

Box 6.2 Primary health care models in the USA

In the USA, the 'patient-centred medical home' model, in which a patient can receive targeted, accessible, continuous, coordinated and family-centred care by a personal physician, has gained interest as a means of strengthening primary care. Another movement generating considerable momentum among both public and private payers is the creation of 'accountable care organizations' (ACOs), which are networks of providers, including hospitals and physicians, that agree to take responsibility for providing a defined population with care that meets quality targets. In exchange, they share in the savings that constitute the difference between actual and forecasted health care spending for their population (Thomson et al., 2013). Despite this, a recent evaluation found, that 'for at least one type of primary care provider - the RHC - there are substantial costs associated with ACO participation during the first two years' (Hofler and Ortiz, 2016; 1).

Table 6.3 summarizes the policies of integration and coordination in comparative perspective, using the matrix introduced in the previous section (Table 6.2). Interestingly, integration within the medical model is the dominant pattern in many countries, but importantly, differences exist in terms of the substance of the PHC model and the extent to which PHC connects with other models. The substance of the model varies among multi-professional teams in Sweden, multi-professional provider choice in the USA, GP-led PHC in the UK, New Zealand and Australia, ambulatory care with multi-professional teams in the Netherlands, specialists in addition to generalists in Germany, and more classic medical provider models of GPs in Taiwan, Singapore and Japan.

Table 6.3 Comparing integration and coordination in primary health care in selected high-income countries

	<i>Model of integration</i>	<i>Level of integration</i>
<i>Australia</i>	Integration in a GP-led ® model of PHC with strong organizational change and multidisciplinary teams; Integration of professional groups with new roles of nurses	Some integration and improved coordination across providers and sectors, inclusion of preventive services and public health; * High variety and lack of comprehensive coordination

(Continued)

	<i>Model of integration</i>	<i>Level of integration</i>
<i>England./UK*</i>	• Integration within medical model predominant with focus on GP-led PHO; • Some integration across professional groups with a focus on nurses and new roles	• Integration across PHC organizations by merging CP practices into PHC trusts; ® Some integration across health care and policy sectors, as primary care trusts have commissioning responsibility for public health and collaboration with social care
<i>Germany</i>	• Integration within medical model with focus on medial leadership and organizational restructuring; • Limited integration across professional groups, especially for nurses, but few regional pilots aim at shifting tasks from doctors to medical assistants	® Integration across PHC organizations to better connect generalist and specialist doctors; • Some integration and improved coordination but fragmentation of care sectors and weak public health; • Fragmented coordination with different social insurance schemes
<i>Japan</i>	• Some integration within a medical model with some organizational integration with hospitals; • Lack of professional integration	• Integration between medical providers to connect specialized PHC and hospital physicians; • Lack of coordination between sectors and policy fields
<i>Netherlands</i>	• Integration within a medical model with strong organizational change and multidisciplinary teams; ® Integration across professions with new roles of nurses	• Integration and coordination across sectors with strong public health and patient involvement; • Little coordination of policy and fragmented leadership
<i>New Zealand</i>	• Integration in a multi-professional provider model with strong organizational change and large centres; • Integration across professions with new roles of nurses	* Some integration across providers and sectors; • Little coordinated leadership

<i>Singapore</i>	• Some integration within a medical model with little organizational change; • Lack of professional integration	• Lack of provider integration but strong integration of public health; • Some integration across sectors but lack of public integration with hierarchical leadership
<i>Sweden</i>	• Multi-professional teams with strong public responsibility and some organizational change; • Integration of professional groups with strong role of nurses	® Integration and coordination between organizations, sectors and policy fields through local authorities; ® Coordination of leadership with some variety through privatization
<i>Taiwan</i>	• Integration within medical model strongly based on family doctors; • Lack of integration of professional groups, but some integration of TCM providers	• Some integration between medical providers but lack of integration between sectors and policy areas, and of preventive services; • Lack of coordination of leadership
<i>USA</i>	• Multi-professional provider model, although GP leadership is strong, and improved organizational integration; • Integration across profession with new roles of nurses	• Little integration between medical providers, sectors and policy areas; ® No coordinated leadership

■Asa result of devolution, variety is increasing within the UK; more recent information refers to developments in England.

There are also important differences in relation to the level of integration, ranging from strong integration and coordination between sectors and policy fields with coordinated leadership in Sweden towards little integration of public health and lack of comprehensive coordination and leadership in Japan, Singapore and Taiwan. Most of the countries in our sample are clustered between these two poles, however. Across countries, the focus lies on the integration among primary health care organizations, but variations exist relative both to the concrete organizational forms and the extent to which there are additional levels of integration and improved coordination between sectors and policy fields. Most striking is an overall lack of leadership and coordination mechanisms in most countries.

Interestingly, in low-income countries PHC plays a more prominent role as a 'hub of coordination' (WHO, 2008d: 55) and shared decision making than in many high-income countries, while at the same time there is a stronger local and community-based focus in relation to both policy making and the organizational settings (Box 6.3). For instance, developments in a district in Congo over the last 30 years illustrate the robustness of a PHC-led organizational model even under conditions of a sharp economic decline, inter-ethnic strife, a massive influx of refugees and two successive wars (WHO, 2008d). PHC services continued to expand with growing numbers of centres and improved quality of services. 'The continuity of the work under extremely difficult circumstances can be explained by team work and collegial decision-making, unrelenting efforts to build up and maintain a critical mass of dedicated human resources' and effective use of local capacity (WHO, 2008d: 31).

Looking at middle-income countries, a particularly interesting case is the development in Russia and the former Soviet Union countries, where PHC meets with a mix of new market politics and established public health care provision stemming from the Communist area. Here, integration of PHC emerged within a medical model with elements of general practice added onto an existing system of polyclinics. Rechel (2015: 244) argued that the Soviet model of administration, under which PHC was managed by the central district hospital, has persisted in countries like Azerbaijan, Kyrgyzstan, Tajikistan and Uzbekistan, but also in rural areas of Russia and Ukraine. As a consequence, evaluation of pilots found that PHC enjoys overall low priority, implementation is scattered and is narrowly defined by GP services (Kringos *et al.*, 2009). Only few

Box 6.3 Primary health care as robust model and hub of coordination in low-income countries

Primary-care teams cannot ensure comprehensive responsibility for their population without support from specialized services, organizations and institutions that are based outside the community served. In resource-constrained circumstances,... the classic image of a healthcare system based on PHC is that of a pyramid with the district hospital at the top and a set of (public) health centres that refer to the higher authority. ... The coordination (or gatekeeping) role this entails effectively transforms the primary-care pyramid into a network, where the relations between the primary-care team and the other institutions and services are no longer based only on top-down hierarchy and bottom-up referral, but on cooperation and coordination....The primary-care team then becomes the mediator between the community and the other levels of the health system. (WHO, 2008d: 55-6)

comprehensive PHC models exist, and Moldova is one of the pioneering cases: in rural areas PHC is built on a family physician model and in urban areas on health centres (Rechel, 2015).

In China, another example of a BRICS country (as Brazil, Russia, India, China and South Africa, all ‘emerging’, are called) shaped by communist politics, PHC has become an important hub for system innovation (Mossialos *et al.*, 2016: 33) and integrated PHC approaches have been established, including a wide range of providers. The health reforms in 2009 mentioned PHC as one of five pillars of reform. Lin and Zhao describe the model of PHC as ‘establishing a comprehensive network of basic health services through a three-tier rural network and urban community health services, with Chinese medicine integrated into these service delivery networks’ (2015: 141). Hu *et al.* (2016) argue that people prefer hospital settings rather than PHC, because they perceive higher quality in hospitals. Patients in rural settings are encouraged to use village clinics, but they are also entitled to use upper-level GP services in hospitals (Mossialos *et al.*, 2016: 33). In China, the major constraints of PHC development are severe shortage of doctors and other higher-qualified health professionals. Under these conditions, most PHC services are provided in rural areas by low-qualified village doctors (not-licensed GPs) and community health workers, while GPs usually work in urban areas (Mossialos *et al.*, 2016:33). Therefore, the boundaries among professions are more flexible and service provision is strongly linked to the community level.

Another example of PHC serving as ‘coordinator’ of an integrated service network and ‘promoter’ of inter-sectoral coordination are developments in South America (Giovanella and Faria, 2015: 216). Here, the model of PHC is described as more integrated in relation to the professional groups and local stakeholders and comprises a wide range of attempts to improve coordination across sectors. In their report on health systems in South America, Giovanella and Faria (2015) place the development of participatory decision making in PHC in the wider context of emergent new democratic institutions in the region.

In summary, the development of PHC in middle- and low-income countries shows similarities with the range of models found in high-income countries - from GP-led services to multi-professional teams and non-medical providers. Yet the PHC models seem to be more polarized in middle- and low-income countries, while high-income countries cluster in the middle with various forms of mixed models and levels of integration and coordination.

Long-term care

In most OECD countries, LTC services have rapidly expanded and moved up on the policy agenda, but unlike PHC no uniform reform model and coherent strategic response exists. Moreover, the policies and services

are highly diverse, with much the same applying to the demand for LTC and the needs of the user groups. The OECD defines LTC as ‘a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended time on help with basic activities of daily living (ADL)’ (OECD 2011: 1). Characteristically, a personal component of care is frequently provided in combination with basic medical services and can be combined with ‘lower-level care related to help with instrumental activities of daily life (IADL)’, such as housework and transportation (OECD, 2011: 1).

User groups reflect the support required at different stages of the lifespan, ranging from severely ill infants to adults at the end of life. Other beneficiaries include people with mental illness and disability, physical disability, drug-related disorders, and progressive illness. Care is also located in different settings, such as residential care and nursing homes, day hospitals and sheltered housing, as well as people’s own homes. The professionals involved include nurses, community nurses, mental health nurses, care assistants, home helps, counsellors, physiotherapists and other therapists. Moreover, funding schemes range from inclusion in tax-based systems to the development of new statutory insurance-based models and subsidiarity of family care and self-payments (Carrera *et al.*, 2013; Campbell *et al.*, 2016; Fernandez and Nadash, 2016; Mossialos *et al.*, 2016).

The diversity of care in the LTC sector reflects the varied yet interlocking needs of people who require long-term care (Rummary and Fine, 2012). At the same time, care services are often locally specific and even tailored to individuals, so it is difficult to identify the typical, let alone generalize (Burau and Kroger, 2004). Although care services outside hospitals are central to the health of individuals, they can be remote from the health system.

We focus here on care for older people who represent the largest user group of LTC and, in the face of ageing societies, have attracted considerable attention in health policy terms (Olivares-Tirado *et al.*, 2011; Pavolini and Theobald, 2015; Gori *et al.*, 2016). We refer to home care as an umbrella term for a wide range of services provided to elder people regardless of location, thus including various forms of resident care as well as care in one’s own home. Although home care is related to health systems, it traverses the boundaries between health and social care, and between formal and informal care. It primarily involves nurses rather than doctors and, most importantly, principally women as informal care-givers.

LTC policies are pushed by demography and costs, but are shaped by country-specific factors. Key factors include how the funding and provision of health care is organized, where health systems draw the boundary between health and social care, and cultural assumptions about the

appropriate relations among the generations and between women and men, what Pfau-Effinger (2004) calls ‘gender cultures’. LTC (as well as public health discussed in Chapter 7) also demonstrates that many services now central to health are at the margins of health systems and, unlike other areas of health care, the medical profession is less directly involved.

Compared to other sectors of the health system, international statistics on LTC are meagre and often non-existent. Our comparative analysis looks at trends in institutionally based care, for which more adequate statistics are available. While information is improving for OECD countries (OECD, 2011; Ranci and Pavolini, 2013; Pavolini and Theobald, 2015; Campbell *et al.*, 2016), there is a lack of standardized definitions of ‘disability’ and ‘need’ for care (Wittenberg, 2016: 15), which limits the opportunities for comparison. Furthermore, with few exceptions, middle- and low-income countries largely remain a black box regarding LTC policies.

Expenditure for LTC services is a relatively robust indicator for comparison and an indication of different policy models and priorities, while ‘life expectancy’ can reveal differences in demand. Table 6.4 provides a first comparative overview of LTC (including recipients in institutions and at home) expenditures as share of GDP and of total health care expenditure, differentiated for funding schemes and provider groups. The comparison reveals enormous differences in LTC expenditure, which cannot be explained by life expectancy. Sweden and the Netherlands spend more than one-quarter of their health care expenditure on LTC, while in Germany, Japan and the UK the share is in a range of 14 to 18 per cent. In the USA and Australia only 2 to 5 per cent is allocated to LTC! There are also important differences in relation to the share of public and private funding and of residential homes, ambulatory and hospital-based LTC providers, which cannot easily be explained by health system typologies.

The percentage of LTC recipients 65 years and over in relation to the total population in Table 6.5 offers a further indication of the relative size of home care services and reveals a relatively low proportion of institutional care in relation to care provided at home, which is, except in Australia, more than double.

When looking at the supply side of institutional care there is no uniform trend in the last two decades. As Table 6.6 reveals, Australia, Germany and Japan have increased the beds in residential LTC facilities over time, while other countries show little change. Sweden is the only country that faced a sharp decline, yet the share of LTC beds is still higher than in other countries. This suggests that institutionally based care continues to be important, despite relevant shifts in policy to encourage older people to live in the community. Similarly, Campbell *et al.*, in their comparative

Table 6.4 Life expectancy and estimated spending on long-term home care as a percentage of GDP and total health expenditure, 2014

Country	Life expectancy	% LTC expenditure as share of GDP	% LTC expenditure as share of total health expenditure					
	Men	Women	Total	Share per funding		Share per LTC provider		
				public	private	residential	ambulant	hospital
Australia	80.3	84.4	0.2	2.3	2.1	0.2	n/a	2.3
Germany	78.7	83.6	1.5	13.8	9.4	4.5	8.9	2.6
Japan	80.5	86.8	2.1	18.2	16.6	1.6	8.0	5.6
Netherlands	80.0	83.5	3.0	27.2	27.2	—	24.1	-
New Zealand	79.8	83.4	n/a	n/a	n/a	n/a	n/a	n/a
Sweden	80.4	84.2	2.9	26.2	24.2	2.0	18.5	7.7
UK	79.5	83.2	1.8	18.0	12.0	5.9	6.4	3.8
USA	76.4	81.2	0.9	5.4	3.2	2.2	5.4	n/a

Source: Data from OECD (2016a).
All financing schemes.

Table 6.5 LTC recipients aged 65 years and over in different LTC settings as a percentage of the total population, 2014

	<i>LTC recipients in institutions</i>	<i>LTC recipients at home</i>
Australia	6.4	8.1
Germany	4.1	8.9
Japan	2.8	n/a
Netherlands	5.3	13.1
New Zealand	4.8	12.2
Sweden	4.5	11.8
USA*	3.3	n/a

^a Data from 2011.

Source-. Data from OECD (2016a).

Table 6.6 Number of beds in residential LTC facilities per 1,000 population, 2000-14

	<i>2000</i>	<i>2005</i>	<i>2010</i>	<i>2014</i>
Australia	4.5	5.2	7.8	7.9
Germany	8.2 ^a	9.2	10.3 ^b	11.2 ^c
Japan	4.2	5.1	5.5	6.2
Netherlands	10.6	10.4	10.4	10.6 ^d
New Zealand	n/a	n/a	8.0	8.3
Singapore	2.1	2.3	n/a	n/a
Sweden	16.9	15.2	14.2	12.8
Taiwan	1.9	2.0	1.8	n/a
UK	n/a	9.0	8.4	8.5
US	5.4	5.3	5.4	5.1

^a data from 2001; ^b data from 2009; ^c data from 2013; ^d data from 2012.

Sources: Data from OECD (2016a); Singapore Ministry of Health (2008); Bureau of National Health Insurance (2012).

analysis, found that ‘high HCBS [home and community-based] spending does not necessarily go with low institutional spending - if anything, the opposite is true’ (2016: 60).

A more specific indication of shifts in supply is the number of LTC beds per 1,000 population aged 65 years. Table 6.7 shows a decrease in supply in most countries, especially large in Sweden. In contrast, Australia, and to a lesser extent Germany, increased facilities, while in Japan supply remained relatively stable.

Table 6.7 Number of beds in residential LTC facilities per 1,000 population aged 65 years and over, 2000-14

	2000	2005	2010	2014
Australia	36.2	40.4	57.6	53.5
Germany	49.2 ^a	49.3	50.5 ^b	53.1 ^c
Japan	24.2	26.4	24.1	24.9
Netherlands	78.4	74.5	67.8	65.5 ^d
New Zealand	n/a	n/a	61.9	57.5
Sweden	98.5	88.4	78.9	66.2
UK	n/a	56.4	51.6	48.7
USA	43.6	42.8	41.1	35.4
^a data from 2001 ^b data from 2009; data from 2013; ^d data from 2012.				

Source-. Data from OECD (2016a).

In terms of both funding and provision, home care is marginal in all countries, in some more so than in others, and trends in institutional supply of LTC are not uniform. The next section analyses in more detail the LTC policy models for home care.

Policy, funding and provision of home care

Home care is an important area of health policy but often not fully integrated in the institutional fabric of health systems, thus creating distinct features in the funding and provision of services. Funding is relevant in two respects - the security of funding and the relative level of public funding - which give an indication of the extent to which LTC, especially home care, is an integral part of a health system (Campbell *et al.*, 2016). Funding models range from taxes and social insurance contributions to out-of-pocket payments and private insurance. The first two bases of funding provide secure funding, whereas out-of-pocket payments are a much less reliable source. Home care funding is typically highly mixed because funding from public sources is often insufficient and a substantial amount of services are funded from private, out-of-pocket payments (Pavolini and Theobald, 2015). Diverse approaches to funding create different types of access. In countries with tax funding, patients tend to have direct access to services. In contrast, in countries with social insurance funding patients often need a medical referral to access services, since service is provided as an earned right rather than a need.

The provision of home care reflects the level and security of funding, but is influenced by other factors. This includes policies explicitly aimed at substituting together with cultural expectations about the role of the family in care-giving. Substitution policies refer to a set of policies that are intended to replace institutionally based care with care in the home and related settings. Subsidiarity assigns primary responsibility for welfare to the individual and to the family and resonates with a gender culture that builds on part-time caring by women and full-time paid employment by men. In terms of the provision of formal services, priority is given to non-governmental, non-profit organizations.

A bundle of diverse factors creates variety of home care funding and provision. Major characteristics of funding are summarized in Table 6.8, while Figure 6.1 provides a comparative picture of the predominant types of home care provision in our countries.

Table 6.8 Funding home health care"

<i>Predominantly tax-based funding</i>	<i>Predominantly social insurance contributions</i>	<i>Predominantly private funding</i>
• Australia • Britain/England • New Zealand • Sweden	• Germany • Netherlands • Taiwan (NHI)	• Singapore • USA
[*] Japan is difficult to categorize because home health care is funded equally by taxes and social insurance contributions.		

<i>Predominant Type of Provision</i>		
<i>Level of Provision</i>	<i>Public</i>	<i>Non-profit</i>
<i>High</i>	Sweden	Netherlands
<i>Low</i>	Britain	Australia, Germany, Japan, New Zealand, Singapore, Taiwan, USA

Figure 6.1 *The provision of home health care*

Only in Britain and Sweden are home care services provided publicly and firmly integrated into the health system. This situation is typical of national (centralized or community-based) health services, which are mainly tax funded and characterized by a high degree of public integration (see Chapter 3). This does not necessarily guarantee a high level of service provision, however, as the case of England demonstrates (Glendinning, 2013). Home nursing services are provided publicly with GP-led Primary Care Trusts responsible for organizing the provision of services. The Primary Care Trusts are intended to commission home help services which should help to better integrate the provision of home-based care services across the health and social care divide. However, the level of service provision is low, not least reflecting lower overall spending on health care in Britain/England compared to other countries (see Chapter 3), as well as the hollowing out of entitlements to tax-funded home care. Instead, home-based health care over the last decade has focused on acute care needs, while other care needs have been redefined as social care for which older people must pay depending on the local authority areas (Lewis, 2001). Family care is only partly shared with the state, and, consequently, the availability of social care service is uneven.

This contrasts with Sweden where services for older people with long-term care needs have long been well developed and social preferences for home care, together with the need for de-institutionalization, were recognized very early (see Gough, 1994; Trydegard, 2000; Ancell *et al.*, 2012). A crucial factor is that home care is embedded in a gender culture that combines ideas of universal access to services with ideas of individual independence from the family as a source of financial and care support. Recent financial constraints combined with an emerging ideology of 'welfare mix' have put a strain on the system (Burau *et al.*, 2007). Private providers have come to play a significant role in the delivery of home care; between 1993 and 2010 the number of publicly funded hours of home care delivered by private providers increased from 2 per cent to 19 per cent (Meagher and Szebehely, 2013). The overall commitment to tax funding, female employment and universalism remained unchanged, however (Theobald, 2003; Lyon and Gluckmann, 2008).

Other policy models in predominantly tax-funded systems illustrate that the development of home care services also can be impeded by strong liberal elements in the health and welfare system. For example, the Australian government and state/territory governments jointly fund the Aged Care Assessment Program (ACAP) to conduct client assessments in relation to five dimensions of need: physical, psychological, medical, cultural and social. The core objective is to comprehensively assess the care needs of frail older people and to assist them to gain access to the most appropriate types of care, including approval for government-subsidized residential and community care services. The legacy of strong

liberal elements remains present, even when there are moves towards greater public involvement as in New Zealand. Under the national 'Ageing in Place' programme in New Zealand, home care services progressively have been publicly subsidized (Miller *et al.*, 2008) and expenditure increased significantly. At the same time, eligibility and level of service are determined by needs assessment, although since 2005 asset testing has been gradually phased out (Miller *et al.*, 2008). This is typical of a care regime that combines very limited universality with means-testing and where privately paid and charitable services complement family care (Campbell *et al.*, 2016).

In the Netherlands, as in Sweden, home care traditionally has been viewed as an important part of welfare provision. It is covered by a separate type of health insurance that was introduced in the late 1960s and covers a range of exceptional medical risks (Knijn, 1998). The insurance is compulsory for all employees irrespective of income and is supplemented by central government funds and out-of-pocket payments. This represents a strong element of universalism in a health system with relevant elements of private insurance and provider organizations. A mixed provision of services, which is dominated by non-profit providers, coincides with a high overall level of service provision comparable to Sweden (Knijn, 1998). Interestingly, the Netherlands historically had a higher proportion of people living in institutions than any other European country and it was only in the 1980s that policies focused more explicitly on substitution (Loo *et al.*, 1999). Recent data indicate a marked shift from residential to non-residential care, which is likely to be reinforced in the future and forms one of the four pillars of the 2015 policy reform (Maarse and Jeurissen, 2016).

Public funding of home care has traditionally been less well established in social insurance systems, reflecting an implicit focus on the working population, together with a communitarian orientation that reveres self-help by individuals and communities (see Chapter 2). Here, the principle of subsidiarity underpinning German social policy is indicative. In Germany, LTC insurance was introduced in 1995 as a fifth pillar of the social welfare system with its own funding and governance procedures (Theobald and Ozanne, 2016). In Japan, in 2005 the government revised the Long-term Care Insurance Act to better promote the development of an integrated community care system and the establishment of community integrated support centres in all municipalities (Tamiya *et al.*, 2011).

Even under new insurance schemes, the legacy of subsidiarity can be influential. For instance, Japan imposes a 10 per cent co-payment for all services under LTC institutional provision and charges further costs based on income level (Campbell *et al.*, 2016). In Germany, high security of the new funding arrangement and comprehensive provision (including cash benefits that older people can use to pay informal care-givers)

contrasts with the limited levels of funding available. Thus, many older people must depend on out-of-pocket payments and/or unpaid care-givers (Theobald and Hampel, 2013; Theobald and Ozanne, 2016).

Other countries largely rely on private funding of home care. In Singapore, for instance, users are expected to pay for home care services out of their Medisave accounts or through the private or public insurance they can purchase with those accounts (Teo *et al.*, 2003). Health care services for the elderly in Singapore are mostly run by voluntary welfare organizations, although government financial assistance is available. All Singaporeans over 60 are entitled to a subsidy of 75 per cent of the fees charged at polyclinics (Mehta and Briscoe, 2004). Medisave has been expanded gradually to cover chronic conditions, and in 2014 further chronic diseases were added to the Community Health Assist Scheme (Mossialos *et al.*, 2016: 150).

Like Singapore, Taiwan customarily depended on informal, largely family, care-givers, but the rapid urbanization and changes in family structures have led to a decrease in the number of family members who can take responsibility for caring for their elders, thus requiring the hiring of carers or entering care facilities (Hsiao and Huang, 2012). In 2008, the government initiated a ten-year, long-term care plan to create a more integrated service delivery system and to lay a foundation for the establishment of a long-term care insurance programme (Nadash and Shih, 2012). Nevertheless, the family still plays a dominant role in home care in Taiwan (Wang, 2011).

As expected in a market-based health care system, in the USA public sources of funding are minimal, commonly means-tested and highly fragmented. In recent years, largely to reduce costs, Medicare has initiated programmes targeted at home care to encourage people to stay at home. All Medicaid beneficiaries are now eligible for home nursing care if they meet certain conditions. At the same time, 'with its severe means-testing the US leaves a substantial burden on individuals and families' (Campbell *et al.*, 2016: 61).

There seems to be growing awareness of the need to bring LTC policies to the agenda of middle- and low-income countries, as demographic changes are likely to increase future demand for such care (Rhee *et al.*, 2015; Ikegami, 2016). With few exceptions, however, there is no substantiation of a systematic response and data on home care especially remain extremely limited (Brodsky *et al.*, 2003; Muiser and Carrin, 2007). However, this is bound to change with the increased interest in the advantages of home care.

The comparative view shows that, notwithstanding the substantive differences and continued insecurity of funding and the limits on funding, some countries have witnessed the wholesale introduction of new schemes over the last two decades. In Germany and Japan this took the