over 20 years, although it is only part of "a complex interplay of several policy schemes".[136] The system is characterized by mandatory quality assurance and a lack of means testing (except for those claiming welfare benefits for care support outside the LTCI).

Significant debate about the need for a LTCI system began in the 1970s, stimulated by three key concerns: the rising numbers of elderly people (often with full employment records) requiring welfare support in the form of 'special public long-term care assistance'

130. Laliberté 2017.
131. Hong 2015.
132. Ibid.
133. Feng et al. 2012.
134. China Labour Bulletin 2016.
135. Heinicke and Thomsen 2010.
136. Theobald et al. 2011: 140.

(*Hilfe zur Pflege*); the social stigma associated with this; and cost pressures at the municipal level as local authorities administered *Hilfe zur Pflege*, introduced in 1962.[137] A variety of solutions and various combinations of private and social insurance were debated in the 1980s, but the chosen scheme only began operating in 1995 (delayed, in part, by German reunification in 1990).

Social LTCI is the central pillar of Germany's eldercare system, but since 1995 arrangements have also included private insurance (which only specified groups, notably higher earners,[138] may opt for instead) and state welfare funds, which those with fewer resources can claim. As one analyst put it, the German system provides "universal public support on a medium level embedded in a framework of cost containment policies; federal law strictly defines levels of care dependency, related benefits and assessment procedures valid in the entire country".[139]

The social LTCI scheme is intended to meet basic rather than all care needs, and users are also expected to contribute private resources, to make use of family support and, if needed, to apply for the (means-tested) additional support available through the (separate) state welfare system.[140] This includes, for example, 'Elder Assistance' services and means-tested support through 'Help to Long-Term Care' schemes, for which those with (primarily lower level) needs not covered through the LTCI scheme may apply.[141]

Eldercare in Germany continues to rely heavily on family, especially female, participation in the work of care (92 per cent of LTCI beneficiaries have an 'informal carer', often a female relative).[142] With LTCI established as the state's main way of providing eldercare, Germany has kept tax-based public LTC expenditure relatively low; in 2013, just 1.0 per cent of GDP (Figure 3-1), well below the OECD average and among the lowest of the European countries considered here.[143] The long-term financial sustainability of its LTCI scheme nevertheless remains an ongoing concern.[144]

The social LTCI system is a 'pay-as-you-go' scheme, covering people of all ages with care needs, financed through insurance premiums payable into LTCI funds administered by the (mainly pre-existing) health insurance funds rather than an independent administrative organization.[145] In 2013, it covered 69.8 million people (while private LTCI [2012] covered 9.5 million people) and there were 2.5 million social LTCI beneficiaries, 1.7 million receiving support at home (and 151,000 private LTCI beneficiaries, 106,000 receiving support at home); some two thirds of LTCI beneficiaries were elderly people.[146] Figures in all the aforementioned categories rose every year from 2002 to 2013. Total expenditure in the social LTCI scheme also increased annually, from €17.4 billion (2002) to €24.3 billion (2013).[147]

Scenario assumptions produced in a comparative assessment of the public costs of LTC in different national settings[148] showed German social LTCI covering 88 per cent of home care costs, 48 per cent of residential care costs and 41 per cent of nursing home costs. Remaining costs were covered by tax-funded income support payments (respectively 2 per cent, 19 per cent and 30 per cent) and by service users' out-of-pocket expenditure (respectively 10 per cent, 33 per cent and 29 per cent).[149] Germany's rather low use of tax-funded welfare is a notable difference from the arrangements in Japan and Korea, where up to half of LTC costs are subsidized by general taxation. Another important distinction is that Germany's scheme is not restricted to elderly people.

137. Heinicke and Thomsen 2010: 2.
138. Heinicke and Thomsen (2010) explain that: "Civil servants, soldiers and people older than 65 years are exempted from unemployment insurance. Self-employed are exempted from health and SLTC insurance, and civil servants from pension insurance in addition" (p. 5).
139. Theobald et al. 2011: 157.
140. Robertson et al. 2014.
141. Theobald et al. 2011.
142. Heinicke and Thomsen 2010.
143. EC 2012, 2013.
144. Heinicke and Thomsen 2010.
145. Ibid.: 5.
146. OECD 2010.
147. Ministry for Health 2014b.
148. Karlsson et al. 2007.
149. Ibid.: 116.

Several significant reforms have been implemented since the German LTCI scheme was introduced. In 2008, benefits and contribution rates were revised upwards, arrangements were made to regularly review scheme financial viability, and the contribution period for eligibility to receive benefits was cut from five to two years. More recently, the *First Act to Strengthen Long-term Care* raised the benefits payable from the start of 2015 (by 4 per cent), expanded access to respite and short-term care benefits, increased reimbursement rates for people with dementia and introduced some other flexibilities.[150]

A further key change relates to the rules on assessment of care need.[151] Between 1995 and 2016, access to LTCI benefits was based on physiological impairments assessed at three levels: help needed once daily for (average) 90 minutes; help needed three times a day for 180 minutes; and round-the-clock help needed 300 minutes per day. From 2017, the *Second Act to Strengthen Long-term Care* replaced this system with one based on physical, mental and psychological needs (assessed at five levels) and with mobility; cognition and communication; behaviour; self-sufficiency; restrictions linked to therapies; and everyday life and social contacts all taken into account. New payment limits were also set, with payments for the five levels set between lower and upper monthly limits: €125–901 (care allowance), €689–1,995 (home care) and €125–2,005 (residential care).[152]

Social LTCI contributions are set at a fixed proportion of the insured person's earnings (2.55 per cent since 2017, with people without children paying 2.8 per cent – an increase from 2013 when the figures were 2.05 per cent and 2.3 per cent, respectively).[153] Employers fund about half the cost of the social LTC system, although employees in most of Germany gave up a public holiday when this was negotiated.[154] Private LTCI premiums, by contrast, are based on age at enrolment, with a statutory upper limit.[155]

Subject to having made the appropriate LTCI contributions in the decade before applying for support,[156] people needing care can access a cash care allowance (often used in the context of care provided at home by family members), home care with a professional care worker visiting the recipient, or residential care. The cash allowance is a further difference from the Japanese and Korean LTCI systems (which are structured as purely social insurance programmes). Karlsson et al. (2007), based on comparisons of the net present value (NPV) and 'money's worth'[157] of the German, Japanese, Swedish and UK schemes in 2006, claim the German system lacks the inbuilt redistributive mechanism of these other schemes.[158] They note that "in the German system, the only link between contributions and benefits is the … period required to become entitled to benefits" (p. 112), and conclude that "Germany systematically offers the worst benefit-to-contribution ratio of (…) the countries compared. This result arises because high-income earners do not receive any benefits from the system, whereas individuals in lower income groups face disproportionately high social insurance contributions".[159]

Eligible people with assessed needs can use the LTCI cash benefits they receive as they wish, have some choice about the type of care they receive and, when using services, can select a provider of their

150. Federal Ministry of Health 2014a.
151. The social LTCI system is not focused exclusively on elderly people but also insures the LTC costs of adults with a disability or other LTC needs, another feature that differentiates it from the schemes in Japan and Korea.
152. Backer 2016.
153. In 1995, the social LTCI contribution rate was 1 per cent. It was raised to 1.7 per cent in 2000, and in 2005 the additional 0.25 per cent contribution for childless people was introduced. The base rate was raised to 1.95 percent in 2009 (Heinicke and Thomsen 2010, Table 1, p. 5).
154. Heinicke and Thomsen 2010: 6.
155. EU 2014.
156. OECD/EU 2013b.
157. Karlsson et al. (2007: 112) state: "calculating the 'money's worth' of the public LTC system requires the following … information: The population sub-divided by severity of disability at each point in time; A mapping from different levels of disability into different care settings; Individual and aggregate care costs; Benefit and contribution rules; A rate of investment return."
158. Karlsson et al. conclude: "the German system offers few improvements for most people whilst using a regressive method of financing. It is very likely that the development of the German system is more a product of German welfare traditions than of endeavours to solve the problems of LTC financing in a rational way" (2007: 125).
159. Karlsson et al. 2007: 122.

choice.[160] In their comparative assessment of different European systems, Kraus et al. described the German LTCI system as "somewhat fragmented" and "potentially challenging for users to access"; however, since 2009, service users and their families have been legally entitled to advice about how to access support through case managers (employees of the LTCI fund holders) or other qualified experts. Service users with adequate resources must share the cost of institutional services within the LTCI scheme, paying any excess above the regulated, fixed amount of the care element, plus their 'board and lodging' costs and (in some regions contributing to 'investment' costs), although co-financing is not required for home care or home nursing provided within the LTCI scheme.[161]

By 2011, Germany had about 12,000 nursing homes and a similar number of home care providers. Most of both types of provision was in the private for-profit sector, although not-for-profit providers were also important and a few public providers also existed.[162] National data show significant growth (+30 per cent) in the LTC workforce between 1999 and 2008,[163] an ongoing trend confirmed in other sources.[164] Between 2005 and 2008, their number was equivalent to 50 workers per thousand people aged 65+. German LTC workers are overwhelmingly female (according to national data, 88 per cent in home care employment and 85 per cent in institutional care jobs are women), with most positions held by mid-skilled workers. Both these patterns were stable across the period 1993–2008. The proportion of LTC workers employed part-time increased from 47 per cent to 58 per cent between 1998 and 2008. About 7 per cent of those classified as 'personal care and related' workers were foreign nationals (in both 1998 and 2008), while among those designated 'domestic and related helpers, cleaners and launderers' the figures were much larger and rose from 22 per cent to 26 per cent across the decade to 2008.[165] Analysis of routes into care work for foreign workers suggests three main reasons for care migrants entering Germany: 'family reunion'; 'ancestry' (mainly ethnic Germans from the former Soviet states with rights of abode); and the free movement of EU labour, with most migrants working in care coming to Germany initially for 'non-economic' reasons.[166]

Some 18 per cent of all care workers are thought to be migrant care workers, many originally from Eastern Europe, including the Russian Federation and Ukraine, but they are typically already resident in Germany when they take up care work. There is also evidence of newly arrived migrants entering this type of work, in some cases working for citizens benefitting from the tax concession arrangements available to those paying for household services. Theobald et al. (2011) calculate that about 120,000 migrant care workers (arriving from the EU 'accession' States from the mid-2000s) provide 24-hour care to households 'on a rotational basis', supplying domestic services and undertaking care activities for some 5 per cent of elderly people needing care at home. These workers come from several EU States, principally Bulgaria, the Czech Republic, Hungary, Poland, Slovakia, Slovenia and Romania.

Federal Statistical Office data show that between 1999 and 2011, the number of people working in nursing homes increased by 50 per cent from 441,000 to 661,000 (480,000 full-time equivalents [FTEs]), while the figures for staff working in home care rose by 58 per cent from 184,000 to 291,000 (193,000 FTEs). As elsewhere, these workers are overwhelmingly female, and the proportion working part-time hours has been increasing.[167] Shortages of qualified LTC nurses and care worker recruitment difficulties are widely reported.[168] These concerns about labour shortages may partly explain why Germany has been described as "the only country currently planning to perform an active recruitment of non-EU care migrants".[169] In 2014, Cangiano nevertheless identified Germany (and Austria) as countries that were "already relying substantially on migrant caregivers at the end of the

160. Kraus et al. 2010.
161. Ibid.; Shultz 2010.
162. EU 2014.
163. Geertz 2011: 7.
164. Cangiano 2014.
165. Geertz 2011.
166. Cangiano 2014.
167. Theobald et al. 2011.
168. Heinicke and Thomsen 2010; EU 2014.
169. Lamura et al. 2013: 16.

1990s but have seen little expansion of the migrant workforce in the subsequent decade".[170]

As noted already, many German care users claim the LTCI 'care allowance'; in 2013, 80 per cent of people receiving LTCI-funded support at home took this in the form of a cash payment, and 63 per cent of all LTCI expenditure on care at home was spent in this way.[171] Home care relies heavily on family support, much of it provided by relatives, especially women, aged 50–64. Precise figures are not available, but it is known they are substantial (in 2011, 407,000 'informal' carers were insured as such in the German Social Pension Insurance scheme, with €900,000 of LTCI funds; the qualifying criteria for this include caring for 14+ hours per week).

Germany has adopted various measures intended to support family carers. Its *Act on Caregiving Leave* entitles them (since 2010) to take up to six months unpaid leave from their paid work, and the *Family Caregiver Leave Act*, implemented in 2011, enables them to reduce their working hours for up to two years, under arrangements through which the carer and employer share the costs of partially protecting the worker's salary. Work-care reconciliation is a significant contemporary issue in both German politics and public discussion, and an Advisory Board on Reconciliation of Employment and Care for Older People (2015–2017) has been commissioned by the Federal Ministry for Families, Senior Citizens, Women and Youth to undertake investigations and prepare a report on this topic. Under a recent reform of these arrangements, German workers are entitled to a short period (10 days) of paid leave to make arrangements for the care of elderly relatives and they can take unpaid care leave from their jobs for up to two years in certain circumstances.

Studies of social attitudes in Europe about how elderly people with care needs should be supported show low support among Germans for residential care: 'moving them to a nursing home' was the favoured response of only 8 per cent of respondents.[172] By contrast, almost a third of Germans (30 per cent) thought sons or daughters should visit their elderly parents to provide care where needed, and 25 per cent felt the best solution was for elderly people with care needs to live with one of their children.[173] Over a quarter (27 per cent), however, felt that in such circumstances public or private service providers should visit them to provide necessary assistance.[174] Despite legal arrangements that mean sons and daughters can be liable for the care costs of their parents, many Germans (82 per cent) said they did not expect to pay for their parents' care (although 8 per cent were doing or had already done this) and even more (92 per cent) did not expect to quit their job to provide care for a parent. This suggests a relatively strong preference for 'ageing in place' (rather than in institutional facilities) wherever possible and a mixed picture in terms of family support, which is increasingly recognized by policymakers as potentially problematic for younger generations to provide.

3.7

Finland: Modified, universalist Nordic welfare model, with privatization features

Finland is usually classified as a Scandinavian welfare state or, more accurately, seen as offering a version of the Nordic welfare model; OECD data show that in 2013 it spent 2.2 per cent of GDP (more than any of the other case studies) on LTC (Figure 3-1). While it continues to demonstrate commitment to universalist social values and public services, in recent decades Finland has 'rediscovered' 'informal' family carers,[175] adopted some features of New Public Management,[176]

170. Cangiano 2014: 139.
171. Federal Ministry of Health 2014b: Table VIII.
172. EC undated b.
173. The question (QA7a) asked was: "Imagine an elderly father or mother who lives alone and can no longer manage to live without regular help because of her or his physical or mental health condition? In your opinion, what would be the best option for people in this situation? Firstly?"
174. EC undated b.
175. Kröger and Leinonen 2011; Jolanki et al. 2013.
176. Dahl and Rasmussen 2012.

introduced significant privatization and marketization and chosen to 'de-institutionalize' eldercare.[177]

LTC in Finland is provided, and primarily financed, through its more than 300 municipalities, which have significant tax-raising powers. One consequence of this arrangement is that there is considerable variation, and some lack of standardization, across the country as a whole. There have been several important recent and ongoing changes in the Finnish system of eldercare.

First, a policy shift towards the provision of care for elderly people at home or in 'intensive service housing units' (rather than in nursing homes) has been articulated and set out in legislation. One effect of this is that local authorities have been able to shift some costs to central Government. Whereas in nursing homes clients' user fees consist of a single, means-tested payment covering all services provided, in the new and rapidly developing intensive service housing units, which offer round-the-clock assistance, each aspect – housing, care, support services and medication – is billed separately, with those eligible able to claim some reimbursement of their housing and medical expenses from central agencies.[178]

Within home care (where services may also include meals, washing/bathing, transport and shopping services), the focus has shifted to elderly people with more intensive needs. This has led to a greater emphasis on the provision of personal and bodily care (rather than help with food preparation or cleaning). In addition, some elderly people whose needs would previously have been met through municipal home care are being cared for by relatives receiving payment through the 'informal care allowance' that all municipalities now offer, although it is not mandatory for them to do so.[179]

Alternatives to direct service provision have also been developed, including voucher and tax credit systems. Vouchers, which can be used to purchase any relevant services, were introduced in 2004 with the objectives of increasing consumer choice and promoting efficiencies through competition; clients must, however, be provided with a service if they prefer this to accepting vouchers. Voucher use (mainly for cleaning and home care) trebled between 2004 and 2009, and by 2009 about 9 per cent of home care clients were receiving their publicly funded support in this way.[180] The tax credit option, available since 2001, is used to partially offset the costs of, for example, household repairs or building work, care of elderly family members and cleaning. Services may be purchased from a company or by directly employing a worker. Some 100,000 elderly people, mainly the more affluent, use this system, which "partially compensates for the decline of publicly funded home care provision".[181]

By 2011, Finland's eldercare system was providing home care to 6.5 per cent of the population aged 65+, home help to 11 per cent and other support services to 12.1 per cent; 2.7 per cent had the support of a relative receiving the Informal Care Allowance (ICA). Apart from the ICA figure (which increased), all these figures have declined over the past 15–20 years.[182] Analysis of the number and percentage of elderly people of different ages receiving home care between 1990 and 2005 reveal a sharp decline (minus over 60 per cent) among elderly people aged 65–74; a drop of more than 50 per cent in the percentage of 75–84 year olds; and a reduction by 19 per cent even among those aged 85+, where absolute numbers increased (by 39 per cent).[183]

Social attitudes in Finland still strongly favour use of available services, and the quality of LTC provision and training of care workers is high by most European and international standards. People in Finland are much less likely than those in the other European countries

177. Karsio and Anttonen 2103; Antonnen 2016.
178. Karsio and Antonnen 2013: 92.
179. Ibid.: 90.
180. Ibid.: 101.
181. Ibid.: 103.
182. Ibid.: 90.
183. Kröger & Leinonen 2011: 120. These changes have several causes. Finland experienced a serious recession in 1990–1993 that constrained public expenditure; the general health of the 65–74 age group improved across the period; much family care was previously 'hidden'; and since 1987, "Finland has been governed by majority cabinets, based on co-operation between two of the three largest parties (Social Democrats, Conservatives and the Centre Party)" (Karvonen 2014: 77).

considered here to think an elderly person requiring care should move in with a daughter or son if they need care; this was the first choice option of just 7 per cent of Finns questioned about social attitudes in 2007.[184] A quarter of respondents (25 per cent) thought a daughter or son should visit an elderly parent needing help to provide support, but two thirds felt the main assistance should be provided by service providers – either through home visits from care workers (51 per cent) or by moving into institutional care (13 per cent). In addition (and as in all the European countries considered here), a large majority of respondents in Finland (79 per cent) did not expect to have to pay for their parents' care.

Attitudes to LTC in Finland are doubtless influenced in part by the expectation there that care will be delivered by professional, formally trained workers. Finland's national curriculum sets out a three-year vocational training programme for LTC workers, in which 120 credits – including 29 awarded on the job – are accrued.[185] While most Finns expect to, and do, provide some support for their spouse or parents in older age, it is not expected that this will include that person's personal care if they prefer this assistance to be given by a professionally trained care worker.

Although the LTC services available in Finland are not means tested, and elderly people with assessed needs are automatically entitled to receive them, some user fees are payable. As indicated, the eldercare system includes home care services, 'informal' care, institutional care, services for elderly people at home or in day and service centres, social assistance or other social care services. Trained municipal staff assess an individual's need for these services. While most support continues to be provided in-kind, reliance on vouchers, tax allowances and the 'informal care support' provided by the Informal Care Allowance is increasing.[186] A Care Allowance for Pensioners, paid by the Social Security Institution (KELA) is also provided to help pension recipients with illness or disability remain at home. In one comparative assessment, co-ordination between LTC and other services in Finland was judged to be generally good, although a choice of provider was not usually offered for either type of provision and no mandatory quality assurance arrangements were identified.[187]

Finland has, in relative terms, one of the largest LTC workforces in the EU. In 2012, its 221,000 care workers represented just over 9 per cent of Finland's total workforce, with most staff working in home care (58 per cent), a large group employed in institutional settings (38 per cent) and just over 3 per cent working as live-in workers in households.[188] Still consisting primarily of public sector employees, this workforce has been changing in recent decades, in line with the trend towards marketization. Outsourcing was strictly regulated until 1993, although many Finnish municipalities traditionally procured some services from non-profit welfare organizations. This has subsequently changed, with for-profit organizations increasingly part of the picture.[189] One result has been a rapid increase in the proportion of workers employed in the for-profit care sector: between 2000 and 2010, their share of all employment in service housing settings rose from 16 per cent to 29 per cent, and in home care services from 5 per cent to 13 per cent, a trend expected to continue.[190]

Historically, Finland's care workforce has comprised very few foreign workers (although this may be changing). In 1990, only about 26,000 foreign citizens legally resided in Finland (less than 1 per cent of its population). By 2009, this figure had increased to 155,700 and about 5 per cent of the Finnish population claimed some foreign background, i.e., born outside Finland, speaker of a foreign language or foreign citizenship.[191] By the mid-2000s, when Finland had 114,000 residents with foreign citizenship, the two largest groups were Russians (25,000) and Estonians (15,000), with Swedes comprising a further 8,000. Other, much smaller, groups came from many different nations.[192] Of this

184. EC undated b.
185. OECD 2013.
186. EU 2014.
187. Kraus et al. 2010.
188. Cangiano 2014.
189. Karsio and Antonnen 2013: 92.
190. Ibid.: 108.
191. Tanner 2011.
192. Ylitalo 2007.

total, 51,000 were active in the labour force and 37,000 employed (with considerably more men than women). The list of sectors in which they worked included cleaning and 'other social sectors', but there was no evidence of large-scale migrant employment in care work. Developments in the past decade include increased migration to Finland by asylum seekers and refugees, family reunion migration and settlement of ethnic Finns previously living in the USSR (Ingrian Finns, who until 2010 had special immigration rights).[193]

3.8

United Kingdom: Mixed public/private market approach

The Beveridge-inspired welfare state in the United Kingdom (UK), which includes its universally accessible National Health Service (the NHS, first established in 1948) is often described as the archetypal liberal/Anglo-Saxon mixed welfare model. The system is funded primarily through general taxation and compulsory 'national insurance' payments, the latter levied mainly through a PAYE (pay as you earn) system on employees and employers. Although Attendance Allowance – a non-contributory, non-means-tested cash benefit – is payable to all people aged 65 or older who have a disability or care need,[194] much of the other welfare support in the UK (apart from NHS services) is means-tested and acts mainly as a 'safety net'. This includes 'social care', the support delivered to elderly people with care needs through local authorities, which have a statutory obligation to assess the 'adult care' needs of local residents. The system they operate is regulated at the national level, with local authorities' tax-raising powers strictly controlled by the Government.[195]

193. Tanner 2011.
194. Some 1.5 million people receive a modest Attendance Allowance (AA), paid at two rates for people with different degrees of need (£56 and £83 per week in 2017). AA is a state welfare benefit intended to help pay for personal care costs. How older people spend it is not monitored or regulated, and it is administered separately from, and does not affect, entitlement to any local authority support for which the person may be eligible.
195. Kispeter and Yeandle 2015.

In 2010, the UK spent 2.0 per cent of GDP on LTC.[196] Although local authorities are obliged to support elderly and disabled people with care needs, the system relies heavily on families, who supply without payment most of the care provided at home. In 2011, the UK Census showed some 6.6 million people, 12 per cent of the population, were providing such support, over 2.4 million of them for 20+ hours per week.[197] Carers' numbers have been rising steadily since data on unpaid care began to be systematically collected in the 1980s. Most receive no financial support for this, although about 9 per cent of carers receive the Carers' Allowance, a state benefit paid to working-age carers who have no (or very low) personal income from paid work and are providing at least 35 hours of care per week to an elderly or disabled person whose assessed needs enable them to receive a state disability benefit.[198] The Carers' Allowance (first introduced under a different name in 1976) is a modest payment to the carer intended to partially offset the financial impact of reduced earnings from paid employment; it is not otherwise assets- or means-tested, and the incomes of other family members (including a spouse and/or the person needing care) are not taken into account.

In 1990, the UK made a major change to its publicly provided care services, introducing a 'mixed economy' of social care provision through the *NHS and Community Care Act 1990*. This led to substantial outsourcing of adult social care to the independent sector (including to for-profit providers). In the late 1990s, Parliament devolved responsibility for health and social care policy (and some other policy areas) to the four UK nations' administrations, and following this there has been some diversification of LTC arrangements in these four constituent nations.[199] England, by far the largest of these by population, has since introduced a degree of consumer-directed choice for care users, administered by its local authorities, that encourages elderly people to have personalized budgets and to choose direct payments, using these to purchase the care services or support they require.[200]

196. EC 2013.
197. Buckner and Yeandle 2015.
198. Fry et al. 2011.
199. Gray and Birrell 2013.
200. Yeandle et al. 2012.

Since about 2010, England's system of care and support for adults with care needs has been further privatized and (in a new development) the numbers of elderly people receiving home care (or using day-care services in their communities) arranged by public authorities following assessment have begun to decline.[201] Most English local authorities have now eliminated almost all provision of eldercare in publicly run institutions (or by state employees), and almost all publicly funded eldercare is now contracted from 'independent' sector providers. The system is officially described as under 'financial strain', with some providers 'exiting the market' as a consequence of this, claiming that the financial viability of their businesses is compromised by the twin pressures of tight local authority financing and rises in the national minimum wage.[202] The entire care system in England is now widely viewed as financially unsustainable and frequently described as 'in crisis'; the causes of this are complex but include persistent problems in integrating the historically separate 'health' and 'social care' systems – health care being 'free' at the point of use within the popular but now 'underfunded' NHS;[203] and social care being locally means-tested support, funded (for those eligible) by local authorities whose budgets have been severely curtailed as part of the ongoing 'austerity' measures introduced in 2010 to address the consequences of the global financial crisis.[204]

Despite some reform of these (still primarily separate, especially in England) financial arrangements for health and social care, and major new legislation (the *Care Act 2014*), these problems have continued, exacerbated by difficulties in some localities in arranging timely or adequate home care support for elderly people on discharge from hospital (particularly those living alone or with a spouse who is also old and unwell).[205] The *Care Act 2014*, heralded as 'landmark' legislation in social care, provides improved rights and entitlements for family/friend carers[206] and in theory emphasizes the principle of 'wellbeing' for all care users. Its implementation has been slow, however, hampered by financial constraints.[207] These have led to ad hoc extra public funding in response to political and public pressure, including a new 'social care precept' in 2016[208] and the allocation of additional funding in the 2017 budget.[209]

Social attitudes in the UK about arrangements for eldercare nevertheless continue to support the use of public or private services to attend an elderly person at home in the case of need. Over one third of UK respondents (34 per cent) stated this as their preferred option in a recent Eurobarometer survey.[210] Almost a quarter thought adult children should visit their parents to provide support if needed (23 per cent), and one in five (20 per cent) thought a frail elderly person should move to live with a daughter or son. Very few (10 per cent) favoured the use of institutional care.

UK Governments over the past 20 years have failed to make many reforms called for, including proposed reform of how care of and support for elderly people is funded.[211] Many users of care services now make substantial co-payments or pay their full cost from private means; as mentioned, publicly funded home care is declining,[212] despite increased demand,[213] and the care home sector is considered, by its own representative body, to be 'at risk'.[214] There have, however, been some measures to address work-care

201. Buckner and Yeandle 2015; Yeandle 2016.
202. CQC 2016; Humphries et al. 2016.
203. RCP 2016.
204. Luchinskaya et al. 2017.
205. National Audit Office 2016.
206. HMG 2014.
207. Carers Trust 2016.
208. In 2015, the UK Government announced the introduction of a new 'social care precept' whereby local authorities would be allowed to raise council tax levels by up to an additional 2 per cent in 2016–2017 and 2019–2020 to help fund adult social care.
209. HCCLGC 2017.
210. EC undated b.
211. Dilnot Commission 2011; House of Lords 2013.
212. "The number of elderly people receiving local authority funded social care fell 26 per cent from more than 1.1 million in 2009 to around 850,000 in 2013/14 (the last year for which comparable data is available), and 81 per cent of local authorities have reduced their real-term spending on social care for elderly people over the last five years. Unmet need has also grown: a recent assessment for Age UK indicated that more than a million people who have difficulties with the basic activities of daily living – such as getting out of bed, washing and dressing – now receive no formal or informal help at all (CQC 2016: 42-43).
213. Yeandle 2016.
214. UKHCA 2013.

reconciliation pressures for people of working age, including the introduction of a 'right to request flexible working' (initially for some parents and carers, later extended to all UK employees with six months' service), although paid leave options, such as seen in Japan, have not been legislated.[215]

Local authorities continue to have responsibility for assessing the care needs of elderly people and must apply national guidelines in doing this. They have some discretion in the extent to which they apply means testing, but in recent years almost all have tightened their eligibility criteria (which are based on assessed needs) and introduced more stringent assessments of an elderly person's ability to pay. They have no powers to charge family members for an elderly person's care, however. Most families in the UK view supporting an elderly or sick family member as a moral obligation, but the law does not require relatives to provide (or pay for) support; on the contrary, under pressure from an active carers' movement, the trend in UK legislation in the past 20 years has been towards recognizing the state's obligation to provide some support to families providing care,[216] culminating in the *Care Act 2014*, under which they have a legislated right, if they wish, to have their own needs for support assessed and (subject to eligibility criteria) to receive services to address these needs. How far this change can be successfully implemented with the care system under significant strain remains to be seen.

Tighter means testing and underfunding within the social care system means many more elderly people are paying an hourly rate for home care (often covering its full cost, sometimes contributing to it through a co-payment), typically around £16 per hour. Workers in home care remain low paid, and homecare businesses complain of difficulties in managing funding, recruiting staff and meeting demand.[217] In residential care, local authorities fund only about half of placements and the NHS only 8 per cent, with self-funding making up the remaining 40 per cent.[218] The costs of residential care for privately funded residents have risen significantly in the past decade, falling hardest on those with dementia or frailty in extreme old age, who cannot be adequately supported at home and often require care for extended periods.

By 2009, some 1.8 million workers were employed in social care, about 6 per cent of the UK workforce.[219] Survey-based estimates (using the European Labour Force Survey) showed over half (53 per cent) worked in home care (typically making short daily visits to clients' homes); 44 per cent in institutions ('residential care', with or without nursing); and a few (<3 per cent) 'lived-in' as care workers in households. In 2015, adult social care workers in England alone were employed in 19,000 organizations, 78 per cent of which were in the 'independent' sector (most in for-profit companies, with some in not-for-profit voluntary organizations). A small group (8 per cent) was employed by local authorities and 9 per cent worked directly for elderly and disabled people receiving publicly funded direct payments.[220]

Studies have reported endemic problems in the sector, including low pay, poor working conditions, entry costs borne by workers[221] and high annual staff turnover, especially in the independent sector where turnover averaged 24 per cent in care homes and 31 per cent in home care, with most home care providers (70 per cent) recording shortages for weekend and unsocial work hours.[222]

Migrant labour plays a significant role in delivering this work, although (by contrast to developments in Mediterranean Europe), most migrant care workers are "employed in the market by care-providing agencies".[223] The 'foreign born' share of the UK's care workforce almost doubled in the decade to 2009 (reaching around 17 per cent by the latter date), a "response to employers' inability to recruit sufficient workers from the domestic labour market".[224] Offi-

215. Yeandle and Buckner 2017.
216. HMG 1999, 2008.
217. UKHCA 2013.
218. Eurofound 2015.
219. Cangiano 2014.
220. Skills for Care 2016.
221. Christensen et al. 2016.
222. Rubery et al. 2011.
223. van Hooren 2012: 143.
224. Cangiano 2014: 137.

cial data for England[225] show particular reliance on migrant care workers in London. In 2014, 51 per cent of the capital's adult social care workforce were of non-British nationality, compared with 17 per cent in England as a whole. The London figure comprised migrants from other EU countries (12 per cent of the total) and those from outside the European Economic Area (EEA) (39 per cent).[226] Migrant care workers are most strongly represented in those residential institutions where nursing care is provided and among private care sector organizations.[227]

Analysts have identified various entry routes for migrant care workers in the UK, finding (based on data for 2008) that the three most important were EU (free movement of labour), 'family reunion' and the 'labour admission route'.[228] The increased importance of the EU route was affected by the UK's decision (unlike most other EU member States) to allow immediate free entry to citizens of the eight 'accession' countries[229] that joined the EU in 2004. In the following five years, more than a million workers from these States entered the UK.[230] This route is likely to be restricted in future, following the UK's decision in 2016 to give notice (in March 2017) of its intention to leave the EU.[231]

Official data for 2003–2013 show the numbers of foreign nationals employed in all lower-skilled jobs in the UK rose particularly sharply in 2004–2008 and again in 2010–2012.[232] In these years, figures on the entry of care workers were volatile: non-EEA[233] workers (from outside Europe) were by far the largest group for much of 2003–2013, but their numbers declined sharply after 2008; entry of care workers from the 'A8' countries (eight lower-income countries that joined the European Union and EEA in 2004 – Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia) peaked in 2005–2007 but did not return to that level; numbers from the non-A8 EEA countries (the other, higher income, EU countries, plus EFTA members Iceland, Liechtenstein and Norway) were modest but stable and rose after 2011.[234] In mid-2013, those from Bulgaria and Romania (both of which joined the EU in 2007, three years after the 'A8' States) exceeded all those from outside the EU. These developments have various causes; in particular, the 'labour admission' route, affecting immigrants from outside the EU, changed after 2008 when a 'points-based' immigration system was introduced[235] (making it harder for employers to recruit care workers from outside the EU), followed (in 2010) by an 'immigration cap'.

225. UK-wide statistics are not available.
226. Skills for Care 2014.
227. Skills for Care 2011.
228. Cangiano 2014: 141.
229. The Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia (Cyprus and Malta joined the EU in 2004 and Bulgaria and Romania in 2007).
230. Sumption and Somerville 2010.
231. The UK invoked Article 50 of the Lisbon Treaty in March 2017, a process expected to lead to its formal withdrawal from the EU in March 2019.
232. Campbell et al. 2014: 8.
233. Through an international agreement, the European Economic Area (EEA) provides for free movement of persons, goods, services and capital within the single market of the 28 Member States of the EU plus Iceland, Liechtenstein and Norway (which belong to the European Free Trade Association, but not the EU).

3.9

France: Modified corporatist/ conservative welfare state

France's system for LTC in a welfare system variously described as corporatist or conservative, is funded through a mix of general taxation and insurance funds. Like Germany, it has introduced universal and mandatory LTCI arrangements that cover some care costs but still require users to make certain co-payments and relies heavily on family input.[236] The history of these dates from the post WWII establishment of France's social security system, which by the 1960s was funding services to elderly people at home through its social health insurance scheme. Since 1997, when a major reform of LTC financing permitted for a time recovery of expenses from elderly persons' estates after death, several other major reforms and developments have been introduced that underpin the current situation.[237]

234. Christensen et al. 2016.
235. The UK has made frequent changes to immigration rules in recent years. For details see House of Commons 2016.
236. Forder and Fernandez 2011.
237. Chevreul and Brigham 2013.

By 2013, France was spending 1.9 per cent of GDP on LTC (Figure 3-1) and there was universal access to its main LTC scheme, the 'Allocation Personnalisée d'Autonomie' (Personalized Autonomy Benefit, or APA), introduced in 2002 for people aged 60 and above. Involving, over time, a "shift from national solidarity-based financial protection to local tax-based financial protection",[238] the system, implemented at the regional level, is funded through a 'mixed' funding system that includes local authorities' contributions, compulsory social contributions and user co-payments[239] and uses a formal, five-level system of needs assessment applicable nationwide. Those entitled to support on the basis of their assessed needs get funded support paid at between 10 and 90 per cent of service costs, the exact percentage varying according to their income and assets. As in Germany, those in residential care must pay the full cost of their accommodation ('hotel costs') from their own resources, with those unable to afford this entitled to apply for means-tested social assistance. For more affluent residents, the costs payable in residential care, within the APA system, are substantial.

The APA system also relies significantly on families to provide care, and while it offers quite substantial allowances and payments to both elderly people and their family carers, cost sharing between the state and the family is significant. Scheme rules offer considerable flexibility in how payments are spent but cannot be taken as direct payments or used to pay a spouse.[240] The APA can be used to pay a relative (except for the spouse), but "this payment is regarded as a wage from an employer to an employee, for which the relative is expected to perform the caring tasks defined in the care package".[241]

The APA has been one of several ways France has stimulated jobs in the 'personal and household services sector' over the past 20 years, using policy measures including service vouchers (*chèque emploi-service universel* – universal service employment check), direct allowances for care services (as in the APA), exemptions from social contributions, selective exemptions from value added tax (VAT) and tax deductions/credits. The latter have proved the most costly measures for France's public budget, costing over 3 billion euros in 2012.[242] This sector, with 'home caregivers' officially designated a specific occupation from 2002,[243] was also stimulated by the so-called 'Borloo Plan', introduced from 2005, which stimulated significant development of personal and care services.[244]

Alongside these developments, arrangements in the French taxation system encourage the employment of household workers to provide care or household services, with families able to deduct significant sums from their income tax if they employ a household worker, and users of residential care permitted to do likewise for some of the costs they incur. A large (by European standards) and voluntary private insurance market has also emerged in recent years, through which growing numbers of elderly people and their families fund the LTC costs for which they are personally responsible. Significantly incentivized by the Government, particularly under the Sarkozy administration,[245] – which has encouraged employers to offer such schemes to their employees within pay and remuneration packages –such policies were held by some 3 million French people in 2008[246] and 5.7 million in 2012, representing over 11 per cent of all French citizens aged 18+, with the market continuing to grow at around 5 per cent per year.[247]

This differentiates France from the other countries considered here, including the UK, where pre-funded LTCI products are no longer available on the private insurance market,[248] and Germany, where taking out private LTCI is compulsory for affluent citizens outside the main scheme. By contrast, in France a "simple, cheap, cash-based product" has "gained traction among middle income individuals when

238. Ibid.: 219.
239. Farvaque 2015.
240. Kraus et al. 2010; Forder and Fernandez 2011: 13.
241. da Roit and Le Bihan 2010.
242. Farvaque 2015.
243. Devetter and Lefebvre 2015.
244. Jany-Catrice 2015.
245. Doty et al. 2015.
246. Forder and Fernandez 2011.
247. Doty et al. 2015.
248. Mayhew et al. 2017.

offered by employers and combined with a steeply income-adjusted universal public program", although the "adequacy of such coverage … is a concern".[249] As Doty et al's analysis points out, most policyholders are still below the age at which claims arise, and in 2015, private LTCI insurance was paying only about 0.5 per cent of total LTC expenditure in France. They note that this private LTCI market is "unique among highly developed Western nations" and that "only Israel and Singapore have robust private LTCI markets" (although in Singapore, unlike France, coverage is mandated for all workers by the Government) (p. 362).

The support provided through the APA scheme includes nursing and residential homes, hospital,[250] home nursing and care services, day centres and some support for 'informal' carers. France made a number of major changes to the APA system in the 2000s and continues to have a lively public debate about how LTC needs should be addressed in future. Some major recommendations, proposed after the global financial crisis put pressure on French public finances, have recently been rejected on grounds of excessive public cost.

When introduced as a universal benefit for elderly people in 2002, the APA replaced an earlier allowance for frail elderly people (the Specific Allowance for Dependency, PSD), introduced five years before and widely criticized as inequitable. APA aimed to increase the number of recipients through reformed financial arrangements, providing wider access (to include people with a greater range of needs) and eradicating some local variations in applicable financial arrangements.[251]

By the end of 2011, APA was paid to 1.2 million people (compared with 469,000 in 2002), about 60 per cent of them living at home. Many APA recipients get much of the care they need from 'informal carers', mainly family members (about 85 per cent of carers are relatives, although some support is also given by neighbours and friends). It should also be mentioned that about half of elderly people receiving care at home in France receive exclusively informal care, with about 30 per cent having a mix of formal and family support and about 20 per cent (mainly people living alone) receiving formal care only.[252] Most family care in France is provided by wives (often elderly people themselves) and daughters, and there is concern in public and policy debate about the availability of this support in the future.[253]

Although France has not developed comprehensive support for carers, it accords them a legal status and gives them basic information about their rights. Some get financial support through the APA, their caring qualifications can be officially recognized and family carers who are in employment may take unpaid leave from their job for up to three months without losing retirement rights.[254]

The value of the APA is determined by an individual care plan based on formal assessment of the person's needs and covers part of its cost (and the full cost for those on low incomes). Remaining costs (typically about a quarter, but varying according to assessment of the recipient's means) are covered by co-payments (user fees) that the recipient must pay from private resources.[255] Most of the public costs of the APA are met by France's *Departements*; the rest (a little under a quarter) are covered by a National Solidarity Fund for Autonomy (CNSA), formed from employers' social insurance contributions and taxes linked to the one day's wage per year that French workers contribute by "working for free".[256]

France's LTC system also relies on some 10,000 institutions in which (in 2011) over 700,000 elderly people (nationally about 10 per cent of the age group but with large local variations) received care.[257] In 2007, families were estimated to have spent at least €6 billion on

249. Doty et al. 2015: 360.
250. The health costs of the French LTC, including home nursing, are met primarily through France's compulsory health insurance scheme.
251. Joel et al. 2010.
252. Joel et al. 2013.
253. EC 2013.
254. Ibid.
255. Ibid.
256. Joel et al. 2010.
257. EC 2013.

the costs of this type of care, covering accommodation expenditure and a share of care costs.[258]

In 2006, France introduced a new disability compensation benefit, the *Prestation de Compensation du Handicap* (PCH) to support disabled people of any age. The PCH can be used for home care, home adaptations, assistive technology or other appropriate support. Its uptake increased rapidly from about 7,000 people in 2006 to almost 185,000 at the end of 2011.[259]

Social attitudes in France favour the use of home visits to elderly people by private or public service providers more strongly than in any of the other European States considered here: 46 per cent of French survey respondents said this is the best response if a parent needs support; just over a third (36 per cent) felt children should support a frail or sick elderly parent by either living together or visiting them to give support (18 per cent in each case); and only 12 per cent thought residential care the best solution.[260] French people are much more likely than those in the other European countries considered here to expect to contribute to the cost of their parents' care (23 per cent) – although, as elsewhere, a majority (68 per cent) do not expect to do this – and French respondents are almost unanimous in feeling that they should not have to quit their job to care for their parents (97 per cent).

Care workers in France represent a comparatively large share of the overall workforce (8.8 per cent in 2012) and, as in most other European countries, include a rising proportion of foreign-born workers (16 per cent in 2009 compared with 13 per cent in 1999). In 2012, just over a quarter of France's care workforce (almost 27 per cent) provided care in institutional settings, almost half (nearly 48 per cent) worked in home care and around a quarter (just under 26 per cent) were 'live-in' workers based in households.[261]

Most foreign-born workers in the French care system originally entered the country for family reunion, came as freely mobile labour from other EU countries or entered as labour migrants.[262] In 2008, France had approximately 3.6 million residents with foreign nationality, about 6 per cent of its population. Some were EU nationals but about two thirds came from outside the EU, principally from Algeria, Morocco and Turkey.[263] Detailed analysis of official survey data (INSEE, Survey of Employment) for 2010 show that among the 26 million female workers, 264,000 (1 per cent) were immigrants living in France since childhood (who arrived when under 16 years old), while a further 649,000 (2.5 per cent) had come to live there at age 16 or older.[264] The employed female workforce included half a million women working as 'home helps and housekeepers', among whom 14 per cent were immigrants, and 238,000 'household employees', among whom 32 per cent were immigrants. Less than a third of immigrant home helps and housekeepers originated from EU countries (the vast majority of these women coming from Portugal), while most (71 per cent) came from elsewhere, principally Africa, including quite large numbers from Algeria and Morocco. Immigrants who were household employees had come (in roughly equal numbers) from both within and outside the EU. Most of these migrant domestic workers were aged 30 or older and about two thirds were in part-time work.[265]

The residential care sector in France also employs large numbers of workers (some 300,000 in 2009, most in residential homes for 'dependent' elderly people); that year, 88 per cent of all workers in these settings were female, as were over 90 per cent of workers providing activities, supervision and 'services'.[266]

258. Joel et al. 2010.
259. EC 2013.
260. EC undated b.
261. Cangiano 2014.
262. Ibid.
263. Urso and Schuster 2011.
264. Condon et al. 2013b.
265. Ibid.: 40–43.
266. Silvera 2010: 13.

3.10

Spain: a modernizing Mediterranean welfare state, rooted in a strong family care model

Spain, a Southern European State, became a parliamentary democracy in 1977. Its Constitution (1978) introduced the fundamentals of its welfare system, empowering the state to make provision for elderly and disabled people and to establish social services. Initially Spain focused much of its welfare resources on pensions and social security.[267] It continued to rely heavily on families for the provision of care and supplied care services only where poor families could not provide these. Most adults aged 65+ in Spain live with others: 37 per cent with a spouse and 35 per cent with other relatives, although the proportion living alone is growing – reaching 19 per cent in official data (2012), with figures much higher for women (25 per cent) than for men (11 per cent) and rising with older age.[268] Long characterized by relatively low rates of female employment (Table 1-1), especially among older workers, Spain still had only around 33 per cent of women aged 55–64 in employment in 2010, compared with 50 per cent in Germany and 57 per cent in Finland).[269]

In a major development relevant to the care of elderly people, however, and after almost a decade of debate, Spain passed a *Law on Promotion of Personal Autonomy and Care for Dependent Persons* in 2006. This "aimed to provide universal access to long-term care services on a needs based approach"[270] and introduced a new System for Autonomy and Care of People in a Dependent Situation (SAAD). The system provides (tax-funded) benefits in kind and in cash, "financed and provided jointly by the central government and the autonomous regions, with a certain degree of co-payment by beneficiaries in most cases", and for care service providers to be registered and inspected by regional authorities, which also evaluate the services offered (which can include tele-assistance, home care, personal care and residential care).[271]

The new law gave all citizens the right to have their care needs recognized and introduced publicly funded cash transfers and services (with means testing). Four types of support were introduced, to be fully implemented by 2015: in-kind benefits (e.g., day-care centres); cash benefits (enabling people to buy services where access to publicly funded services was impracticable); a cash benefit for care within the family (intended for exceptional use); and a cash benefit to support the personal autonomy of disabled people, which they could use to employ a personal assistant.[272] With the adoption of this law, Spain chose to focus its LTC system on the goals of guaranteeing basic welfare conditions and forecasting the future need for social protection.[273]

As Spain's system of government gives considerable autonomy to its regional governments, implementation in the ensuing decade was variable; it was also affected by serious economic difficulties in the country after the 2008 global financial crisis.[274] In 2012, these led to a reform of the LTC system through which €2.3 million was to be saved between 2012 and 2014; this delayed the planned extension of coverage to people with moderate care needs, reduced minimum funding levels by an average of 13 per cent, cut the cash allowance for family care by 15 per cent (or €55 per month, with further reductions when regional funding was also cut) and suspended the Government's payment of social security contributions for 'non-professional carers' working in private households.[275]

In 2013, Spain was still spending less than any of the other European States considered here on LTC, just 0.7 per cent of GDP (Figure 3-1). About half of this expenditure was allocated to costs of institutional care, about one fifth to homecare and about one seventh to cash benefits. Given this low level of expenditure

267. da Roit et al. 2013.
268. Serrano et al. 2014.
269. Simonazzi and Deriu 2013.
270. da Roit et al. 2013: 162.
271. EC 2013: 128.
272. Flaquer et al. 2014.
273. Gutiérrez et al. 2010; Gallego 2014.
274. For details, see EC 2013.
275. Gallego 2014.

by EU standards, it is perhaps not surprising that considerable unmet need was also identified in a recent assessment.[276] In 2007, it was expected that the new LTC system would stimulate many new jobs in social care – some 300,000, according to one report[277] – but far fewer in fact emerged, a consequence of the financial pressure on Spain in the years after 2008 and perhaps too of the considerably greater uptake of the cash benefit for family care[278] than had been anticipated.[279]

By 2009, around 10 per cent of the population aged 65+ received a home care service (in just over half of cases, a remote monitoring service rather than home care visit) and about 4 per cent were supported in a residential care home.[280] Almost half of Spaniards of this age (47 per cent) were enrolled in senior citizen clubs and just under 1 per cent attended day-care centres for dependent persons.[281] In 2010, there were 29.4 LTC beds in hospitals per 100,000 inhabitants, slightly over the EU-27 average (26.5).

Later data (for 2013) suggest rather rapid change in the support provided to elderly people in Spain, with over 403,000 people (55 per cent of all dependants) receiving the cash benefit for home care, 17.5 per cent residential care, 16 per cent help at home, 16 per cent a remote monitoring service and 9 per cent care in day/night centres.[282]

Spaniards are more likely than the other Europeans considered here to think it best for an elderly person needing care to move in with one of their children (39 per cent), and a further 19 per cent think children should visit their parents to provide such support. They are the least likely to think the appropriate response is for private or public service providers to attend their parent at home (15 per cent), although 12 per cent think residential care the best response. Most (83 per cent) do not expect to pay for their parents' care and a large majority (91 per cent) – albeit a slightly smaller percentage than in the four other European countries – think they should not have to quit work to care for them.[283]

Between 1993 and 2008 (before the impact of the 2006 legislation on LTC and the global financial crisis), employment across all care occupations in Spain more than doubled, increasing from 966,000 to 2,155,000 workers – growth that far exceeded the more modest uplift seen in Germany. This was a period of rapid socio-economic and political change in Spain in which female employment rates rose fast (Table 1-1). National figures show the number of LTC workers (a more specific group than the generic 'care workers') grew from 146,000 to 186,000 from 1999 to 2005;[284] growth in 'personal care and related' workers was on a particularly sharp upward trajectory that peaked in 2007. These occupations, already strongly feminized in the early 1990s, saw an increasing concentration of women workers in the period to 2008, when 90 per cent of 'personal care and related' workers and 94 per cent of 'domestic and related helpers, cleaners and launderers' were female. Across all care occupations, the percentage of women workers increased from 87 per cent to 92 per cent between 1993 and 2008,[285] a period that also saw a modest increase in the educational level of these workers.[286]

Spain experienced an unprecedented increase in immigration in the early 2000s, with remarkably high net inflow rates in care occupations and the total

276. EC 2013.
277. Gutiérrez et al. 2010.
278. In 2011, this benefit was paid at between €180 and €520 per calendar month (pcm), according to the care recipient's level of need; carers paid this benefit were required to be registered and were obliged to make social security contributions (Gutiérrez et al. 2010).
279. Flaquer et al. 2014.
280. The average cost of home care was €12.71 per hour; remote assistance cost €21.16 pcm. The public price for a day-care centre for dependent persons was €656.11 pcm; a place in a nursing home cost €1,294.25 pcm (cited in Flaquer et al. 2014).
281. Flaquer et al. 2014, citing IMSERSO, 2009. *Las personas mayores en España* 2008. Accessed 7 Aug 2017. http://www.imserso.es/InterPresent2/groups/imserso/documents/binario/infppmm2008vol1.pdf
282. EC 2013.
283. EC undated b.
284. Geertz 2011: 6. Note that Geertz's analysis uses European Labour Force Survey data and 'national sources' (her sources for Spain are listed as *"LTC workers: Miguélez et al. (2006), care workers: Encuesta de población activa (EPA), Instituto Nacional de Estadística, calculation FEDEA"*). These data are thus likely to exclude most informally employed domestic care workers.
285. Geertz 2011: 12.
286. Ibid.: 14.

number of jobs in these increasing by 46 per cent, or about 600,000 jobs,[287] a development interrupted after 2008 by the severe consequences of the global financial crisis on the economy. The 2000s saw marked growth in the use of privately funded migrant labour to meet the care needs of elderly people living in affluent private households. This reflected the very large increase (from 2.3 per cent to 28.9 per cent between 1998 and 2008) in the share of all care workers who had foreign nationality.

Immigrant women working in care came mainly from Latin America (most were Spanish speakers) and became particularly prominent as home help assistants.[288] This type of work, historically undertaken without contract and based on personal arrangements, has since begun to be regularized and in some cases undertaken through care sector companies, albeit still often with minimal training opportunities, low wages and poor working conditions.[289] Most of these workers have come from Colombia, the Dominican Republic, Ecuador and Peru, although latterly new arrivals have been from Argentina and Bolivia, as well as from other parts of Europe – including Bulgaria, Poland, Romania and Ukraine – and from the Philippines.[290]

287. Geertz 2011: 20.

288. Miguelez et al. 2006: 26.
289. Geertz 2011: 16.
290. Luppi et al. 2015: 55.

4.

IMPACTS AND IMPLICATIONS OF CHANGING ELDERCARE ARRANGEMENTS AND POLICIES FOR WOMEN AND FAMILY

This section considers the implications of the evidence already presented about developments at the national level for the selected countries and areas in East Asia and Europe. We ask the following questions: Is eldercare being de/re-familialized (or not)? How and why is it being marketized? How do migrant care workers fit into this picture? Are the new forms of provision and developments in existing systems 'crowding-out' family care, or meeting new and expanding demand for eldercare? What steps are being taken to help families reconcile work and care? The section concludes with a broader consideration of how these factors influence or contribute to family and gender relations, gender equality, and to social and economic inequalities.

4.1 De/re-familialization of care

The above review of recent developments in eldercare policy in East Asia and Europe suggests that the relationship between these changes and shifts in values and expectations about family life and intergenerational responsibility is complex, with many countries experiencing processes that are (paradoxically, and perhaps unintentionally) simultaneously de-familializing and re-familializing in their impacts.

In East Asia, Japan and Korea are the two countries where a trend towards the de-familialization of eldercare is most evident, largely as a result of the development and implementation of these countries' LTCI schemes. Here, these new arrangements have facilitated the development of new service options designed to relieve families of some of the work and tasks of eldercare that, in previous generations, families (principally women) provided to their elderly members. These LTCI schemes have also been a policy response to the ageing of these societies and to changing expectations about women's participation in the labour force. In addition, the Japanese and

Korean Governments also see expansion of social care (through both universal childcare and LTCI) as a potential 'economic growth engine', creating service sector employment for women.[291] The introduction of LTCI, however, does not mean that Japanese and Korean families no longer provide care for their elderly members; they remain the main providers of eldercare but can now access LTCI-funded support to reduce the amount of care they would otherwise need to provide.

A Japanese survey of the eldercare situation shows that about half (51 per cent) of respondents find their care situation has improved since the introduction of LTCI, while 29 per cent saw no change or evident improvement in their situation.[292] LTCI has also helped influence people's ideas about family relations. For example, fewer younger people in Japan and Korea adhere to the idea of being the primary carer for their ageing parents, and fewer elderly people expect their children to look after them in old age. A 2012 Korean social survey found only a third of respondents (33 per cent) thought the family should be mainly responsible for the support and care of elderly family members, a major change from 1998, when 90 per cent thought this; instead, nearly half (49 per cent) thought 'the family, government and society' should all be responsible for the care of elderly people, a marked change from 2002, when only 18 per cent held this view.[293] As stated above, the proportion of people in Japan expecting to live with their children, or expecting to have their children take care of them in their old age, also declined dramatically between 1983 and 2008. In both countries the introduction of LTCI appears to have led to discernible ideational/cultural changes in people's thinking about eldercare, away from sole reliance on family support and towards partial de-familialization.

In China, Singapore and Taiwan Province of China, policy changes have had more mixed outcomes. Some policies – the Foreign Live-in Caregiver Programme and Long-Term Care Plan in Taiwan Province of China, tax concessions for hiring foreign domestic workers in Singapore, homecare services for elderly people living alone in Shanghai and the expansion of public/private eldercare institutions in China – can be seen as facilitating de-familialization. On the one hand, these programmes 'support' families by enabling them to 'outsource' or off-load part of their care 'responsibility' to paid non-family care workers; on the other, the same sets of policies – the Foreign Live-in Caregiver Programme and tax concessions for hiring foreign domestic workers – also have a re-familializing effect, as under these arrangements care responsibility (if not the work of care itself) is ultimately assigned to the family to be dealt with. In China and Singapore, however, legal mandates requiring children to take care of their ageing parents (whether they work in practice or not) make substantive de-familialization difficult, and other processes – the retrenchment of state welfare support and reinforcement of filial piety through re-culturation of Confucian ideas about familial care obligations (China) and tax allowances and credits for families co-residing with elderly parents (Singapore) – may be viewed as re-familializing processes.

Developments in Europe are equally complex, again shaped by the wider social changes seen in these societies: here too, population ageing and increased female labour force participation have been dominant influences affecting policy developments on care of the old. Some policy changes have also been responses to other factors. These include: the implications of smaller 'working age' populations for countries' established welfare, pensions and health and social care systems (whose projected costs have come under intense scrutiny); the expansion of the EU (with its commitment to free movement of labour) to include countries in Eastern Europe; the EU's adoption of a 'social agenda', particularly in the 2000s; and the global financial crisis of 2007–2008 that, particularly in countries within the Euro currency union (but also in the UK), led to severe austerity programmes, especially in Mediterranean countries, and large movements of labour.

Of the European countries reviewed in this paper, Finland alone had a really well-established, tax funded, universal scheme for the support of elderly people before the 1990s. This reflected Finnish culture and values, which historically have included an emphasis on gender equality (including in labour

291. Peng 2014.
292. Cabinet Office 2010.
293. Statistics Korea 2013; KWDI 2013.

force participation), respect for individual autonomy and a view of the state as the main guarantor of social protection in times of need. Some degree of re-familialization in the past two decades can be discerned here. It is evident, for example, in reduced access to publicly funded care services for older citizens with lower levels of need; in policy changes affecting family carers (previously 'invisible' in Finnish social policy); and in the policy shift away from institutional care towards supporting elderly people in their own homes and in special housing units within communities. De facto, families in Finland are finding they need to spend more time supporting their elderly members or arranging the help they need, although by recognizing carers in law, Finland has also (modestly) expanded the support and services they can access.

In France and Germany, where insurance-based systems have been introduced for LTC, the picture is more complex. These systems have stimulated the development of new household and care services that elderly people and their families can access (on a large scale), but nevertheless (as for example in Japan) remain highly dependent on the contribution family members make in arranging care, supporting elderly relatives and providing much of the help they need (in both systems, LTCI resources can be used to pay relatives to provide the care needed by elderly people living at home). As one review explains, for Germany, "within the framework of the LTCI, the mix of home-based and family care provision have been reorganized towards the familialization and marketization of care provision".[294]

In the UK, families are recognized as the 'bedrock' of the country's health and social care system, and monitoring of family/friend carers' numbers in the UK's Censuses (2001, 2011) showed growth, particularly among those caring intensively. While the NHS remains universal and free to access, this has never been true of its system of providing care for elderly people with care needs, where means-testing and service rationing (through manipulation of eligibility criteria at the local level) apply. Significant policy changes were introduced from 1990 onwards, including (in care of elderly people) an emphasis on 'personalized' support, leading to some service changes, a greater emphasis on home rather than residential care, increased use of monitoring and assistive technologies and the introduction of direct payments and personal budgets. The latter enable elderly people to buy their own support but often increase the family's role in arranging and overseeing care.

Spain is the country in this group with the heaviest reliance on family care in supporting elderly people. The country's rapid transformation after democratization in 1977, and particularly after joining the EU in 1986, involved increased female employment and the development of systems for care, welfare and social protection, bringing major changes in family life (itself also reshaped by a rapid decline in fertility rates and increased longevity). In the past, Spain had few service options for elderly people needing care as alternatives to family support, but in the 2000s it developed a policy debate about the need for support for elderly and disabled people, culminating in legislation in 2006 through which it aimed, over a 10-year period, to provide universal access to a comprehensive set of LTC services. This development leaves Spain, among the European States considered here, as the country with the greatest claim to a recent process of de-familialization.

Parallels can also perhaps be drawn between the Spanish situation and recent developments in Taiwan Province of China, also affected by recent democratization and care system development and extensive use of migrant care workers. Two points regarding Spain should be emphasized, however. First, the radical plan adopted in 2006 could not be implemented with the generosity of service provision intended given the economic crisis that followed the dramatic near-collapse of the world's banking and finance system in 2008. Second, while there are certainly new options – and additional services for elderly people – since the changes that were implemented, families continue to play a major role. Where 'in-home' care (often provided by migrant care workers) is used, families still play a key part in organizing and supervising their work (as is also the case in Taiwan Province of China); and the cash benefit option, intended for exceptional use to

294. Theobald et al. 2011: 140.

support the delivery of care by family members, has proved much more popular than anticipated. Here the state is expending resources on the care provided, but it continues to be family members who deliver this support.

Previous research using the welfare and care diamond framework[295] has shown significant institutional reconfigurations among the state, market, family and community/voluntary sector in relation to care since the 1990s.[296] In many countries, the expansion of the state's role in provisioning and coordinating care (both childcare and eldercare) has led to concomitant and yet diverse market reorganizations as families, private for- and not-for-profit and NGO/community service providers as well as other civil society actors contend for optimal care arrangements.[297] The above review of recent developments in East Asia and Europe shows an ongoing reconfiguration of welfare/care diamonds in both regions. While some common patterns are evident across the two regions – such as increased state engagement in care policies, increased use of the market as a channel for care delivery and increased use of foreign or domestic migrant workers in care services – considerable differences also exist between and within the two regions in relation to the content of eldercare policies, the modalities of care support and provision, and the extent and nature of de/re-familialization as these processes intersect with existing and changing cultures and institutions. Such manifold and dynamic processes also underscore the complex and non-linear forms of de/re-familialization processes and that there is still a long road ahead to gender equality.

4.2

How and why is eldercare being marketized?

Eldercare is increasingly being marketized in East Asia and in Europe. In East Asia, the processes involved include both the privatization of eldercare services previously provided publicly by the state (as in China) and substituting public care services with care allowances, tax credits and/or other forms of financial support (as in Singapore and Taiwan Province of China), leaving the individual or family members to source care from the market. In the current political and economic context, most governments consider marketization inevitable. Many East Asian countries are committed to controlling welfare spending – even as they are actively expanding the welfare state – and are attracted to marketization as an expedient and cheaper way of providing care and as a means of increasing individual choice. Even in Japan, where market regulation of social care is probably the strictest among the five East Asian case studies, there has been a gradual loosening of the state's regulatory control over social care since the 1990s as more private sector service providers have entered the care market.

Across East Asia, as elsewhere, there is a shared belief among policymakers and economists that the market is the most efficient and economical way of delivering eldercare, as market competition is seen as inevitably leading to lower prices. This belief is augmented by growing public expectations of social care but strong aversion to tax hikes in all these countries and areas, leaving policymakers with little option but market-based care provisions. A good example is Japan, where government attempts to raise consumption tax to help offset an ageing society and eldercare programmes were repeatedly met with political backlash.[298] With infrastructure for eldercare still underdeveloped, East Asian governments are also tempted to use the market to facilitate its expansion. For example, the Korean Government enlisted private market providers to provide eldercare under the LTCI

295. Jenson and Saint-Martin 2003; Razavi 2007.
296. See UNRISD undated.
297. See Razavi 2011.

298. The first attempt by the Japanese Government to introduce consumption tax in 1979 failed against a huge political backlash. The Government managed to introduce a 3 per cent consumption tax in 1989. The second attempt to raise consumption tax to 5 per cent in 1997 succeeded only because of the introduction of LTCI law that year, but the public then blamed this for causing the 2008 recession. Between 1997 and 2014 various governments and prime ministers raised the issue of consumption tax increases, only to be defeated by opposition before the bill reached parliament. Only in 2014 was the tax raised to 8 per cent. An attempted bill to raise consumption tax to 10 per cent in 2015 was postponed to 2017 and then again to 2019, as the Government feared a political backlash.

as it realized it was unable, by itself, to develop adequate eldercare infrastructure and services. Similarly the Chinese Government also felt compelled to rely on the market to provide eldercare.

In Europe, marketization is a feature of all the countries studied. Its characteristics are similar, although developments have occurred at a different pace and pattern in each case. In the Nordic countries, which include Finland where marketization has recently been comprehensively studied based on extensive evidence,[299] the process has involved four main developments: (i) importing market-like arrangements into publicly funded systems; (ii) using competitive tendering to commission services; (iii) developing consumer choice models and service vouchers; and (iv) offering tax rebates to those purchasing care or household services.[300] As reported in the preceding overviews of developments in each country, all five of the European States considered here have adopted some or all of these approaches.

The UK has introduced all but the last of these in a process that began with the 1990 *NHS and Community Care Act,* which legislated for a mixed economy of care, and has proceeded through various subsequent developments. These include the shift to care services being provided mainly by the private sector (rather than publicly employed staff); the introduction of local authority commissioning arrangements that use competitive tendering to let contracts for residential and home care; and the introduction of 'cash for care' options, including direct payments and personal budgets, enabling elderly people to purchase the services and support they require directly from the market and to employ their own care workers. Recently, the *Care Act 2014* has introduced new statutory obligations on 'market shaping and commissioning' for English local authorities.

Germany's system of support for elderly people, including its LTCI scheme, has adopted most of these four features too: the LTCI scheme has played a key role in developing a market in care services there; the cash options the LTCI offers provide for user and consumer choice; and most care services are now delivered by private sector workers. In France, tax incentives have been used extensively and deliberately as a way of increasing employment in households, with care of elderly people a key target in this. There is widespread use of service vouchers, and most employment of those who work in care has been transferred to, or has developed in, the private sector. In Spain, cash benefits are also an important feature of the reformed scheme, both for the purchase of market services and (where appropriate) to employ a personal care assistant. Most employees in Spain's LTC services work for independent or private providers or on their own account, and the widespread use of migrant care workers there (mainly in care provided to elderly people at home) has developed entirely within private (and in some cases unregulated) arrangements.

There is considerable diversity across these cases in both regions in how governments are seeking to regulate and standardize the care services increasingly provided by for-profit and not-for-profit providers, and systems using tax breaks to incentivize private LTC purchase arrangements tend to benefit only the more affluent. For-profit providers in some countries (e.g., the UK) are now targeting users able to pay higher prices (some thereby subsidizing publicly funded clients). This review has confirmed that marketization and privatization have evident and continuing appeal for governments for a number of reasons. First, they highlight choice for service users and competitive pricing. Second, they minimize the use of state employees, who are increasingly seen to be expensive and inflexible. Some governments have also been attracted by the scope in eldercare policy to create additional jobs in 'household services', with France "a pioneer in terms of developing tax schemes to promote" these, albeit such schemes have subsequently been assessed as having high public cost "compared to their job creation efficiency".[301] Third, marketization and privatization are also seen as effective and efficient ways of achieving rapid service expansion without incurring a huge public expenditure, particularly if the existing institutional and

299. Meagher and Szebehely 2013.
300. Szebehely and Meagher 2013.
301. Morel and Carbonnier 2015: 29.

service infrastructures are inadequate, as in the cases of China and Korea. However, other detailed studies suggest their consequences include significant risks both to service quality and to working conditions in the care sector.[302]

4.3

How do migrant care workers fit into this picture?

Migrant care workers are increasingly drawn into eldercare as the demand for care continues to outstrip the supply of care workers. This underscores the low valuation of care work, a seemingly universal feature, since low pay, inferior working conditions and problems with recruitment and retention of staff are reported in all case studies in both East Asia and Europe. As most native-born women, if they have other options, prefer not to do this type of work, migrant workers have become a convenient substitute. Most are willing to, or find they must, accept the poor pay and low status of eldercare work, partly because of global and regional economic inequalities (resulting in wage differentials between sending and receiving countries), partly due to lack of choice and partly swayed by active recruitment by public and private recruitment agencies.[303] Some (especially those migrating between European countries) may see this work as temporary and an opportunity to acquire valued language skills and/or benefit from the higher pay (relative to wage rates at home) that they can command by working in a more affluent country.

As shown in the country overviews, migrant workers and workers with foreign nationality have become available for care work in the East Asian and European case studies through a variety of entry routes. These include family reunion, free movement of labour (throughout the EU), special employment visas based on co-ethnic status (Japan and Korea), bilateral trade agreements (Japan) and, in some cases (Finland and Germany), rights of access based on historic ethnic ties. Many are primarily economic migrants, and some can legally work in the receiving country because care work is treated there as a shortage occupation, with entry possible via favoured labour immigration routes (or because of other skills they possess). Invariably, despite the huge demand for their caring labour, international migrant care workers are not viewed by governments as 'desirable immigrants' (in the way highly skilled workers are, for example) and as such their immigration status often remains temporary, with few granted citizenship regardless of the length of their employment. The implications for care work of the UK's expected departure from the EU in 2019 remain unclear, but its growing reliance on the labour of workers from other EU States in recent years will leave the care sector vulnerable to major labour shortages unless special measures are introduced to secure their jobs if (as now seems likely) free movement of labour from other EU countries comes to a negotiated end.

While migrant care workers are being increasingly used in all the countries and areas studied, they work in different types of care employment and have entered the host country in different ways. For example, most migrant care workers in Spain work in private households, whereas migrants in the UK frequently find employment in the residential care sector. In Europe, the main sending countries include the poorer EU States, countries in the former Soviet bloc and countries with historic ties and other links (including in some cases a colonial past) with the receiving country. Thus many migrant care workers, or those with foreign nationality, in France come from North Africa and in Spain from Latin America. In Korea, Chinese Koreans (*Joseonjok*) are granted special H2 visas that allow them multiple entry, longer-term stays and easier and increased access to work in the country. A large number of older *Joseonjok* women work in the eldercare sector as nursing assistants or personal attendants for frail elderly people outside of the LTCI system. Latin Americans of Japanese origin (mostly Japanese Brazilians and Peruvians) are also granted special visas allowing them longer-term

302. Comparative international assessment of the effectiveness of regulation of service quality was beyond the scope of this paper, although where possible this has been commented on in the case study summaries in section 1. See also, for Europe, Angermann and Eichhorst 2012; Genet et al. 2012; Feng et al. 2011; Feng et al. 2012.
303. Lindquist 2010; Groutsis 2009.

stays and access to employment. However, unlike Korea, very few of these Japanese Latin Americans are employed in the eldercare sector, partly because of the institutional entry barriers to the care labour market and partly because of evident racial/ethnic and linguistic differences between them and the native-born population, as compared to *Joseonjok* in Korea. Currently small in number, but more conspicuous, are the Filipina, Indonesian and Vietnamese EPA nurses and care workers in Japan. In all cases these foreign care workers work in institutions as a part of the LTCI rather than in private homes. In Singapore and Taiwan Province of China, most of the foreign care workers come from neighbouring Southeast Asian countries, particularly Indonesia, the Philippines and Viet Nam, and almost all are employed privately by families as live-in caregivers or live-in domestic workers in private households.

Although it is beyond the remit of this paper to fully discuss, it is nevertheless important to note that the working conditions of migrant care workers in all cases, in both East Asia and Europe, are dire. There is now ample evidence showing that they are paid low wages, that their jobs are typically insecure and come with little or no social protection, and that these workers also often experience a wide range of physical and/or psychological abuses at their workplace. This is particularly the case for those in live-in and home-based care situations, where the invisibility and isolated and confined nature of these jobs makes them highly susceptible to employer abuses on the one hand and difficult for the authorities to regulate, inspect and intervene to prevent such abuses on the other.[304]

These factors highlight class and race/ethnicity inequalities, including those between women, as well as continuing patterns of global inequality, whereby the global North continues to extract care resources from the global South.

304. Ylitalo 2007; Pan and Yang 2012; Yeoh and Huang 2009; Luppi et al. 2015; Parrenas 2017.

4.4

‘Crowding-out’ family care – or meeting new and expanding demand?

As already seen in the discussion of de/re-familialization, the various new and developing forms of eldercare provision are far from ‘crowding-out’ family care. Indeed in most countries, despite notable expansion of private care markets and significant growth in the number of workers employed in care occupations, families continue to be an important, often the main and sometimes the only provider of care. This can be attributed largely to the increase in the absolute demand for eldercare resulting from population ageing and increased life expectancy, while at the same time, intergenerational care support is being challenged by shrinking family size, increased distanciation between generations, changes in social and cultural expectations about familial care and, on the part of governments, less fiscal space to meet growing demands for care.

In European States, the rationing of publicly funded services in eldercare has led to concentrations of this type of support on the very old and on those with the most complex needs. Especially in institutional care (care homes and nursing homes for the old), residents are increasingly likely to be over age 85, extremely physically frail, with limited mobility and cognitive impairments and other problems, such as incontinence, that are difficult for families or home care services to manage. Families, however, are increasingly taking on the lower level needs of the less needy old who remain in their own homes, typically living as an elderly couple or alone in widowhood. This is partly because the number of elderly people is rising while the number of people of working age is contracting, and also because more people need support. In East Asia, even with the expansion of publicly funded services, supply cannot keep up with demand because of the huge and rapid increase in the number of elderly people, particularly the very old. In countries such as China and Korea that hitherto had been demographically ‘young’ but are now experiencing rapid population ageing, the supply problem is further

compounded by the lack of pre-existing eldercare institutions and service capacity. Hence, the family continues to be the main provider of eldercare.

Where family members live nearby, evidence suggests they provide a range of supports covering practical aspects of daily life. However, elderly people are less likely than in previous generations to have family members living with them or within easy daily travelling distance, a trend evident throughout European and East Asian societies. This suggests that family care is not so much being 'crowded out' as 'reorganized'. Constant care (living with a frail elderly relative) is often impractical (even if either party desires it) as most families no longer have one adult member entirely inactive in the formal labour market, and sacrificing a job and salary when eldercare needs arise can put household financial survival at risk. Frequent care (for example, visiting daily to provide assistance with practical tasks) can be managed only if travel distances between the homes of elderly people and their children are short, an arrangement still used in many European and East Asian families where feasible, but increasingly difficult with dispersed family networks, whether between rural and urban districts or living in different cities or even countries. This suggests that a new role for families may be emerging, as the planners, coordinators and monitors/supervisors of the care of their frail elderly members rather than as its direct, daily providers. This implies an ongoing need for care services and for new supports for family members when enacting these roles, including flexibilities at work and good systems of communication across the networks of support increasingly needed by elderly and disabled people with care needs who are living in their own homes.

4.5

How do these influence or contribute to family and gender relations and social and economic inequalities?

The review of eldercare policies and changing sociocultural contexts in the 10 East Asian and European case studies reveals two glaring facts. First, despite the reorganization of care, the family continues to play a central role in providing this. In all the countries and areas examined, the family continues to 'supply' as well as to manage much of care, albeit increasingly with supplementary help from public and/or private care services, often undertaken by female migrant care workers. Also, and despite its diversification and distanciation, the family remains an important base for eldercare as the increased emphasis on and expansion of home-based care has, if anything, further embedded the family and the home as the main site of care. The 'outsourcing' of care therefore does not mean that care has left home or the family; rather, it is about partial transfer of the direct labour of care from family members to people other than the family. More fundamentally, this also reflects an enduring sociocultural ideal and shared norm about the importance of the family in providing care to its elderly members, and the desire of the elderly, at least in some cases, to receive care from their families. Put another way, regardless of changes in policies and cultural norms or of economic and functional constraints, because care is fundamentally an intimate and deeply personal act – and often an act motivated by and associated with love and affection – most people still share a common desire to care and to be cared for by their families to some extent. For this reason it would be extremely difficult, and perhaps undesirable, to completely eliminate familial care. Thus, any future eldercare policies would have to take into consideration the significant contributions made by family caregivers in providing unpaid care work.

Second, despite its reorganization, care remains stubbornly and pervasively gendered work, with women undertaking much paid and unpaid care labour at home, in the community and in the labour market. Although in both Europe and East Asia more men are now caring for their wives and elderly relatives than before, the vast majority of family caregivers and paid care workers are still women.[305] For example, although men now make up about 23 per cent of workers in the LTCI sector in Japan, 89 per cent of home care workers and home helpers within LTCI are women.[306] A similar

305. UN Women 2016; World Bank 2012.
306. MOHLW 2014.

pattern is also evident in other countries in East Asia and Europe, as discussed earlier. Time-use surveys also show that in all 10 case studies women spend far more time daily than men on unpaid work, ranging from 1.5 times more in Finland (232.0 minutes per day for women versus 159.0 minutes for men) to over 4.6 times more in Korea (227.3 for women and 45.0 for men), most of the unpaid work being care and domestic work.[307]

What does this evidence reveal about family and gender relations and social and economic inequalities? First, it shows that despite notable socio-economic and cultural changes, such as women's increased education and labour market participation, increased acceptance of diverse household structures, greater shared aspirations about gender equality and more women-friendly social policies, little substantive change has happened in some key aspects of family and gender relations. The family continues to be the bedrock of care, and women and men continue to perform traditional gender-assigned roles, particularly in relation to care. Second, the lack of substantive changes in family and gender relations means that many of the traditional forms of gender inequalities remain unresolved. Having to spend a disproportionate amount of time and energy in care and domestic work means that women are less able to participate in the labour market, gain secure and standard employment and earn wages comparable with men's. Moreover, these disadvantages, combined with persistent societal level gender stereotyping and discrimination based on ideas about women's work and men's work, further devalue the work of care and entrap women in the low-wage, low-status, insecure and precarious employment sector. Much more effort needs to be put into changing societal and cultural ideas and arrangements about the gender division of labour, particularly in relation to care, and to re-appraise the value of care work.

Finally, the work of care today makes explicit the intersection of different forms of socio-economic inequalities. There is a class dimension to this also. As they have developed, some systems are creating options that enable the affluent to make different (and presumably superior) arrangements for their own or their parents' care in old age. Germany, for example, allows higher paid workers to choose their own private LTC insurance; systems using co-payments create opportunities for subsidized, higher cost support (for example, in France, Spain and the UK); and schemes enabling families to recruit foreign, live-in care workers (as in Singapore and Taiwan Province of China) work best for those with spacious homes and private means. These forms of inequalities not only highlight the socio-economic class differences in access to and quality of care but also underscore the 'within-group' inequalities between wealthier women, who can purchase care services to supplement or substitute their family care responsibilities, and poorer women who provide care services to support their own and their families' livelihoods.

As demand for care in richer cities/regions and countries draws more women from poorer locales and countries, a significant realignment of inequalities is also taking place along racial/ethnic and class lines as well as between women and men and among women themselves. In all 10 case studies in this report – including Japan, where the use of foreign migrant care workers is strongly resisted – there are signs of increased use of migrant care workers and of increasing absorption of migrant women, often racial and ethnic minorities, into care and service sector employment as low-wage and flexible substitutes. This realignment of socio-economic inequalities brings into focus not only the growing interdependencies between rural and urban regions (and globally) but also the importance of between-group and within-group differences and the diverse and complex ways in which people's lives are connected to each other through care.

307. OECD undated.

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