

FINANCING LONG-TERM CARE: LESSONS FROM ABROAD

BY HOWARD GLECKMAN*

Introduction

As the United States searches for ways to reform its system of financing long-term care, it may learn from the experiences of other developed nations. In Japan and much of Europe, public benefits for the long-term care of the aged have become a pillar of social policy, on par with retirement and health care.

Many of these nations embarked on major reforms in their long-term care programs beginning in the mid-1990s. However, they have taken quite different approaches. This *brief* will review the experiences of Germany, Japan, France, and the United Kingdom and highlight potential lessons for the United States.

Overview

In contrast to acute medical care, long-term care is aimed at assisting those with chronic illnesses manage their daily lives in relative comfort and security. Such care is provided to both the aged and the disabled, and may include assistance with eating, bathing or toileting, cooking or eating. It may be provided at home or in an institution, such as a nursing home or assisted living facility.

In the United States, about half of paid long-term care is funded by Medicaid, the joint federal-state health program for the poor. Another 20 percent of paid care is financed by Medicare, the universal federal health insurance program for seniors. The remainder is paid out-of-pocket or through private long-term care insurance.¹ However, it is important to note that more than half of all long-term care is informal unpaid assistance by family members, usually spouses or daughters.²

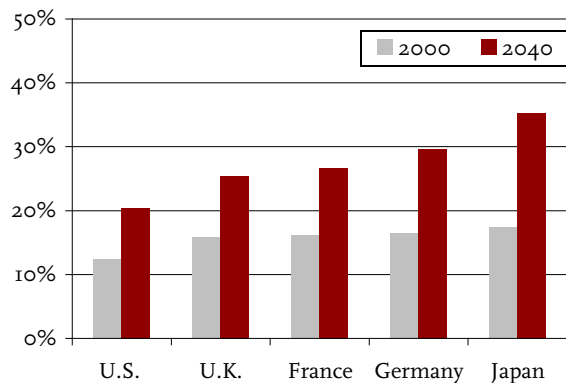
The growth in long-term care costs for both the elderly and disabled is driving substantial increases in government health expenditures, especially for Medicaid, which spent more than \$100 billion on such assistance in 2005.³ As a result, policymakers are exploring ways to slow future cost growth in the program.

Other major industrialized nations have remade their long-term care systems over the past decade. Germany, France, and Japan have fundamentally restructured their financing programs. By contrast, the United Kingdom continues the process of revisiting its more established system by issuing major new studies pointing the way to change.

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As shown in Figure 1, these four countries face more severe demographic pressures from long-term care than the United States. In 2000, about 12.4 percent of the U.S. population was 65 or older. The comparable numbers were 15.9 percent for the United Kingdom, 16.1 percent for France, 16.4 percent for Germany, and 17.4 percent for Japan. By 2040, this disparity will be even wider. About 20.4 percent of the U.S. population will be 65 or older, compared to 35.0 percent in Japan.⁴

FIGURE 1. PERCENT OF POPULATION AGE 65 AND OLDER, 2000 AND 2040



Source: Organization for Economic Cooperation and Development (OECD), (2005).

It is also important to note that these four nations have developed their long-term care models in the context of well-established public health insurance systems. Long-term care and medical treatment often overlap for the chronically ill, who frequently receive both kinds of care at the same time. Thus, it may be somewhat easier for countries with national health insurance to develop public systems to pay for long-term care. While even those countries struggle to make the links seamless, their environment contrasts with the patchwork system in the United States, where those in long-term care may be receiving acute medical benefits from traditional Medicare, private Medicare supplemental insurance (Medigap), Medicare managed care, employer-sponsored retiree health insurance, or Medicaid.

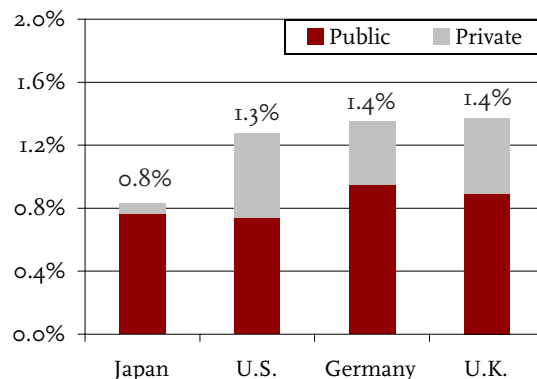
Given that Japan and many European nations do not have such a vast array of programs, they have developed long-term care financing arrangements that are quite different from those in the United States. Both Japan and Germany have established long-term care as social insurance, financed through a payroll tax. The United Kingdom, by contrast, operates a means-tested program funded through general rev-

enues, similar to that in the United States. In France, assistance is available to everyone over 60. However, high-income individuals receive only a small fraction of the maximum benefit.

Some countries have chosen to provide extremely flexible benefits, while others have not. While the United States is making some consumer-directed care available through Medicaid, most payments are still made directly to highly-regulated and licensed providers, such as nursing homes or home health agencies. Japan provides only services. In France, seniors receive a cash payment, which they may use to purchase any assistance they choose. Germany and the United Kingdom allow families the option of a cash grant or direct benefits. In many of these countries, benefits are designed to encourage home care rather than institutionalization.

Controlling the costs of long-term care is one common concern among the different countries. Currently, the costs in the major industrial countries studied in this *brief* are roughly 1 percent of GDP (see Figure 2). A major question facing policymakers is whether the widespread availability of insurance or government-funded care will drive out *unpaid* care by family members and increase the demand for *paid* care, forcing costs to unsustainable levels. It remains unclear from the Japanese and European experience whether this phenomenon, sometimes called the “woodwork effect,” is a serious concern. In Japan, long-term care costs appear to be far higher than expected. However, more than one quarter of those eligible for government benefits choose not to receive them. In Germany, the number of families taking cash benefits for home care has remained fairly steady over the life of the program. At the same time,

FIGURE 2. PUBLIC AND PRIVATE EXPENDITURES ON LONG-TERM CARE, PERCENT OF GDP, 2000



Note: France is excluded because comparable data were not available.

Source: OECD (2005).

the number of individuals relying on nursing home care has increased somewhat, especially for those with lower levels of acuity.

Germany

In 1995, Germany created a mandatory, universal long-term care insurance system. The social insurance portion is funded with a payroll tax of 1.7 percent, divided equally between workers and employers. In 2005, an additional premium of 0.25 percent was imposed on those with no children. The premium was added to reflect the likelihood that this group will require higher insurance benefits in the absence of children to provide unpaid care.

The social insurance program covers about 70 million people. Another 9 million higher income individuals choose to purchase private insurance, rather than participate in the public program. All workers, however, must have some long-term care coverage.⁵

Insurance provides both home and institutional care. Families may opt to obtain benefits in one of three ways. They may receive cash, which they can use for a wide range of purposes that include hiring professional caregivers, paying family members for caregiving, or renovating their homes to make them accessible to the disabled. They may opt for an in-kind service benefit, where care is provided directly by an agency under contract to the insurance program, or they may choose a combination of both.⁶

The cash payment is significantly lower than the direct service benefit. For instance, a patient who needs around-the-clock long-term care at home is eligible for direct benefits valued at the equivalent of \$1,927 per month, but would receive a monthly cash payment of only \$895. Those who need full-time institutional care also receive up to \$1,927 per month, depending on their level of disability, with an added supplement of up to \$619 for those with dementia. It is important to note that the institutional benefit level is based only on the cost of care services in a nursing home, but does not pay for room and board.

The social insurance program also provides for medical equipment, respite care, and caregiving training for family members. Benefits are available for both the aged and the disabled. However, applicants must show a considerable need for care before receiving benefits.⁷

The program has succeeded in substantially reducing the number of long-term care patients on public assistance, especially for those receiving care at home.⁸ It has also provided families with flexible benefits they may tailor to their individual needs.

About 2 million Germans are receiving benefits under the program. Two-thirds opt for home care.⁹ However, there has been a slight increase in demand for nursing home care since the program was created. In 1997, the first full year that institutional care was funded under the new program, 24.6 percent of beneficiaries chose nursing homes. In 2005, 27.9 percent were using such care. Expenditures for institutional care increased from about 42 percent to 48 percent.¹⁰

In terms of financing, German long-term care is operated as a parallel, but separate, system to its health insurance plan. It is governed and financed through the states (or *Länder*). Initially, the program built up strong cash balances, although it was intended to operate as a pay-as-you go system.

Since 1999, however, the system's annual cash flow has been consistently negative, though by

modest amounts. In 2004, for instance, expenditures exceeded revenues by 4.5 percent.¹¹ Some analysts in Germany are troubled by this trend, especially as they look ahead to the nation's growing dependency ratio.¹²

Maintaining current standards of care could require significant payroll tax increases in coming years. According to one estimate, the payroll tax rate, which the Germans prefer to call a premium, would have to increase to at least 3.2 percent by 2040.¹³

In sum, the German system has provided universal coverage for long-term care. It has reduced the number of people receiving such care who are on public assistance. It remains financially viable, though long-term cost trends are potentially troubling. As a result, the nation is in the midst of an intense debate about future changes to the program.

Japan

Japan created its own social insurance system for long-term care in 2000. Unlike Germany's program, which provides assistance for all, regardless of age, Japan limits benefits to those 65 and older. Those who are 40-64 are only covered if they suffer from age-related diseases, such as dementia.

Germany and Japan provide broad coverage through a social insurance model.

The system was explicitly aimed at meeting four objectives: reducing the burden of home care on families of the elderly; linking benefits to premium costs; providing more comprehensive care by integrating medical and long-term care programs; and reducing the numbers of hospitalized elderly.¹⁴

The pressures on Japan to address long-term care were among the most severe in the world. High life expectancy, low birthrates, and restrictive immigration policy have all combined to create severe demographic challenges. At the same time, the nation struggled with difficult payment and delivery issues. For example, because Japan offered free hospital care to the frail elderly, but provided no long-term care benefits outside of these institutions, hospitals had become the default care setting for many elderly Japanese. As many as one-third of elderly patients remained hospitalized for a year or more.¹⁵

The insurance program is designed as a pay-as-you-go system. While it is structured as social insurance, it is financed by a combination of both contributions and general tax revenues. The general fund portion, which covers half the program, is divided among the central government, prefectures, and municipalities. The social insurance element is financed by a combination of payroll taxes and modest monthly premiums.

All workers aged 40-64 pay a contribution rate of 0.9 percent, divided equally between employers and employees. This amount is an add-on to the health insurance payroll tax. Those 65 and older pay an income-based monthly premium, which averages about \$30 and covers about 17 percent of the program's cost. Together, the premium and payroll contribution finance about 50 percent of costs. Users of the long-term care are also required to contribute a 10 percent copayment for all services.¹⁶

In 2003, 3.7 million Japanese were certified as in need of long-term care, and 2.7 million were receiving benefits.¹⁷ The system covers both institutional and home care but, unlike in Germany, it provides no cash benefits, only services. While a growing share of home care is provided by newly-created for-profit firms, institutional care is delivered by non-profits. For those in nursing homes, the insurance system pays for care only. The cost of housing and meals is not covered.

The program is built on what one analyst calls a decentralized yet centralized system. The insurance is provided by each of Japan's 3,200 municipalities,

and eligibility and premiums vary by jurisdiction. However, prices, and co-payments are fixed by the central government.¹⁸

Once individuals apply for benefits, they are given a medical assessment and approved for one of six levels of care. Monthly benefits for each level of care are capped and any costs that exceed those maximum levels are borne by the aged and their families. Benefits range from around \$632 to \$3,702. Patients are assigned a care manager who helps them build an appropriate care plan.¹⁹

The 2000 law that created the social insurance system called for a five-year review in 2005. Partly as a result of higher-than-anticipated costs, the government made several changes to the program by both raising fees and reducing benefits. The changes included requiring families to pay an additional \$300 monthly fee for nursing home care. Benefits for those requiring the lowest levels of care were also cut, and were limited to preventative services.²⁰

France targets coverage by income, reducing benefits for high-income seniors.

Despite these changes, the system continues to face financial strains. Long-term care insurance outlays were

estimated at the equivalent of \$50 billion in 2004, but by 2025 are expected to reach \$200 billion.²¹ Japan has seen a significant increase in demand for paid care, especially at lower levels of acuity. Japan has also seen an increase in waiting lists for skilled nursing facilities since the adoption of the social insurance system.²²

France

France, along with Germany and Japan, has substantially reformed its long-term care system in recent years. However, while Germany and Japan adopted social insurance as a model for providing long-term care needs, France chose a hybrid approach. The German and Japanese systems provide benefits based on medical need, regardless of income, and are funded in large part by contributions and dedicated payroll taxes. The French program reduces benefits for high-income seniors and is financed entirely through general tax revenues. (See Table 1 on next page for key features of long-term care systems in different countries).

France adopted its new system, called the Allocation Personnalisée d'Autonomie (APA) or Personalized Independence Allowance, in 2002. It offers a

monthly cash benefit, which individuals may use for a wide variety of long-term care purposes, from hiring caregivers to renovating homes. The cash benefit may be used to hire family members as caregivers (though not spouses).

The APA is available for those 60 and over. Benefits are paid based on four levels of need. Eligibility, however, is quite strict. No benefits are paid unless a patient needs help with at least three activities of daily living — a test comparable to what is required by private long-term care insurance in the United States.²³

Everyone who meets the minimum disability test is eligible for some benefits. However, the level of assistance declines sharply with income. For instance, an individual with resources of \$1,232 per month or less is eligible for benefits of up to \$1,436 per month. A person at the same level of medical need, but with resources of \$4,104 would receive only \$286.²⁴

While the program is managed by the regional departments, benefits are equal throughout the country. To compensate for differences in resources across regions, the central government redistributes funds to the departments.²⁵

The APA was enacted amidst great uncertainty about the number of families which would take up assistance. Two previous attempts at reform had failed, in part, because so few elderly participated. However, both participation and program costs have been far higher than anticipated. For example, the expected first-year cost was \$3.6 billion, but actual expenditures reached \$4.9 billion.

In response to these costs, the government began trimming benefits in 2003. Among the changes: a longer waiting period before benefits may be accessed, restrictions on how the benefit may be spent, and a reduction in the income ceiling below which one can receive full benefits.²⁶

United Kingdom

In many ways, the U.K. long-term care system is most similar to that of the United States. In a scheme reminiscent of Medicaid, personal long-term care services are provided on a means-tested basis by local government.

Nursing care both at home and in skilled nursing facilities is provided at no cost by the National Health Service (NHS). However, personal care, which is excluded from the NHS, is financed separately through the long-term care system. Interestingly, Scotland has established its own separate system, through which the government pays for personal care as well as medical care.

Local governments have coordinated the U.K. system since 1993. It is funded with a mix of central government grants, local taxes, and beneficiary copayments.²⁷ The United Kingdom spends \$30.8 billion, or about 1.5 percent of GDP on long-term care. One-third is paid privately, while the government pays the rest.²⁸

Roughly 5 percent of the aged in the United Kingdom receive institutional care. In 2006, those with assets that exceeded \$41,700 were not eligible for government support. Those who fall below that cap must share costs. This copayment rises with income. As noted, these costs exclude nursing care.²⁹

An estimated 4 percent of seniors in the United Kingdom receive government provided home care, while about 9 percent have purchased it on their own. Again, actual nursing care is funded through the NHS. All other personal assistance, sometimes known as social care, is subject to means-tested copays that are set by local governments.³⁰ Provider fees are set by contracts with local governments and vary widely throughout the country.

TABLE I. AN INTERNATIONAL SPECTRUM OF LONG-TERM CARE

Country	Funding	Eligibility	Means-testing	Benefits
Germany	Payroll tax	Universal	No	Cash, services, or both
France	General revenues	60 and older	Benefits tied to income	Cash only
U.K.	Local taxes, federal grants, copayments	Varies by benefit	Yes	Cash or services
Japan	Payroll tax, premiums, copayments	65+, limited for 40-64	No	Services
U.S.	Medicaid, state/federal match	Aged and disabled	Yes	Services, limited cash pilot programs

Sources: Weiner, Tilly, and Cuellar (2003); OECD (2005); and Merlis (2003).

Following the recent trend in Europe, local governments have been required since 2003 to provide a cash alternative to traditional in-kind service benefits. The take-up rate has been very low however, only 0.5 percent of those over 64 after the first year.³¹ The United Kingdom also provides an additional Carer's Allowance — an extra cash benefit to low-income families who provide an intensive level of care.³²

The level of government support for long-term care has been the subject of intense policy debate in the United Kingdom for nearly a decade. In 1999, a Royal Commission proposed that both nursing and personal care be paid through general tax revenues, with no means test for beneficiaries. An asset test would be imposed only for room and board.³³ Scotland adopted these recommendations. England dropped the means test only for nursing care in nursing homes.

In 2006, two important new studies were released. The first, by the Joseph Rowntree Foundation, followed a 1999 report by the same organization. It found that “the public finds the present system incomprehensible and considers its outcomes unjust.” It recommended fundamental reform, but also suggested some incremental changes. These included providing more flexible benefits, increasing the personal allowance for those in nursing homes, and requiring those who are admitted to nursing homes under the NHS to pay room and board, and using the savings to increase benefits for all nursing home patients.³⁴

The second study came from the Kings Fund and was authored by Derek Wanless, a former chairman of NatWest and an outside adviser to the Blair government on long-term care issues. This report included an extensive review of several different funding models. It recommended what it calls a partnership model. Under this plan, the aged would receive a minimum guaranteed level of care at no cost. This care would represent about 66 percent of need. Additional assistance would be funded on a 50/50 match between individuals and government. This proposal would substantially increase both overall costs and government expenditures.³⁵

Conclusion

Japan, France and Germany have all reformed their long-term care systems since 1995, while the United Kingdom, like the United States, continues to struggle in its efforts to restructure the way it delivers and finances this care. The social insurance model adopted by Germany and Japan has succeeded in increasing financial support for the aged, those under 65 with coverage, and their families. Especially in Japan, however, the cost has been far more than anticipated. France's hybrid model has been aimed at focusing benefits on those who need them most, but its costs have been higher than anticipated as well.

This *brief* is the second in a series on long-term care. The first looked at the structure and financing of long-term care in the United States. Succeeding briefs will review private long-term care insurance and describe reform options for the United States.

Endnotes

- 1 Kommisar and Thompson (2007).
- 2 Johnson, Toohey, and Weiner (2007).
- 3 For a review of Medicaid long-term care spending, see Gleckman (2007).
- 4 OECD (2005). Another way to look at the aging population is to measure the number of people 65 and older relative to those aged 20-64 — those of prime working age who generate the bulk of national income (and pay most taxes) needed to support public programs for the aged. In the United States in 2000, this dependency ratio was 21.1 percent, compared to 27.5 percent in France, and 27.9 percent in Japan. By 2040, this ratio will rise to 37.9 percent in the U.S. but will grow to 50 percent in France, 54.5 percent in Germany and 59.9 percent in Japan. This increase will place intense pressure on government's ability to finance long-term care in the future.
- 5 A description of the German system is available through the Federal Ministry of Health and Social Security at http://www.bmg.bund.de/cln_041/nn_617014/EN/Long-term-care-insurance/long-term-care-insurance-node,param=.html__nnn=true.
- 6 Those who opt for private insurance receive cash benefits only.
- 7 In Germany, as in the United States, need is measured by the ability to perform activities of daily living (ADLs), such as bathing, getting in and out of bed, or going to the bathroom without assistance. The minimum requirement for receiving benefits in the German system is needing help with at least two ADLs.
- 8 Arntz, et al. (2007).
- 9 von Schwanenflugel (2006).
- 10 von Schwanenflugel (2006).
- 11 German Ministry of Health and Social Security (2006).
- 12 Arntz, et al. (2007).
- 13 Hacker, Höfer, and Raffelhuschen (2004).
- 14 Mitchell, Piggott, and Shimizutani (2004).
- 15 Campbell and Ikegami (2000).
- 16 A description of the Japanese system is available through the Ministry of Health, Labour, and Welfare at <http://www.mhlw.go.jp/english/topics/elderly/care/index.html>.
- 17 All-Japan Federation of National Health Insurance Organizations (2003).
- 18 Mitchell, Piggot, and Shimizutani (2004).
- 19 For an excellent description of the inner workings of the program, see Campbell and Ikegami (2000).
- 20 Ikegami (2006).
- 21 Saidel, Andrew (2004).
- 22 Mitchell, Piggott and Shimizutani (2004).
- 23 Merlis and Van de Water (2005).
- 24 International Reform Monitor (2007).
- 25 Morel (2004). This paper also provides a good history of the political environment in both Germany and France as these countries reformed their long-term care programs.
- 26 Morel (2004).
- 27 OECD (2005).
- 28 Hancock, et al. (2006).
- 29 OECD (2005).
- 30 For a basic description of benefits and means-testing, see www.lifetimecare.co.uk/ltc. People who have no spouse or partner are expected to contribute all of their income, less a small personal care allowance, to the cost of a nursing facility. Those who are married must contribute their state pension, along with half of any personal pension.

- 31 Wanless (2006).
- 32 Weiner, Tilly, and Cueller (2003); and Gibson (2003).
- 33 The Royal Commission on Long-Term Care (1999).
- 34 Joseph Rowntree Foundation (2006).
- 35 Wanless (2006).

References

- All-Japan Federation of National Health Insurance Organizations (AJFNHIO). 2003. Available at: <http://www.kokuho.or.jp/>.
- Arntz, Melanie, Ralf Sacchetto, Alexander Spermann, Susanne Steffes, and Sarah Widmaier. 2007. *The German Social Long-Term Care Insurance: Structure and Reform Options*. Discussion paper 2625. Bonn, Germany: Institute for the Study of Labor.
- Campbell, John Creighton and Naoki Ikegami. 2000. "Long-term Care Insurance Comes to Japan." *Health Affairs* 19(3): 26-39.
- Gibson, Mary Jo. 2003. "Consumer-Directed Home Care in the Netherlands, England, and Germany." *AARP Public Policy Institute In-Brief*. Washington, DC.
- Gleckman, Howard. 2007. "Medicaid and Long-Term Care: How Will Rising Costs Affect Services for an Aging Population?" *Issue in Brief* 7-4. Chestnut Hill, MA: Center for Retirement Research at Boston College.
- German Ministry of Health and Social Security. 2006. *Time Series Data*. Available at: http://www.bmg.bund.de/cin_040/nn_617014/EN/Long-term-care-insurance/long-term-care-insurance-node,param=.html__nnn=true.
- Häcker, J., M.A. Höfer, and Bernd Raffelhüschen. 2004. "Wie Kahn Die Gesetzliche Pflegeversicherung Nachhaltig Reformiert Werden?" Discussion Paper 119/4. Freiburg, Germany: Institut für Finanzwissenschaft der Albert-Ludwigs-Universität Freiburg.
- Hancock, Ruth, Raphael Wittenberg, Linda Pickard, A. Comas-Herrera, A. Juarez-Garcia, D. King, and J. Maley. 2006. *Paying for Long-term Care for Older People in the UK: Modeling the Costs and Distributional Effects of a Range of Options*. Discussion Paper 2336. London: London School of Economics and Political Science.
- Ikegami, Naoki. 2006. Speech to AARP Global Aging Program Idea Exchange. Summary available at: http://www.aarp.org/research/international/events/apr19_06_ikegami.html.

- International Reform Monitor. 2007. *Implementation of a Personal Autonomy Allowance* (APA Allocation Personnalisée d'Autonomie). Available at: <http://www.csls.ca/irm.asp>.
- Johnson, Richard, Desmond Toohey, and Joshua Weiner. 2007. "Meeting the Long-term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions." Discussion Paper 07-04. Urban Institute: Washington, DC.
- Joseph Rowntree Foundation. 2006. *Paying for Long-term Care: Moving Forward*. London.
- Kommisar, Harriet L. and Lee Shirley Thompson. 2007. "National Spending for Long-Term Care." Fact Sheet (February). Washington, DC: Georgetown University Long-Term Care Financing Project.
- Merlis, Mark. 2003. "Long-Term Care Financing: Models and Issues." Washington, DC: National Academy of Social Insurance.
- Merlis, Mark and Paul N. Van de Water. 2005. "Long-Term Care Financing: Models from Abroad." *Health and Income Security Brief* 9. Washington, DC: National Academy of Social Insurance.
- Mitchell, Olivia, John Piggott, and Satoshi Shimizutani. 2004. "Aged-Care Support in Japan; Perspectives and Challenges." Working Paper 10882. Cambridge, MA: National Bureau of Economic Research.
- Morel, Nathalie. 2004. "Providing Coverage against New Social Risks in Bismarckian Welfare States: The Case of Long-term Care." Paris: Université Paris I, Pantheon-Sorbonne.
- Organization for Economic Cooperation and Development (OECD). 2005. "Long-term Care for Older People." Paris.
- Saidel, Andrew. 2004. "Japan's Long-Term Care Insurance System Faces Overhaul: Straining to Meet Demand, Lawmakers Set to Make Changes." Washington, DC: AARP Global Aging Program. Available at: <http://www.aarp.org/research/long-termcare/trends/a2004-04-01-JapanLTCI-Saidel.html>.
- The Royal Commission on Long-Term Care. 1999. *With Respect to Old Age: Long-Term Care — Rights and Responsibilities*. Presented to Parliament by Command of Her Majesty.
- von Schwandenflugel, Matthias. 2006. "The Course of Finances of the Social Long-Term Care Insurance Scheme." Bonn, Germany: Directorate of Long-term Care Insurance, Federal Ministry of Health. Available at: http://www.bmg.bund.de/cln_040/nn_617004/SharedDocs/Download/EN/Long-term-care-insurance/time-sereis-data-5,templateId=raw,property=publicationFile.pdf/time-sereis-data-5.pdf.
- Wanless, Derek. 2006. *Securing Good Care for Older People*. Kings Fund, London.
- Weiner, Joshua, Jane Tilly, and Alison Evans Cuelar. 2003. *Consumer-Directed Home Care in the Netherlands, England and Germany*. Washington, DC: AARP.

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