Ageing & Society (2022), 1–24
doi:10.1017/S0144686X22001076

REVIEW ARTICLE

Cost-containment long-term care policies for older people across the Organisation for Economic Co-operation and Development (OECD): a scoping review

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(Accepted 2 August 2022)

Abstract

In most Organisation for Economic Co-operation and Development (OECD) countries, the government has to manage tension between growth in the need for long-term care (LTC) services for older people and significant public budget constraints. Not surprisingly, therefore, cost-containment policies are of increasing relevance. Nevertheless, despite the flourishing interest in the comparative literature in reforms and the sustainability of LTC policies, a scoping review of these measures has so far not been produced. This article aims to contribute to filling this gap. We present a typology of LTC cost-containment policies across the OECD. Cost-containment policies cluster in two areas according to their focus: demand-side policies, which reduce the actual chances of receiving LTC services and/or make them more expensive for users; and supply-side ones, which modify the provision of services. Furthermore, an indirect outcome of the review is that it allows an overview of potential negative implications of these policies. These negative implications can be grouped in two macro spheres relating to a worsening of the care arrangements for beneficiaries and to increased demand for individual/family resources, in both economic and time and effort terms. In the light of the expected profound impacts of the COVID-19 outbreak on all social security sectors in the medium and long term, this article provides a valuable tool for both academic and policy-making debate. It allows an analytical comprehension of cost-containment strategies adopted in LTC sectors linking them with the related impacts on beneficiaries and their families.

Keywords: long-term care; older people; cost-containment; cross-country comparison; Organisation for Economic Co-operation and Development (OECD); ageing; welfare retrenchment

Introduction

Ageing populations have forced national governments to control growing long-term care (LTC) public expenditure (Swartz, 2013). This has resulted in an increasing centrality of cost-containment policies, which are a significant element in all

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https://doi.org/10.1017/S0144686X22001076 Published online by Cambridge University Press

LTC systems across the Organisation for Economic Co-operation and Development (OECD), regardless of different national particularities.

The international literature has widely investigated LTC cost-containment policies, mainly focusing on reforms and their impact on the characteristics of LTC systems in financial, policy-making and operative terms (Deusdad *et al*., 2016; Gori 2019), or looking at the implications of these changes for users and care workers (Muir, 2017; Rodrigues *et al*., 2018; Luppi *et al*., 2018; OECD, 2020). In this literature, the cost-containment policies have rarely constituted the research object but instead have been outcomes of institutional strategies, intervening factors or the starting point for investigations of their various impacts. These studies have produced much knowledge about cost-containment implementation in the LTC sector (Tsutsui and Muramatsu, 2007; Glendinning and Moran, 2009; Schut and Van Den Berg, 2010; Jiménez-Martín and Prieto, 2012; Vabø, 2012; Zuchandke *et al*., 2012; Gori et al., 2015; Janssen *et al*., 2016; Szebehely and Meager, 2018). Nevertheless, to the best of our knowledge no study has produced a systematic review of LTC cost-containment policies. This article aims to fill this gap by adopting cost-containment policies in the LTC sector as its research object. By means of a scoping review, the work aims to define a conceptual model of cost-containment policies by providing an analytical synthesis of the core of cost-containment measures, grouping them at the analytical level at which they operate.

Cost-containment is a broad and potentially ambiguous concept. Following the OECD, a cost-containment policy is any policy that aims at lower public expenditure than an alternative arrangement (Joumard *et al*., 2010). The latter can be either an existing policy or a policy option. In fact, cost-containment can be the effect of modifying current arrangements to reduce directly the public expenditure needed to operate a policy, or the effect of choosing a policy option which results in a saving compared to a different one (Moreno-Serra, 2014). Therefore, governments have several cost-containment policy options at their disposal. These options vary greatly in the specific channels through which they are expected to influence LTC expenditure.

In the health-care sector, unlike the LTC sector, reviews and typologies of cost-containment policies constitute a consolidated research field (Abel-Smith and Mossialos, 1994; Wenzl *et al*., 2017; Blank *et al*., 2017; Stadhouders *et al*., 2019). A predominant orientation in these studies suggests grouping the alternatives mainly in two broad clusters (Oxley and MacFarlan, 1995; Joumard *et al*., 2010): (a) supply-side measures and (b) demand-side measures. Although the boundaries between these categories can be blurred (Moreno-Serra, 2014), basing the analysis on an initial categorisation of cost-containment policies according to who is primarily affected – providers or consumers – is a safe strategy. Following this consideration and adopting a deductive approach, the first level of categorisation/differentiation of LTC cost-containment policies is between ones which reduce public spending by affecting the older people requiring care (demand-side) and ones which change the supply of care (supply-side). Consequently, the clusters have different focuses: dependent older people and the LTC services provided.

This article, therefore, not only provides a review of research and delineation of LTC cost-containment mechanisms but it extends our knowledge by adopting an analytical strategy to categorise these mechanisms with the aim of providing a

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better understanding of the often highly inter-disciplinary and complex task of framing these policy measures.

The material collected in the scoping review also allows a further step: a preliminary overview of the potential negative implications of cost-containment policies for the beneficiaries and their families. The literature gathered provides an initial, but still reliable, basis for us to reason on the relation between cost-containment policies and their implications for beneficiaries. This reasoning is limited to negative implications since they constitute the more common ones reported in the literature. While the final aim of the article is to provide a useful tool to support further research by creating analytical categories and to inform policy makers by analytically summarising a plurality of evidence, reasoning on the relation between cost-containment policies and their implications for beneficiaries aims to stimulate a debate in the scientific and institutional communities.

Review methodology

A scoping review was chosen as the methodology as this approach is particularly suited to addressing broad topics rather than narrowly defined research questions (Arksey and O'Malley, 2005; Manthorpe *et al.*, 2010). In particular, following Arksey and O'Malley:

> a scoping review constitutes a useful methodology for mapping key concepts underpinning a research area and the main sources and types of evidence available … especially where an area is complex or has not been reviewed comprehensively before. (Arksey and O'Malley, 2005: 21)

Furthermore, among the reasons indicated by these authors for carrying out a scoping review, one perfectly suits our aim: to summarise and disseminate research findings, and in particular to provide a mechanism for summarising and disseminating research findings to policy makers, practitioners and users (Antman *et al.*, 1992). The review follows the principles outlined by Arksey and O'Malley (2005). The key stages – identifying research questions; identifying relevant papers; selecting papers using inclusion/exclusion criteria; recording and analysing the data; and reporting the results – are outlined below. The review process started in 2020, with searches being undertaken between October and December 2020 (studies that focus on cost-containment policies related to the impact of the COVID-19 pandemic were excluded due to the particular nature of these measures).

Identifying research questions

Two research questions shaped the review:

(1) Is it possible to organise types of cost-containment mechanisms according to similarity?
(2) What are the main features of each recognisable potential group/cluster?

Since the prevalent nature of the material collected is policy evaluation, another interesting theme emerged. Although the scoping review focused on

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cost-containment policies, it provided sufficient material to propose some preliminary reasoning on potential negative implications of these policies for the beneficiaries and their families.

Identifying relevant studies

The review included peer-reviewed and grey literature, including several policy reports and policy briefs. Literature was identified by means of systematic searches in several online databases;[1] hand searching key journals and websites; and searching the bibliographies of the articles found using the first two methods. For the systematic search, the following keywords were identified in various combinations using Boolean operators and glossary terms when appropriate:

- Sector: long-term care, social care, aged care.
- Action: reduce, control, contain, decrease.
- Object: expenditure, cost, financing.
- Actor: government, policy.

Inclusion and exclusion criteria

The review was concerned with the intersection of three elements: (a) policies or measures; (b) with a cost-containment aim (direct or indirect); and (c) in the field of LTC. This interaction resulted in the following main selection criteria: a focus on policies or measures (a) in the field of LTC; (b) with a cost-containment aim; and (c) identified as an output in terms of public expenditure. This means that references were selected exclusively according to the presence of a cost-containment output regardless of whether this output is stated or unstated, or expected or unexpected. Therefore, only references that specifically focus on cost-containment policies were included, regardless of whether the analysis took a comparative or case study approach. Conversely, articles in which cost-containment policies and related implications constitute the background orientation were excluded from the analysis. Adopting these criteria allowed compliance with the ambivalence of the subject of our analysis, namely the intersection between different potential cost-containment approaches and various policy aims. Moreover, cost-containment is just one among various consequences of a policy. Indeed, the mix of cost-containment and the other effects of a policy can be various. For example, even if in most cases cost-containment policies lead to negative effects on the wellbeing of older people and their families, sometimes things go differently. Regarding the third subject, the review covered the entire spectrum of LTC service settings, namely residential care, home care, day care and cash benefits (Table 1).

The publications selected had to include either qualitative or quantitative empirical data (Weiss, 1998), be available in English, and be published between 1995 and 2020 (no exclusions were made based on the study design, the data collection method or quality, in line with the scoping method). Across the OECD countries during the 1990s, LTC policies gained relevance and autonomy, resulting in a phase of collective expansion and strengthening of the sector (Gori, 2019). The year 1995 was chosen for the starting date as it can be considered a turning

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Table 1. Review parameters

Parameters	Inclusion criteria	Exclusion criteria
Dates	1995–2020	Pre-1995, post-2021 (excluding COVID-19 literature)
Publication type	Peer reviewed	Grey literature apart from academic research reports and policy briefs
Article type	Empirical data: • Research findings • Reviews of empirical research	Opinion only
Focus	Reference to an output of cost-containment of public expenditure	A general reference to cost-containment policies
Field/sector	Long-term care: • Residential care • Home care • Day care • Cash benefits	Other sectors (*e.g.* health care)
Geographical area	OECD area meeting three criteria: • Presence of well-established LTC sector • Representativeness of LTC model • A high proportion of older adults in the population	Not meeting inclusion criteria

Notes: LTC: long-term care. OECD: Organisation for Economic Co-operation and Development.

point. In this year, Germany introduced mandatory LTC insurance for the entire population, which can be considered a key reform in the LTC policy 'expanding era/phase'. The geographical area of reference was the OECD area, which was narrowed down by adopting three criteria: (a) a presence of well-established LTC programmes; (b) their representativeness of LTC models; and (c) a high proportion of older adults in the population. This choice was supported by the need to reach a similar development level among the LTC sectors investigated. Therefore, the article mainly focuses on Japan, South Korea, Australia, the United States of America (USA), Canada and Western European countries. These LTC sectors differ widely in several respects (such as orientation, financing system and financial capacity, and reliance on the market or the family), and these differences play a role in defining the institutional design and cost-containment policies. However, this work aims to go beyond these differences and identify a typology of cost-containment measures and a summary of potential implications for beneficiaries and their families transversal to the particularity of LTC systems. In other words, the article aims to identify a typology of the different rationales of cost-containment policies disembedded from their institutional context. The characteristics of LTC systems were not included in the scoping review as it would have led to a comparative exercise rather than an analytical summary.

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Data extraction and analysis

A three-stage screening process was undertaken (titles, abstracts, full texts) to assess whether the papers matched the inclusion and exclusion criteria. The abstracts and full texts were read by one researcher (ML), with a second (CG) reading those considered to be at the margins of the study. Decisions were made by consensus and through an iterative process. Proformas were produced to support the systematic extraction of data that captured research methods, the focus of articles, the sector of the study and the geographical area. After controlling for article consistency, we collected 78 articles and book chapters and 13 reports and policy briefs. Most of the papers concentrate on only one country or at most three, and their focus ranges from detailed investigation of cost-containment efforts to analysing LTC reforms. Due to the high number of contributions obtained in the scoping review, the materials collected are reported in the reference list at the end of this article. Furthermore, it is important to note that the heterogeneity of cost-containment policies was reflected in the literature collected. A contribution can inform on a specific detailed cost-containment policy option or provide data on different cost-containment policies ascribable to the same defining area (supply or demand side) or both.

Two distinct data analysis approaches were employed. The first was deductive and involved identifying categories to organise and interpret the data (Whittemore and Knafl, 2005) relating to the two defining areas: supply-side and demand-side cost-containment policies. The second was inductive, allowing prevalent themes to emerge from the papers and materials collected (Coffey and Atkinson, 1996; Ali and Birley, 1999). The categorisation was based on similarities among policies. If a policy or policy option did not fit in an existing group, a new group was created until all the cost-containment policies and options were assigned to groups. This allowed the cost-containment policies to be clustered in groups characterised by the same guiding principle/mechanism. It also allowed differentiation within the groups in relation to the policy option implemented. Therefore, the scoping review allowed three-level grouping of cost-containment policies. At the first level, the policies are grouped in two aggregated areas, demand- and supply-side policies, whereas the second level identifies the actual policies. The third level differentiates among them by looking at the policy options implemented.

Findings

This section divides the findings into four subsections. The first three are connected to the proposed research questions, whereas the fourth one deals with the theme emerging. The first briefly describes the types of cost-containment policies identified and the second and third present them in detail. The fourth section elaborates on the negative implications of these policies for older people and their families. A further and last section deals with paradoxical/unexpected cost-containment effects.

Cost-containment types

The scoping review supported our initial aim. It allowed us to answer the first research question positively. It showed that not only is it possible to organise

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Table 2. Cost-containment policies in long-term care systems

Defining area/cluster	Policies
Demand side	• Tightening eligibility criteria • Reducing care responsiveness • Introducing or raising co-payments
Supply side	• Changing the mix of services • Reducing the intensity and/or the quality of services

types of cost-containment mechanisms according to similarities but also that the usual grouping of cost-containment policies in health-care studies is a useful tool but it needs to be modified. As previously stated, the typology identified consists of two macro-clusters, *i.e.* demand-side and supply-side policies (Table 2). Demand-side policies reduce the actual chance of receiving LTC services and/or make them more expensive for users, whereas supply-side policies modify the provision of services. These two macro-clusters were further divided into groups according to the specific features of the cost-containment measures (second research question). In the first group, which relates to older people requiring care, these policies decrease the population eligible for LTC either explicitly by tightening the eligibility criteria (according to care needs, economic resources and/or the availability of informal care) or implicitly by reducing care responsiveness. In the second group, the people actually receiving care, the policies increase the cost to them by introducing or raising co-payments. Supply-side cost-containment policies can be divided into: (a) changes in the mix of services (community care/home care *versus* residential care; services in kind *versus* cash benefits; the composition of services included in care packages); and (b) decreases in the quality and/or the intensity of services. The first concern the types of input provided while the second involve changes in quality or intensity. In the third stage of differentiation of our typology, the analysis indicated that different implementation options can be identified for almost all the policies. The next paragraphs deal with the characteristics of the policy options identified.

Before proceeding to the analysis of the results, a terminology clarification is needed. Although 'home care' and 'community care services' can present some differences (the first term being more common in Europe and the second in the USA and evoking a broader package of services), the terms are used as synonyms indicating personalised health and social services aimed at helping seniors with a disability (or dependency) to continue living safely and independently at home.

Demand-side policies

Tightening eligibility criteria

The rationale for this cost-containment policy is to modify existing arrangements either explicitly or implicitly leading to a narrower definition of the eligibility criteria. The new policy arrangements require older people to have more needs than previously in order to access LTC public services. The conditions taken into

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account can concern (a) older people's degree of dependency and care needs (needs testing) and/or (b) their economic resources and/or those of their relatives (means testing) and/or (c) the availability of informal care (carer-sighted approach).

Needs testing. This policy option involves targeting LTC services at older adults with a higher level of dependency than previously. Since the early 2000s, most OECD countries have targeted older people with a higher degree of dependency and/or cognitive impairment. This trend is more pronounced in the residential sector, even though access to other in-kind services – especially community care (Ilinca *et al.*, 2017) – has been affected too, although to a lesser extent (Gianino *et al.*, 2017).

In a large number of countries, access to LTC services is regulated by instruments that assess claimants' needs in tiers related to their level of disability. These tiers define the different intensities of the services provided, either in terms of type, hours and money, depending on the type of service, cash benefits or in kind. In several countries, only the higher levels – in which claimants have very severe needs – are ensured public support. For example, in Israel, the Czech Republic and Croatia, low levels of needs are not sufficient to qualify for public care (Muir, 2017). The thresholds for entering the first two levels in the Austrian LTC allowance scheme were raised by about 30 per cent between 2011 and 2015. In England, a needs-testing system has tightly restricted access to publicly funded social care, and in the USA access is only granted in cases of high need and low income (means testing, *see* below) (Muir, 2017). A tightening of eligibility criteria related to the level of dependency of beneficiaries is increasingly characterising the Nordic countries too (Szebehely and Meager, 2018).

Means testing. This policy option involves introducing or lowering means (income and capital) thresholds below which individuals can access, freely or with limited cost, LTC measures and services. According to a recent review, 'most countries apply some degree of means-testing by income' (Muir, 2017). These cost-containment options are primarily applied for residential care. Indeed, the economic resource thresholds used to identify the population eligible for residential services tend to be very strict, whereas for home and community services they tend to be less restrictive. Additionally, means-testing policies, especially in the residential sector, differ not only in terms of their strictness. Further elements concern the pool of wealth defining the 'means', which can differ both in terms of economic sources and the family members considered. Asset tests, in addition to income tests, are a cost-containment policy employed in several OECD countries (Muir, 2017) to reduce the public cost of institutional care. In several countries, for instance Italy, France and Austria, care recipients' family members are legally required to contribute to the cost of LTC. In these countries, means testing is applied not only to the income (and assets, where required) of beneficiaries but also to that of their family members (Costa-Font *et al.*, 2015).

In general, the OECD countries vary significantly in their reliance on means-testing policies since the funding approach clearly influences recourse to this strategy. Indeed, means-testing policies are usually not in place in social insurance programmes (where everyone who has paid an adequate amount of

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contributions and is above a certain threshold of care needs is entitled to LTC), such as those in Japan and Germany, while in tax-based systems, such as those in Italy and England, means testing is employed.

Carer sighting. The rationale for this cost-containment option is consideration of the availability of informal support to establish whether or not, or to what extent, an individual can access public services. Informal care represents the backbone of LTC in every country in the OECD (Colombo *et al.*, 2011). In this regard, adopting eligibility criteria that are 'carer sighted' (as opposed to 'carer blind'), *i.e.* considering the availability of informal carers, is an important cost-containment policy. Two additional elements need to be taken into account here. First, the availability of informal care is exclusively included among the eligibility criteria in schemes that do not recognise LTC as an individual right. Second, it occurs more often in the case of services in kind than in cash-for-care payments because these are usually individual rights (Gori and Morciano, 2019). For example, services in kind in England are primarily directed at older people with disabilities who do not receive informal care (Comas-Herrera *et al.*, 2012), and Sweden and Australia adopt a similar principle regulating access to services by beneficiaries (Rauch, 2008).

Reducing care responsiveness

These policies do not involve eligibility criteria but the actual possibility of receiving public LTC. The rationale for these cost-containment options is a government strategy of reducing access to services by influencing the timing (of actual access to services) rather than the eligibility criteria. Reducing care responsiveness is an implicit strategy that consists of slowing down the procedures that allow older people who live in their own homes to obtain a place in a residential institution or to receive home and community services by increasing the waiting time or extending the time to process cases (OECD, 2013; Boscart *et al.*, 2018). In this way, while reducing care responsiveness can be affected by other supply-side cost-containment policies, this option constitutes a direct strategy that governments (Gori, 2019)) can use to limit access to care and thus control the cost to the public. Long waiting times are a feature shared among OECD LTC sectors. According to a Waiting Times Policy and Data Availability survey in 2012, 13 of the 14 OECD countries examined reported problems or growing concerns about waiting times for LTC services (OECD, 2013). For instance, in Ontario, Canada, waiting times to access LTC are a challenge (Muir, 2017). The average waiting time for admission into a nursing home has grown from 30 days to almost four months over the last decade.

Introducing or raising co-payments

The third demand-side cost-containment policy influences actual access to LTC services by making it more expensive for the beneficiaries through greater recourse to co-payments. These policies do not regulate access to services but instead they define the size of payments required from older adults who actually receive LTC services, which are usually commensurate with their economic resources and needs. All the OECD LTC systems require beneficiaries to contribute to the cost of the service (Muir, 2017). Co-payments are primarily applied in the residential sector, especially concerning non-healthcare-related costs. Growing recourse to

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Table 3. Cost-containment long-term care policies: demand side

Policies	Options
Tightening eligibility criteria	• Needs testing • Means testing • Carer sighting
Reducing care responsiveness	• Increasing waiting time/extending the time to process cases
Introducing or raising co-payments	

needs- and means-testing cost-containment policies has progressively reduced the chance of acceding to LTC support at no or little cost. This trend has led to growth in the proportion of beneficiaries who have to partially or entirely sustain the costs of LTC, resulting in a general rise in co-payment levels across the OECD countries. Increasing co-payments is a strategy to reduce public costs in Australia (Ergas and Paolucci, 2011; Henderson and Willis, 2020), Germany (Zuchandke *et al*., 2012), the Netherlands (Schut and Van Den Berg, 2010; Janssen *et al*., 2016), Japan (Olivares-Tirado and Tamiya, 2014), Austria (Trukeschitz and Schneider, 2012; Lorkovic, 2020) and also in Spain, France, Italy and England (Costa-Font and Zigante, 2014) (Table 3).

Supply-side policies

Changing the mix of services

The rationale for these cost-containment policies is to favour or support access to services characterised by a lower unit cost. This strategy can be pursued directly or indirectly. Indirect strategies aim to redirect potential LTC beneficiaries to solutions that are less costly than an alternative option. There are two alternative strategies: favouring access to home care/community care over residential care; and favouring cash benefit measures over in-kind services. Direct strategies affect the composition of services in care packages. However, it is necessary to consider that these policy options, especially those involving an indirect strategy, are implemented with a plurality of policy aims, among which cost-containment can be considered, in general terms, an indirect effect. Strategies like 'ageing in place', 'freedom of choice' and 'supporting beneficiaries' autonomy' are key elements in the redirection of potential LTC beneficiaries among available LTC measures. These turn out to be less costly alternatives.

Prioritising community/home care over residential care. Targeting the neediest older adults for residential services is a cost-saving 'ageing in place' policy. By favouring the desire of beneficiaries to remain at home as long as their situation enables it, OECD countries have also taken the opportunity to reduce public spending by prioritising community care over more expensive residential care. An increasing community care/institutional care ratio over the last two decades is a trend noted – to

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different degrees – in a number of countries such as England, Canada, Ireland, Finland, New Zealand, Norway, Italy, Spain, Sweden, Czech Republic, Poland, USA, Germany and Japan (Glendinning and Moran, 2009; Rodrigues *et al.*, 2012; Carrera *et al.*, 2013; Gori *et al.*, 2015).

Reablement (dependency prevention). A similar and more recent option that has resulted in reconfiguration, mainly within the home care sector, has concerned the introduction of services aimed at prevention and active ageing. These services, among which reablement services constitute the clearest practical example, have been introduced in various European countries and Japan, New Zealand, Australia and the USA (Rostgaard, 2015; Aspinal *et al.*, 2016; Doetter and Rothgang, 2017; Linnosmaa and Sääksvuori, 2017; Marczak *et al.*, 2017). In particular, in line with dominant discourses on active ageing and prevailing social investment policy agendas, this strategy aims to increase the overall quality of protection against LTC risks (European Commission, 2013). Reablement services usually consist of a short-term intervention in the home of the older person in which the focus is on training in daily functions in order to re-gain or maintain their capacity, but in some countries (*i.e.* Denmark) they are based on a multi-disciplinary approach involving close co-operation between social care workers and occupational therapists (Rostgaard, 2016). In general terms, these measures constitute a supplement to or a replacement of traditional home care. Due to the 'investment' element, this strategy is usually defined as cost-effectiveness rather than cost-containment. However, it can be included in the typology identified, especially if reablement services substitute regular home care measures. Indeed, the Danish case shows that many beneficiaries increase their level of self-sufficiency after benefiting from reablement services, with a potential related drop in the need for regular care (Rostgaard, 2016).

Prioritising cash benefits over services in kind. Monetary transfers involve a minor disbursement of public funds compared to services in kind since they have a lower unit cost (Campbell *et al.*, 2015). Pursuing the aims of increasing the number of LTC beneficiaries, enhancing user choice and promoting 'ageing in place', several countries have boosted the availability of cash benefits. Apart from a few exceptions (*e.g.* Israel; Asiskovitch, 2013), in the countries where these measures are available, cash benefit schemes represent the most important public care inputs in terms of both financing and coverage (Gori and Morciano, 2019). The cost-containment nature of cash benefits is clearly visible when they are offered as alternatives to in-kind services within a single scheme. In these cases, for instance in the Netherlands, Israel, Germany and France, the amount of the transfer is significantly lower than the cost of the in-kind alternative (Da Roit *et al.*, 2015). However, these differences are also marked in countries where cash benefit schemes and in-kind services are not integrated within the same scheme, like Italy, Austria and England (Gori *et al.*, 2015).

However, a (general) clarification is needed: favouring monetary measures over in-kind ones does not always imply an overall cost reduction. Monetary measures can constitute a more favourable option for beneficiaries than in-kind ones and thus result in a more-extensive and more-expensive population of beneficiaries

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(Asiskovitch, 2013; Van Ginneken and Kroneman, 2015). Furthermore, considering the additional in-kind support, both formal and informal, required by the beneficiaries of LTC derived from monetary measures, the actual overall saving attached to cash benefits can be limited (Mosca *et al.*, 2017; Da Roit and Gori, 2019). This reasoning can be applied to various cost-containment strategies. In this regard, the last section deals with these paradoxical/unexpected cost-containment effects.[2]

Shrinking the care package available. This policy consists of excluding various care inputs, like domestic help or lodging services, from the care packages publicly offered.[3] In community care, these policies consist of gradually excluding services related to instrumental activities of daily living (IADL) functions, like household chores, from care packages. In the residential sector, this policy primarily focuses on restricting the care inputs attributable to health treatment, which are usually fully covered with public funds. Shrinking service packages has affected several Nordic countries (Kröger, 2011; Rostgaard, 2012; Szebehely and Trydegård, 2012; Vabø, 2012), the Netherlands (Nowak *et al.*, 2015) and England (Glendinning, 2012), but also Japan (Olivares-Tirado and Tamiya, 2014) and Austria (Trukeschitz and Schneider, 2012).

Reducing the intensity and/or quality of services

The rationale for this cost-containment mechanism is related to a particularity of LTC policies. LTC is a labour-intensive sector with on average at least two-thirds of the total expenditure being absorbed by staff costs (Colombo and Muir, 2015). Considering the intrinsic human-relational nature of care work, it is a challenge for policy makers to optimise the LTC sector by increasing productivity. Due to this intrinsic difficulty in increasing productivity[4] and the need to face increasing public spending constraints, an alternative strategy has been to reduce the quality and/or intensity of the service, the average level of staff training and the general working conditions of the care workforce. Like the previous group, depending on the intentions of policy makers these cost-containment options can be direct or indirect. Reducing the quality and intensity of services constitutes an indirect modification (or missed modification) of the LTC policy setting. Instead, direct policy options, which mainly involve reducing service intensity, are intentional modifications of the previous policy setting. A clarification is necessary: intensity refers to the amount of care offered to each user whereas quality indicates the appropriateness of services given the beneficiaries' health conditions, needs and desires.

Direct reductions. These strategies mainly concern the intensity of services provided in community care. Here, the growth in coverage registered in several OECD countries over the last two decades has been counterbalanced by a reduction in intensity. Countries have followed various paths but the outcome is generally the same: on average, an increase in coverage and a decrease in intensity (Gori and Morciano, 2019). However, while this is the general long-term trend, some exceptions are identifiable, especially in more recent years. In England, for instance, the combined effect of 'tightening eligibility criteria' and 'shrinking care package' cost-containment policies has had an opposite result: higher intensity – due to the more severe average level of the beneficiaries' needs – for a reduced eligible

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population (Glendinning, 2012; Costa-Font and Zigante, 2014). Furthermore, several countries limit public costs by capping the maximum number of hours of community care services that are publicly financed according to characteristics of the beneficiaries. Canada, South Korea, Israel and Slovenia set caps on the maximum number of monthly hours of service that are covered by the public sector for people with low and moderate needs, and if extra hours are needed the beneficiaries themselves have to pay (Muir, 2017).

Indirect reductions. It is possible to identify three policy options involving indirect reductions of intensity and quality. First, in several countries the intensity of services is defined according to predefined categories that rank the beneficiaries' levels of dependency/disability. The cost-containment policy here involves an undervaluation of the severity level of beneficiaries in these categories. In the Netherlands and Belgium, the governments have suspended recognising beneficiaries with the highest level of need as being in the category with the highest severity of disability. These beneficiaries are therefore included in a category of people with a lower level of disability who receive a more moderate amount of benefit (Janssen *et al.*, 2016). Similar approaches have been reported in Japan and Spain (Tsutsui and Muramatsu, 2007; Waldhausen, 2014; Pozo-Rubio and Jiménez-Rubio, 2020).

Second, there is a de-professionalisation of contracted-out services, and to a lesser extent also of direct public provision (Marczak and Wistow, 2015). Competitive tendering processes used by public authorities to outsource services to private providers may lead to lower unit costs of care services at the expense of quality (Fersch and Jensen, 2011; Marczak and Wistow, 2015). Indeed, a reduction in care costs tends to decrease the professional level of the care provided (OECD, 2013). Evidence indicates that where commissioning of care tends to be more widespread the unit cost of care tends to be lower (Fersch and Jensen, 2011). In countries where the commissioning of services is diffuse – such as the USA, Israel, Croatia and South Korea, but also France and Canada (Ontario) – the relativised hourly cost of home care (Gross Domestic Product per hour worked) is significantly lower than in countries less prone to service commissioning, like Sweden (the cost of care is around a quarter in the above group of countries, rising to half the Swedish cost in France and Ontario) (Muir, 2017).

Third, there is an inadequate or missing adjustment of benefits and service appropriateness, with 'appropriateness' referring to indications and criteria related to the pertinence of services. One case concerns the appropriateness of the amount of cash benefits. Governments can tacitly control public spending by not regularly updating the amount of benefits according to the cost of living and to the inflation rate. For example, between 1993 and 2009 in Austria, benefits were only adjusted four times and compensated for less than half the amount of price increases (Trukeschitz and Schneider, 2012). A similar policy was adopted in the German LTC system (Gori and Morciano, 2019). In-kind services were not adjusted to respond to the evolution of beneficiary needs and changes in the diseases affecting the older population. In both cases, the cost-containment option involved not complying with indications from medical and care workers concerning the average time of operations and/or adequate treatments. These strategies primarily concerned the

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Table 4. Long-term care cost-containment policies: supply side

Policies	Options
Changing the mix of services	• Prioritising community care over residential care • Prioritising cash benefits over services in kind • Shrinking the care package available • Reablement (dependency prevention)
Reducing the intensity and/or quality of services	• Direct reductions • Indirect reductions

residential sector, and especially fragile patients afflicted by comorbidity and patients suffering from dementia (OECD, 2018) (Table 4).

Implications for beneficiaries and their families: a preliminary overview

Figure 1 summarises the evidence gathered from the literature analysed of negative implications for beneficiaries and their families attributable to cost-containment mechanisms. This literature suggests that the main implications can be grouped in two macro spheres. The first are implications related to a worsening of care arrangements for beneficiaries, which can be connected to (a) reduced adequacy or quality of care or (b) exclusion from service provision. The second are implications related to increased demand for individual/family resources, (a) in economic terms or (b) in time and effort. Regarding the relation between implications and cost-containment type, in general terms supply-side mechanisms are mainly connected to care provision. In contrast, demand-side ones are primarily linked to family and individual resources. However, as will be shown below, there is a certain overlap between these relations. It should be noted that the proposed reasoning on cost-containment implications is not based on an exhaustive recognition of all the potential implications of these mechanisms since this was not the primary purpose of the scoping review. Instead, it constitutes an initial exercise in organising the complexity of this subject.

The care sphere

Cost-containment policies leading to a tightening of eligibility criteria or to a reduced responsiveness of care tend to favour recourse to informal support instead of formal care, resulting in a lower quality of the care received, especially in the case of serious needs. The findings suggest that informal care can significantly help improve the health status of older adults if it is flanked by formal care. However, when it represents the primary form of support, the quality of care offered may be reduced and this may influence the beneficiary's health status in the long run (Wu and Lu, 2017). Furthermore, a reduction of the adequacy and quality of care is also prompted by supply-side cost-containment policies. The introduction of market principles in care service provision has mainly affected the production cost of services, hitting wages, training, work intensity (shifts) and working

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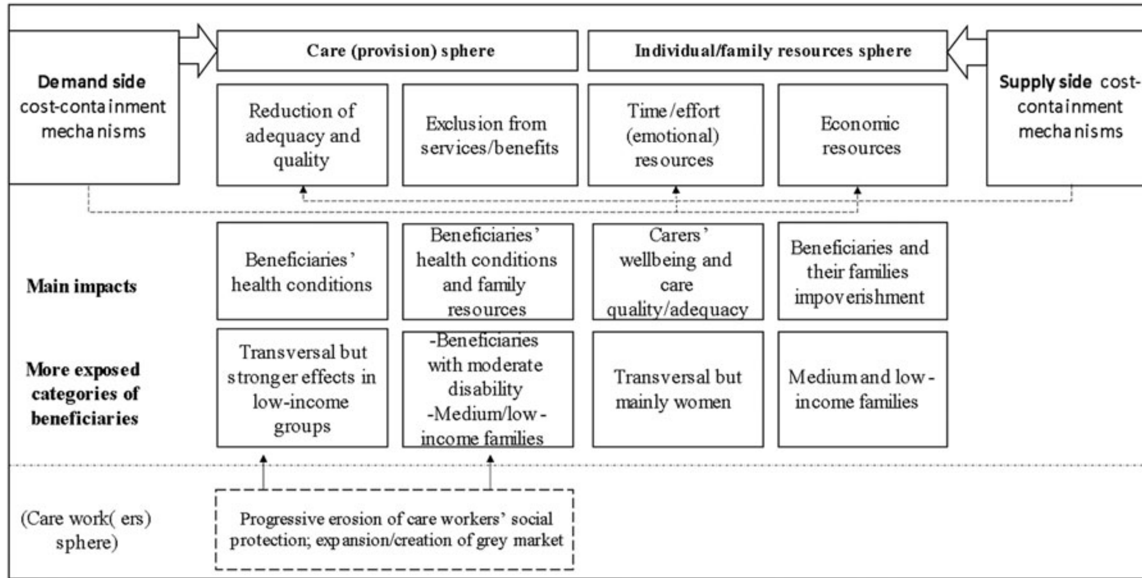

Figure 1. Preliminary overview of negative implications of cost-containment for beneficiaries and their families.

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conditions in general (OECD, 2020). These trends have led to a progressive erosion of the social protection level of care workers, generating a precarious low-wage female migrant workforce (Luppi *et al.*, 2018). Since the quality of services depends very much on the training, salaries, working conditions, benefits and job security of service workers, a decrease in these factors is reflected in a reduction in quality, lowering the adequacy and appropriateness of services (Martinelli *et al.*, 2017). Furthermore, an excessive prioritisation of community care over residential care can worsen health outcomes given the less-intensive care and the resources available (Konetzka, 2014).

Demand-side mechanisms can also lead to exclusion from formal services, especially for moderate needs and preventive care. Narrowing the accessibility of publicly funded care due to a tightening of needs testing leads to a partial or total exclusion from public LTC of older people affected by moderate or less-severe disability. Preventive care services and services for less serious cases have gradually been excluded from public care packages in several countries, leaving older adults with moderate disabilities relying on their own resources and highly penalising those who cannot count on the support of an unpaid carer (Potter, 2019). Similarly, cost-saving achieved through steeper means testing or higher co-payments reduces the eligibility for public support of low- to medium-income people, increasing the likelihood of their needs not being met (Garcia-Gómez *et al.*, 2015). In both the USA (Kaye *et al.*, 2010) and Europe (Krůtilová, 2016), this phenomenon affects a growing number of families that are neither 'poor enough' to obtain public services nor 'rich enough' to buy proper care in the private market, resulting in the so-called 'low–middle income trap'. Unmet LTC needs due to shrinking accessibility of public care or the 'middle-income trap' is an issue in several countries, like the USA (Robison *et al.*, 2012), France (Herr *et al.*, 2014), England (Vlachantoni, 2019), Spain (Garcia-Gómez *et al.*, 2015), Italy (Gori, 2019), South Korea (Boyoung and Soonman, 2017; Wei-Jun and Leng Leng, 2018), Belgium and the Netherlands (Janssen *et al.*, 2016). In addition, exclusion from public services, especially for low-income groups, can also be determined by carer-sighted policies (McCann *et al.*, 2011). If informal care availability results in higher out-of-pocket expenditure being required to access services, low-income families tend to be forced to provide informal support as formal services turn out to be unaffordable (Bakx *et al.*, 2015). A recent study of nine European countries confirms this distortive effect: conditioning access to formal LTC services according to the availability of informal care prevents lower-income families from benefiting from services (Ilinca *et al.*, 2017).

The private resource sphere

The literature suggests that a primary implication of changing the mix of services is an increase in the burden on carers. An often underrated consequence of prioritising community care over residential care consists of little consideration of the cost of the informal care-giving burden in terms of wellbeing and quality of life (Konetzka, 2014). Reducing the intensity of home care services further reinforces this strategy of shifting care costs and responsibility to families, and to women in particular (Kröger and Bagnato, 2017). Similarly, supporting cash-for-care schemes has been widely recognised as a more-challenging and demanding option for families than in-kind provision, primarily in informal care terms (Luppi, 2018). In a

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study of 138 European regions, Wagner and Brandt (2018) find that the less formal care is available, the lower is the level of spouse care-giver wellbeing, indicating that formal care supply also positively impacts on the quality of life of family care-givers.

Shifting the financial burden of LTC on to the shoulders of beneficiaries, *e.g.* by decreasing the care package available or increasing co-payments, can significantly increase the risk of poverty in many frail older-adult households (Luppi, 2018). The presence of this risk is linked to family economic resources and can be particularly severe in medium- and low-income families. As Colombo *et al.* (2011) note, in several OECD countries, for those requiring a broad range of LTC services the expenses associated with care can exceed 60 per cent of household disposable income for those up to the 8th income decile. Mosca *et al.* (2017) clearly capture the magnitude of this risk. Focusing on the English elderly care sector, they show that by aiming to offer comprehensive services to people with lower incomes, the system fails to prevent heavy financial burdens on the middle class resulting from extremely high private costs. This suggests that even for relatively high-income seniors, private LTC expenditure represents a significant burden entailing a rapid run-down of their savings, which in turn can lead to impoverishment of frail older adults and their families, especially when family members are legally bound to contribute to the cost of caring for their relative. Indeed, the growing recourse to family resources, in terms of either money or informal care, affects the economic wellbeing of family care-givers (Jiménez-Martín and Prieto, 2012), increasing the probability that the risk of impoverishment expands at the family level (Lee *et al.*, 2015).

These findings suggest a potentially broad differentiated impact of LTC cost-containment mechanics for frail older adults and their families. The literature on unmet LTC needs[5] indicates that the potential implications highlighted above can result in multiple repercussions, not only at the individual and household levels but also in more aggregate terms. Indeed, unmet LTC needs among older adults are a factor that reduces quality of life (Arlotti *et al.*, 2022) and increases material and social deprivation (Laferrère and Van den Bosch, 2015), inequality and equity (Garcia-Gómez *et al.*, 2015) – further penalising poor groups (Rodrigues *et al.*, 2017) – and social isolation. Furthermore, unmet, or under-met, LTC needs increase the risk of adverse health outcomes and events such as Accident & Emergency attendance, hospitalisation and institutionalisation (Shapiro and Taylor, 2002; Gaugler *et al.*, 2005; Long *et al.*, 2005). As was previously stated, despite the fact that looking at implications generated by different LTC systems which are embedded in quite diverse welfare state models limits the room for generalised considerations, these elements show the potential harmful spill-over effects of cost-containment mechanisms. The negative implications highlighted here not only affect individuals and their families but also potentially other sectors of welfare systems and thus their sustainability (Mosca *et al.*, 2017).

Paradoxical/unexpected effects of cost-containment

The scoping review identified potential paradoxical effects of supply-side cost-containment policies which lead to increased public cost. These effects are related to changing the mix of services between community care and residential care and

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between cash benefits and services in kind. While the latter have been discussed above, a similar logic suggests that excessive prioritisation of community care over residential care can be inefficient in terms of the allocation of public resources. Indeed, if beneficiaries' health conditions are too severe, the residential option turns out to be more appropriate and less costly (Grabowski *et al.*, 2010) and prevents potential long-term hidden costs, like higher hospitalisation rates or additional expenditure on hospitalisation (Wysocki *et al.*, 2014). Furthermore, a further perverse effect of promoting community care concerns the 'woodwork effect'. Weissert and Frederick (2013) show that in the USA the expansion of community care produces marginal costs but little marginal savings. In other words, the saving generated by keeping beneficiaries out of nursing homes by expanding community care is unlikely to come close to offsetting the cost of an expanded number of community care users. In fact, older people and their families who would not have applied for residential care do so for community care, being incentivised by their preference for it (Weissert and Frederick, 2013).

Conclusion

On the basis of a review of the English-language literature on OECD countries, this paper has presented a typology of LTC cost-containment policies for older people and developed an initial framework for linking such polices with their (main) negative potential implications at the level of beneficiaries and their families. This article is – to our knowledge – the first systematic attempt to map these policies. It is an exploratory exercise with several limitations (some already outlined), but we hope it will contribute to the debate on LTC cost-containment despite these shortcomings.

Any policy is ambivalent and cost-containment policies are no exception. This ambiguity lies in policy design, their aims and related outcomes. In broad terms, it is possible to assume that the 'nature' and outcomes of LTC policies are linked to three elements: (a) the policy design itself; (b) the organisation and characteristics of the LTC sector and the welfare state in which the policy is embedded; and (c) the timing of policy implementation. The intersection of these three elements leads to a degree of ambiguity in cost-containment policies. In particular, as our typology highlights, policies can be specifically designed to save public spending or, when pursuing different aims, they can indirectly lead to public spending. Furthermore, national LTC sectors and welfare states clearly vary at the national level in several respects. Of course, the degree of variation can affect cost-containment policies, resulting in more or less room for these measures to intervene, on the one hand, and a heavier or lighter impact on beneficiaries and their families, on the other hand. Moreover, the timing and the related policy need further influence the overall nature of cost-containment policies. Therefore, LTC cost-saving results from a plurality of factors and can be achieved through different pathways, indicating that cost-containment policies are not necessarily linked to a worsening of overall LTC sector capacity. For instance, the expansion of cash benefit programmes in Europe has allowed such a large increase in coverage that it would be hard to achieve through the more costly option of in-kind services. Furthermore, the prioritisation of community care over more-expensive residential

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care and the adoption of dependency prevention measures have stimulated innovation in care policies and improved the quality of life of frail elderly people.

This opens a debate over the upstream strategies conceptualised to minimise the risk of unsustainability of LTC systems in the long term. A consistent and growing amount of evidence indicates a strategy parallel to reducing LTC costs (*e.g.* Greve, 2017). This view, rooted in the interconnection between the social investment approach and LTC, conceptualises social spending (on LTC) as a productive factor and a way to enable individuals to use their capabilities. Although it is beyond the aim of the article, this research, and especially the implications for beneficiaries identified, suggests investigating the role of social spending even on LTC policies as a form of social and economic investment.

This article has dealt with this complexity by focusing on the cost-containment nature of LTC policies. Of course, the concrete presence and functioning of these policies and the related outcomes can vary according to the interaction of the three elements presented above. However, this particular macro-perspective is beyond the main scope of our review, which was to identify a tool to organise logically the evidence on LTC cost-containment measures and link them with an initial identification of the prevalent negative implications for beneficiaries and their families. We hope that our article will serve as a stimulus for further future research that, by adopting a particular perspective, will deal with the interaction of the three 'ambiguous' elements of LTC cost-containment policies. Furthermore, in the light of the expected profound impacts of the COVID-19 pandemic on all social security sectors in the medium and long term, a better understanding of potential cost-containment options and their related impacts should be a crucial issue in both academic and policy-making debate.

Author contributions. The authors contributed equally to the conception and design of the research, the acquisition of data and related analysis and interpretation, and the drafting of the manuscript.

Financial support. This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Conflict of interest. The authors certify that they have no affiliations with or involvement in any organisation or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this article.

Ethical standards. Ethical approval was not required.

Notes

1 The online databases consulted are: the Web of Science Core Collection, the Database of Systematic Reviews, REPEC, PAO – Periodicals Archive Online, the OECD iLibrary, PubMed, IBSS, Web of Science, SCOPUS and CINAHL.

2 However, due to the definition of cost-containment mechanisms – strategies that lead to an intended or unintended lowering of public expenditure – their paradoxical consequences are more in the public dimension than in overall LTC systems.

3 Although this option can overlap with those presented under the 'Tightening eligibility criteria' cost-containment policy, its rationale is different. In this case, cost-containment 'acts' on the services provided, reducing the availability of the range of measurement offered and not on the actual possibility of beneficiaries acceding to the LTC measures, which is instead the rationale for tightening eligibility criteria.

4 It is interesting to note that the scoping review found minimal evidence of expenditure containment through process-oriented ways of improving productivity, such as scheduling home visits or reducing staff time spent on non-essential tasks. In our view, this absence is connected to the level at which these

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process-oriented strategies operate. These strategies are more usually developed at an operational level and are therefore more challenging to capture in the design of public policies.

5 'Unmet needs' refers to 'the difference between services judged necessary to deal appropriately with health problems and services received' in the health-care debate. They are considered simple tools to monitor accessibility and the extent of inequity in health-care access and use.

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Cite this article: Gori C, Luppi M (2022). Cost-containment long-term care policies for older people across the Organisation for Economic Co-operation and Development (OECD): a scoping review. *Ageing & Society* 1–24. https://doi.org/10.1017/S0144686X22001076

https://doi.org/10.1017/S0144686X22001076 Published online by Cambridge University Press