Gray Matters:

Building and Strengthening Long-Term Care Systems

Elena Glinskaya, Ali Hamandi, Dwen Wang, and Sarah Coll-Black

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Outline

1. Introduction
2. Defining long-term care (LTC)
3. The Age of Aging
   i. Determinants of LTC Demand
   ii. Key characteristics of LTC Supply
4. Harnessing Governments' Stewardship Capacity
5. Building and strengthening LTC Systems:
   I. Framework for LTC Systems Design
   II. Operational Examples: North Macedonia and China
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Defining LTC

No consensus definition of LTC exists; for example:

OECD: "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 period of time on help with basic activities of daily living."

European Commission: "A range of health care and social services and assistance, for people who, as a result of old age, over an extended period of time depend on help with activities of daily living, and/or need some permanent nursing care."

WHO: "A range of personal, social and medical services and supports that ensure people… can maintain a level of functional ability consistent with their basic rights and human dignity."

➢ **Activities of daily living (ADLs)** include those activities that a person must perform daily; i.e., eating, washing, etc.
➢ **Instrumental activities of daily living (IADLs)** require more skills vs. ADLs; i.e., cooking, shopping, etc.

However, there is agreement that LTC:

- Includes services for people in many facets of living over an extended period

- Is often performed by formal and/or informal caregivers, either of which can be paid or unpaid

- Can be delivered in various settings – private homes, group homes, communities, institutional settings, etc.

- Contrasts with acute care and does not equate to rehabilitative or palliative care, but there are overlaps

- Deals with social and medical care; requires coordination and integration

The Age of Aging: Determinants of LTC Demand

- **Historically, LTC for older people has been viewed as a family matter or a last-resort State obligation; however, this view is changing as demand for LTC increases.**

- **Today, there are many factors driving the increase in demand for LTC:**

  - *Demographic trends*
    - Increasing share of elderly population due to rising life expectancy and declining fertility, and, in some countries, emigration

  - *Disability patterns (or lack thereof)*
    - No pattern of improvement in disability status among the elderly across countries

  - *Rising expectations of the elderly and young alike*
    - Shifts in the risk of being poor from older to younger age groups

  - *Reductions in the supply of informal care*
    - Supply of informal care is declining due to changes in family size, migration, female labor force participation, among others; hence more older parents are living alone

The Age of Aging: Characteristics of LTC Supply

- LTC for older persons is typically provided by **families**, the **state**, and the **private sector** (including faith-based organizations) and the **informal market**.

- **Familial care** predominates in nearly all countries. Most carers or caregivers (familial, formal, and informal) are **women.**

- Many paid caregivers in HICs, MICs, and LICs are migrants.

- The adverse effects of caregiving on **wellbeing** (i.e., physical and mental health), **formal labor supply** (i.e., dropping out of labor force or reducing hours of work), and **migration-related decisions** (i.e., postponing decision to migrate - even if its economically sensible) are documented by cross-disciplinary research across cultures.

- Historically, the State provision of LTC for older persons is a "**last resort**" function. Because of the increasing demand for LTC, this function needs to be complemented by the Governments taking on a "stewardship" role of the LTC sector, thereby facilitating care for wide population strata. As a steward, the State needs to direct support where need is the highest – to ensure both **fairness** and **value for money** ("**targeted universalism**").

- As a result, **private provision complemented by public financing** is becoming the predominant modality in HICs. At the same time, **private provision with private financing** is predominant in LICs and MICs and is fast increasing everywhere.

- A currently preferred model in HICs is around "**aging-in-place**," or **home- and community-based care**, in part due to unit costs of **institutional care** being very expensive.
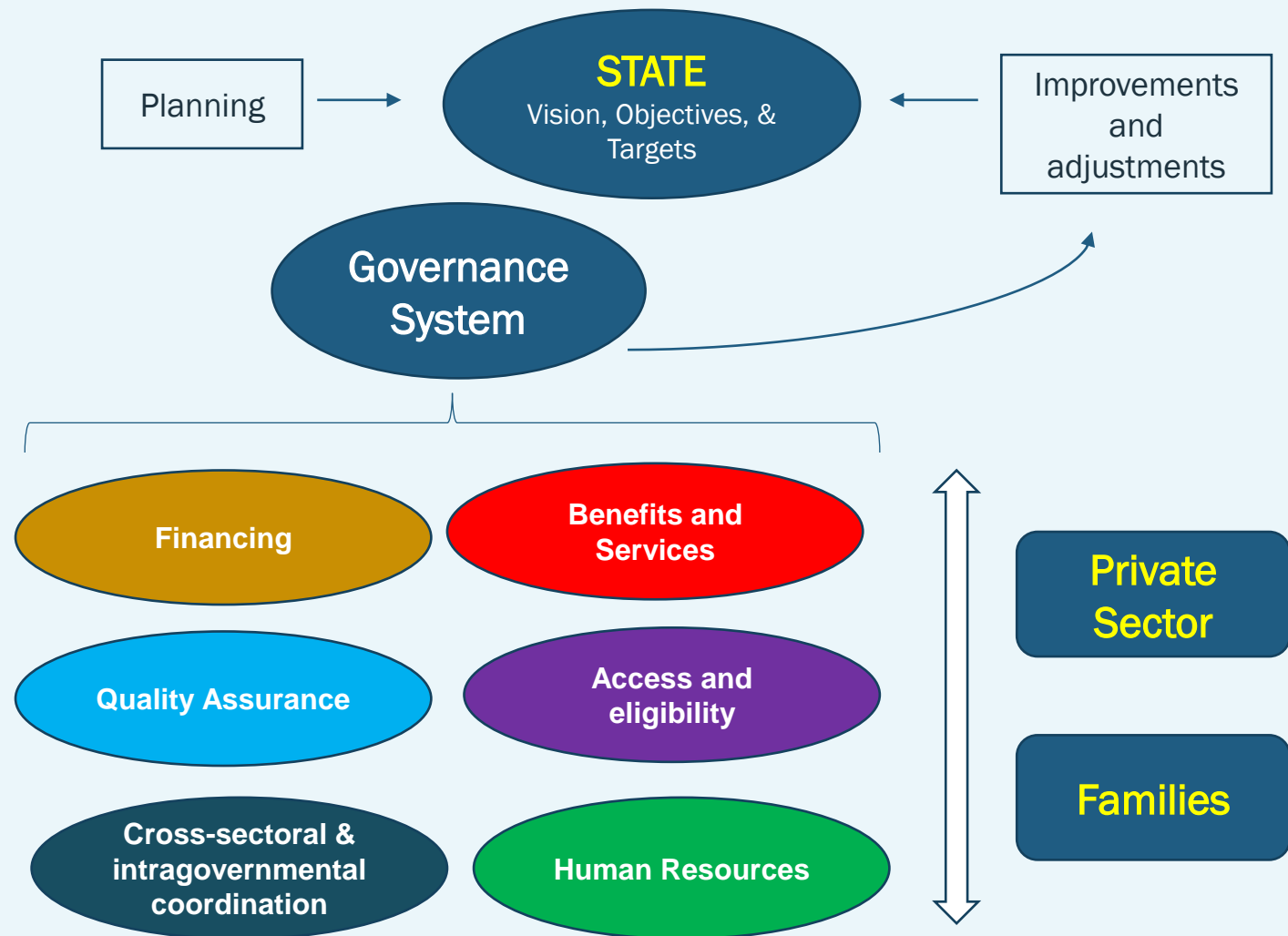
LTC Financing and Provision:
A Public-Private Mix

Financing	Formal Provision	
	Public	*Private*
Public	Example: Publicly financed (fully or partially) services provided through public home care agencies (often last resort)	Example: Publicly financed (fully or partially) services provided through outsourcing, contracting-in, contracting out, etc. Present across all care segments - home care, community care, institutional care. The predominant model in HICs.
Private	Example: Privately financed residential care services provided through public hospitals. "Privately paying" patients in Welfare Homes.	Example: Privately financed services provided through private home care agencies; privately financed services provided through private residential facilities. The predominant "high-end" model in MICs

Harnessing Governments' Stewardship Role

In the context of LTC markets, governments have an opportunity to:

- Provide **stewardship** of the market, which entails interventions at 3 levels. At the **macro-level** (i.e., develop a national policy through a vision and/or strategy for LTC, determine the source of financing, etc), **meso-level** (i.e., develop a national LTC program based on said policy, including mechanisms by which private providers are contracted, quality is regulated, resources for LTC are directed to ensure value for money, different sectors and government levels are coordination, etc. etc.) and **micro-level** (i.e., systems are in place to determine eligibility criteria for LTC and deliver the basket of services)

- Provides regulation of labor market to facilitate care (i.e. policies re. paid leave, flexible work schedule, etc.), offers respite care, and implements other **policies that would mitigate the adverse effects of informal care.**

STATE
Vision, Objectives, & Targets

Planning

Improvements and adjustments

Governance System

Financing

Benefits and Services

Quality Assurance

Access and eligibility

Cross-sectoral & intragovernmental coordination

Human Resources

Private Sector

Families

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Why should the State provide stewardship in, and financing for, the LTC market?

LTC brings about many public benefits:

- **Economic Benefits** (1.reduced expenditures on medical services; 2, increased labor income of family members who have older relatives with care needs; 3. increased earnings from direct job creation at the newly created/upgraded aged care institutions, etc.)
- **Women's Empowerment**
- **Non-quantifiable Benefits** (1.enhanced older person's opportunities to live with dignity; 2. increased set of choices available to individuals and families, especially women; 3. improvements in the overall quality of LTC services, including for the poor, etc.)
- Other potential benefits
    - ✓ Silver Economy (technology, assistive devices, etc.)
    - ✓ Political Economy of Migration

Without the State, the market will fail:

- Private insurance is not viable because of myopia; moral hazard; state-dependent utility, and because LTC services (housekeeping, meal preparation) are normal goods and are desired by all
- Formal markets are characterized by informational asymmetry between providers and consumers, making competition and consumer choice difficult (similar to health care market)
- If the government is not a major financier (and does not set prices – not a monopsonist) it is difficult to influence quality and pricing strategy of private providers (which would be driven by profit maximization in a non-competitive market)

Framework for LTC systems Design

Access and eligibility	Benefits and Services	Financing	Organization and Governance	Human Resources
Assessing and defining the need for LTC, and developing a standardized needs assessment and classification of care needs.	Supporting a range of home-and community-based and institutional in-kind care services, in addition to other types of benefits (i.e., cash for care and/or other supports), based on individual needs.	Collecting adequate revenues, pooling resources; "purchasing" benefits and services; providing financial protection against LTC costs; and ensuring equity and value for money.	Making clear the functions at different levels of government, the relationship between the health and social sectors, the quality control mechanisms, and the role of the private sector.	Preparing for a future LTC workforce, including skilled medical staff and low skilled "caregivers; ensuring flexibility within the workforce while also protecting workers' rights.

(1) Access and eligibility

Macro-level

What is the future demand for care?

- The capacity to assess LTC needs is required at both the macro and microlevel to inform policy formulation and service delivery.

- At the policy or macro level, assessments of LTC needs are required to project future demand for care, project public expenditures on care, and to guide policy reform.

Miso-level

What are the protocols for determining eligibility for public support?

- At the micro or service delivery level, LTC assessments are needed to determine eligibility for benefits and appropriate care plans.
- For example, some countries have implemented needs assessments based on levels of functional impairments (physical and cognitive) which, combined with assessments of income and wealth, are used to determine eligibility for certain benefits and to make care plans. Please see next slide.

(1) Access and eligibility

Defining the need for LTC

How to define who needs LTC?

- The prevalence of dependency is commonly used to determine the level of care needs, typically through a functional (versus medical) assessment based on the number of ADLs and IADLs that one can perform. Cognitive impairments are also sometimes considered.

- Assessment results should be based on a classification of care needs.

- In some countries, for example, inability to perform a certain number of ADLs implies need for LTC; in others, ADL- and IADL- based scores are aggregated using different weights. In some countries, more comprehensive definitions of LTC need are used, accounting for also mental, and psychological factors.

Linking needs assessments and eligibility

Extend benefits to everyone with LTC needs or a fraction of them?

- Identification of people with LTC needs and the selection of beneficiaries (i.e., based on age or income) are linked due to budgetary constraints. However, targeted universalism has the potential to provide fair protection in a fiscally sustainable manner.

- For example, some systems employ, in addition to care needs, factors like age, income, and the availability of informal support as criteria.

- For this reason, eligibility criteria should remain dynamic since budget constraints change from time to time. Moreover, entitlement does not mean no cost-sharing.

Assessing needs and eligibility, and follow-Up

How should needs assessments be performed?

- Needs assessments should be performed by a multi-professional panel including, for example, social workers and medical practitioners.

- Most systems leverage at least one national/uniform assessment tool; for example, the Barthel Index.

- Assessment responsibility should not be held by those providing care; otherwise, there may be bias towards severity.

- Assessment should also factor in the dynamic nature of needs, with might increase with age or be contained with early interventions.

(2) Benefits and Services

Types of Benefits

Health? Social? Or both?

- Many LMICs have a default financing approach for LTC through the health system, which is costly and inefficient. But this is changing due to the nature of LTC.

- Generally, LTC benefits span the health and social sectors and different settings. While the health sector tends to focus on ADL-oriented care, social sector benefits to be more IADL-oriented.

- The division between sectors, however nebulous, has implications for the provision and funding of services (i.e., task shifting).

Nature of Benefits
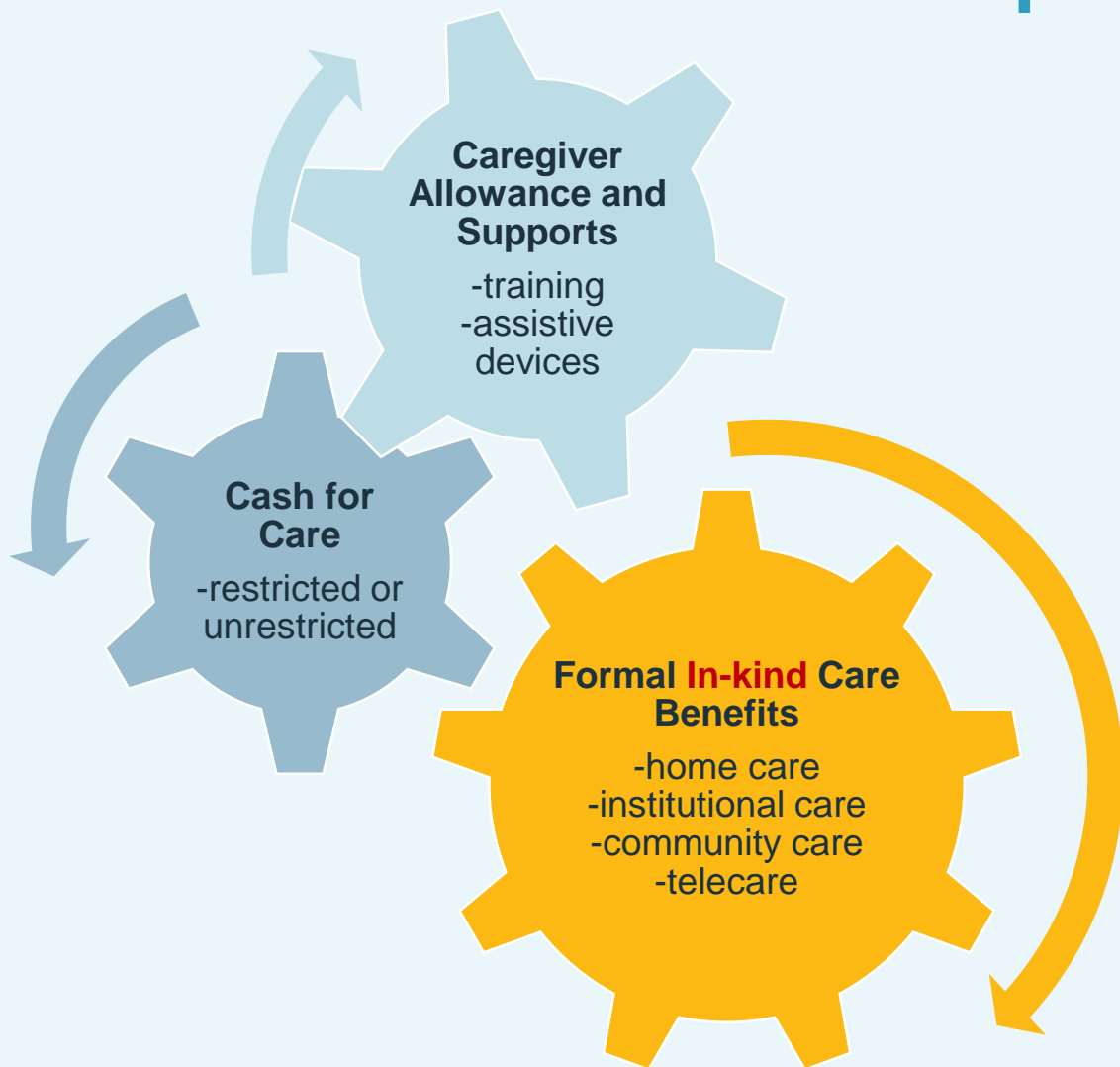
Cash or in-kind services, or both?

- Generally, there are three options for delivering benefits: in-kind direct service delivery, cash allowances and supports for informal carers or caregivers, and/or cash benefits for care recipients. The latter can be "unrestrictive," or "restricted" to the purchase of select services. These options impose trade-offs in terms of efficacy, user choice, and cost-control.

- Some LTC systems extend both in-kind and cash benefits; for example, in Slovenia, users can leverage in-kind or unrestricted cash allowances, or a combination thereof. In contrast, other systems are in-kind based.

Generosity of Benefits

Standardized or customized?

- The generosity of benefits, and their eligibility criteria, impact the financial sustainability of a system. Most governments set minimum and maximum limits to their benefits, balancing coverage, equity and sustainability. Some also offer a range of benefits at different need levels.

- For example, in Germany, the highest benefit (for highest care grade) is five times that of the lowest benefit; in Austria, it is ten times.

- Cost-sharing is present in all systems.

Examples of Benefits

Caregiver Allowance and Supports

-training
-assistive devices

Cash for Care

-restricted or unrestricted

Formal In-kind Care Benefits

-home care
-institutional care
-community care
-telecare

German's LTCI System: A Tiered Benefit System					
Maximum Benefits (euros)	Care Grade (CG) 1	CG2	CG3	CG4	CG5
Home Care: Nursing Allowance	-	316	545	728	901
Home Care: In-Kind Benefit	125	689	1298	1612	1995
Semi-residential day and night care (can be used in addition to home benefits)	125	689	1298	1612	1995
Nursing Home Care	125	770	1262	1775	2005

(3) Financing

Resource mobilization

What kind of financing system is possible?

- Different financing models are possible, with varying trade-offs. See next slide.

Ensuring value for money

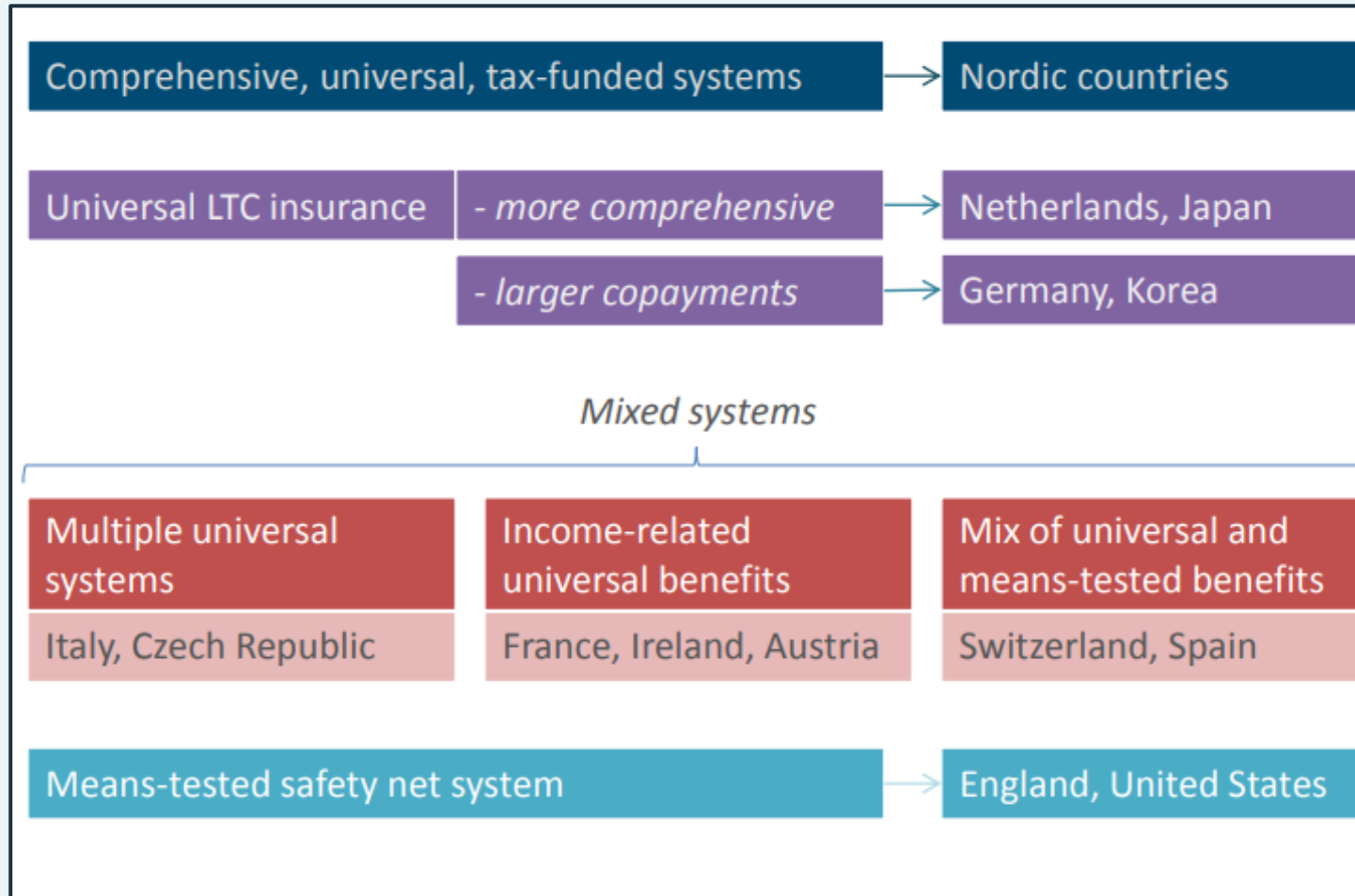*How do we move towards an efficient delivery of care?*

- Measures to improve efficiency in LTC services and systems have focused on four main areas: (i) expansion of home-care supply through regulatory measures and financial incentives (however, evidence re. impact on costs mixed); (ii) employing provider payment mechanisms (i.e., demand-side financing) to improve quality of care; (iii) creating incentives for provider competition (i.e., through supply-side financing, such as vouchers), and (iv) leveraging technological advance to improve productivity of carers and care workers.

Improving financing within sectors
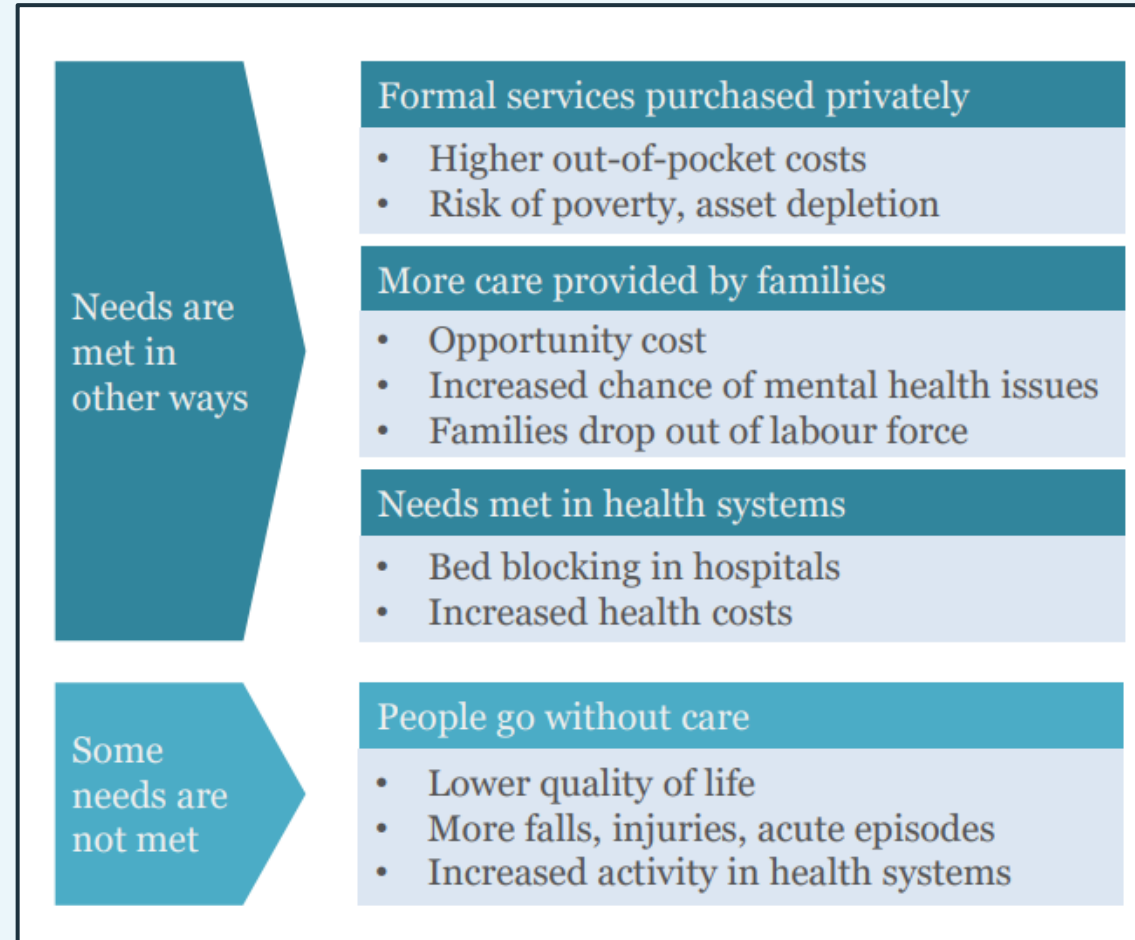
How to incentivize coordination?

- Health and social benefits need to be defined and their spending tracked; otherwise, cost-shifting is possible.
- Concurrently, it is important that intra-sectoral financing be improved; for instance, health can:
  - Move away from addressing episodic health issues towards a continuum of care model, where detection and prevention through effective PHC interventions are core.
  - Enable benefit packages with referrals in mind (i.e., role of PHC in coordination as a key benefit may depend on coverage for secondary and LTC), in addition to home care. For example, in Lebanon, home health programs are beginning to develop as an extension of PHC.

Different financing systems can meet LTC costs

Comprehensive, universal, tax-funded systems →		**Nordic countries**

Universal LTC insurance	*- more comprehensive* →	**Netherlands, Japan**
	- larger copayments →	**Germany, Korea**

Mixed systems

Multiple universal systems	Income-related universal benefits	Mix of universal and means-tested benefits
Italy, Czech Republic	France, Ireland, Austria	Switzerland, Spain

Means-tested safety net system →	**England, United States**

More comprehensive
Wider Access
More expensive

A lack of a stewardship and financing role on behalf of the state can push costs elsewhere and/or leaves needs unmet.

Needs are met in other ways

Formal services purchased privately
- Higher out-of-pocket costs
- Risk of poverty, asset depletion

More care provided by families
- Opportunity cost
- Increased chance of mental health issues
- Families drop out of labour force

Needs met in health systems
- Bed blocking in hospitals
- Increased health costs

Some needs are not met

People go without care
- Lower quality of life
- More falls, injuries, acute episodes
- Increased activity in health systems

(4) Organization and Governance

Defining Sectoral Roles

How are the health and social sectors coordinated? How are objectives set?

- Coordinated care helps to ensure that, as people age, a continuum of care is provided to them to meet their increasing needs. A good continuum of care would include preventative, curative, rehabilitative, palliative, and social care support. It would encourage a seamless transition across settings, harmonized management across roles (for example, health and care workers, caregivers and family), and timely and non-fragmented care.

Quality Assurance

What quality assurance and improvement strategies are in place?

- Quality assurance includes establishing minimum quality standards; monitoring compliance with said standards across public and private providers; and enforcing compliance in providers not meeting standards. It is important to monitor services provided to very vulnerable individuals.
- For example, the Government of Sri Lanka requires residential and home nursing care providers to register with the National Secretariat for Elders, then apply to the Sri Lanka Standards Institute (SLSI) to obtain certification. The SLSI conducts checks to ensure standards.

Defining Private Sector's Role

What regulatory mechanisms are in place?

- Outsourced service provision would ideally create a "triangle system," with a public contractor, a private service provider, and the individual.
- When users can choose their providers (i.e., through cash transfers and/or vouchers) competition has two aspects: i) competition between service providers to be selected and contracted by a public contractor, and ii) competition to be chosen by clients who are free to choose their preferred service providers.
- Role of NGOs can be important; i.e., Ethiopian health development armies.

"This photograph is part of a personal project aimed at drawing attention to often **overlooked stories about dementia from the African continent.** As life expectancy rises, **dementia is increasingly becoming a public health and socio-cultural issue in Africa**. Numbers of people living with dementia in sub-Saharan Africa are projected to double every 20 years. While key policy makers highlight trends in dementia care, treatment, and prevention, less attention is given to cultural perceptions of the condition.

People who hold traditional beliefs in Ghana and across sub-Saharan Africa sometimes see dementia symptoms such as confused speech, uncontrolled swearing, and disoriented wandering as signs of sorcery. **Women are accused of being witches** more frequently than men. In Ghana, they may flee or be sent away to live in so-called "**witch camps**". The camps are controversial. On the one hand, they offer refuge and protection from violence; on the other, residents are stigmatized, and open to exploitation by local chiefs, who earn money from trials and rituals associated with witchcraft. Nurses from local communities who are sensitive to traditional beliefs, can play a bridging role in education about dementia, and so in reducing discrimination and stigmatization."

(5) Human Resources

Achieving adequate supply of human resources (HR)

What mechanisms are in place to improve recruitment and retention of workers?

- LTC continues to be largely provided by informal caregivers, including in high-income countries. A common challenge is securing a flow of well-trained staff, including those with and without medical training.
- Some countries are meeting the increasing demand for LTC through immigration, which requires systems to recognize skills. Some are also looking to offer or expand support to family caregivers through training, cash allowances, etc.

Improving working conditions

Are any policies or support mechanisms in place to the end?

- How best to balance the need for an agile workforce with worker rights?

Figure: Classification of caregivers

REMUNERATION

	PAID	UNPAID
FORMAL	Care worker	Voluntary care professional
INFORMAL	Live-in carers & personal assistants	Informal / family caregivers

PROFESSIONALIZATION

Source: WHO

WB Engagement:
Current Examples and Future Directions

- **ASAs (country-level and regional)**

- **LEN on LTC (self-standing or integration) and on related topics, such as migration**

- **RASs**

- **Collaborations with IFC**
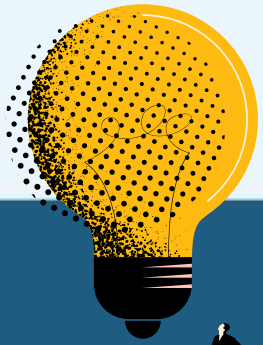
The Case for China

Dewen Wang

China: Anhui Aged Care System Demonstration Project (118 million USD IBRD+80 million USD Counterpart Funds)

PDO: To support the government of Anhui province in developing (focusing on selected prefectures) and managing a diversified three-tier aged care service delivery system for the elderly particularly those with limited functional ability

Main direct beneficiary group: the elderly with limited functional ability, including Sanwu, Wubao, Dibao, low-income empty nesters, and the oldest old elderly - the indigent low income and poor elderly

Indirect beneficiary group: family members and informal caregivers, system administrators and service providers

Four components:
- Supporting the Development of Government Stewardship Capacity
- Strengthening Community-based and Home-based Care Services
- Strengthening the Delivery and Management of Nursing Care, and
- Project management, Monitoring, and Evaluation

PDO-level Indicators:
- Number of direct beneficiaries in the project sites (Number) by tier and by gender;
- Percentage of dedicated public outlays for elderly care spent on purchasing aged care services from private providers in urban areas of the project sites (Percentage);
- Share of aged care service providers who meet the requirements of construction and service standards at the project sites (Percentage);
- Number of aged care professionals who received training certificates financed by the project by gender (Number)

China: Guizhou Aged Care System Development Program (350 USD IBRD + 100 EURO ADF)

The PDO is to increase equitable access to a basic package of aged care services, and strengthen the quality of services and the efficiency of the aged care systems

RA1:Expanding coverage of basic aged care services

- Developing a needs assessment toolkit and carrying out needs assessment
- Defining the basic package of aged care services and level of subsidy
- Defining the eligibility criteria of the elderly accessing to the basic package of aged care services
- Delivering the basic package of aged care services in urban and rural areas

RA2:Enhancing quality of aged care services

- Improving and implementing aged care quality standards
- Introducing case management and promoting coordination of aged care and health care services
- Enhancing and expanding aged care skills by providing training, job subsidies, financial subsidies, and respite services
- Establishing a provincial cloud platform for service delivery, quality enhancement, and public financial management

RA3:Strengthening efficiency of aged care financing

- Enhancing the performance of public financial resources through a zero-based budget reform
- Refining the decision process to comply with the provincial investment management guidelines
- Enhancing the service delivery and management of public aged care facilities
- Setting up a provincial monitoring and evaluation framework

Three lessons from the implementation of two projects in China and four illustration examples

Lessons:

- Follow the LTC framework (a systemic approach) and carry out country-level LTC policy and system assessment

- Engage with clients at the national and sub-national levels to identify champions who are eager to collaborate and move the agenda ahead

- Offer innovative and value-added solutions, but practical, actionable and work with counterparts through learning by doing

Examples to illustrate translating the LTC framework into implementation
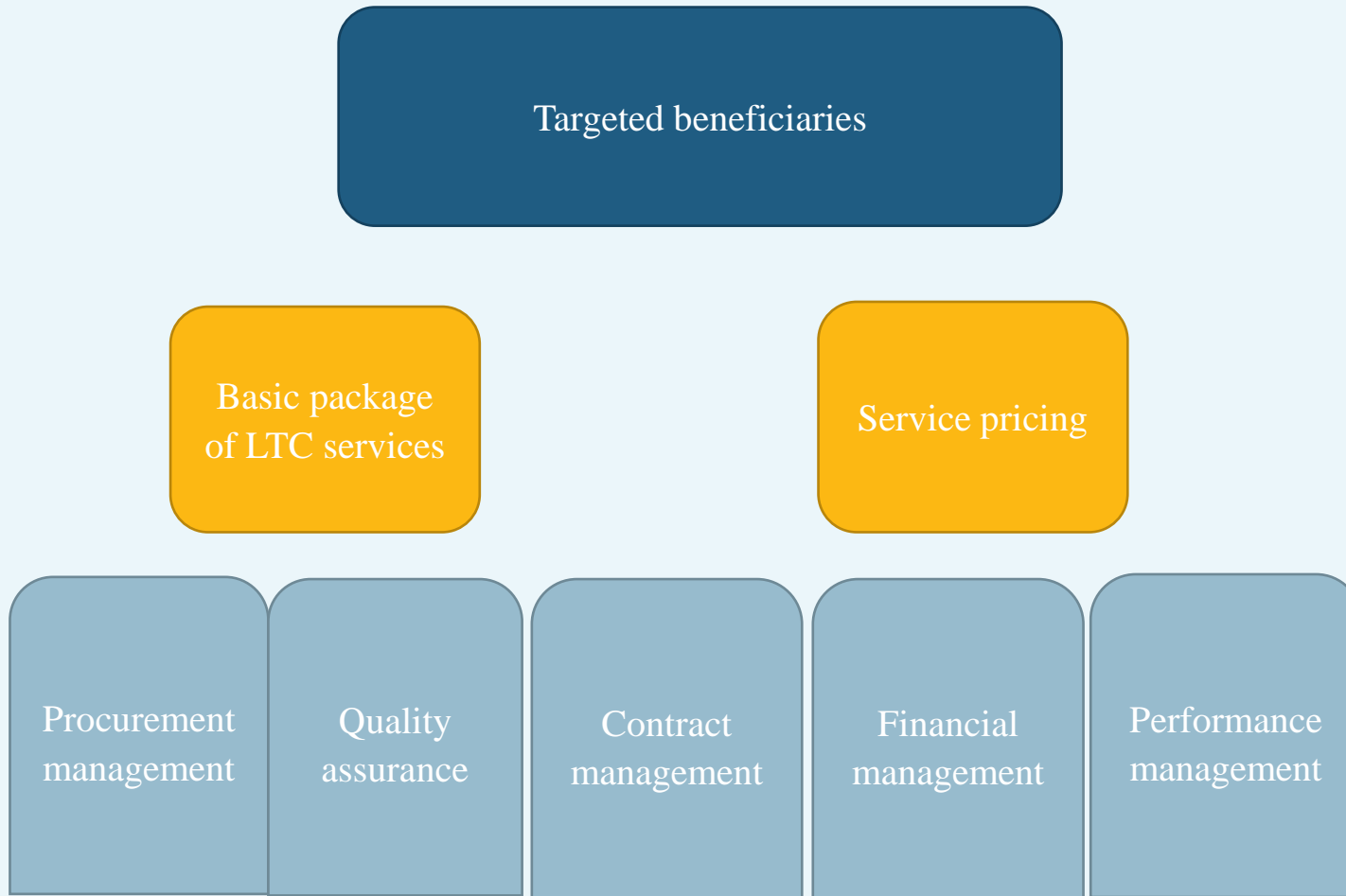
- Example one: Implement the concept of basic package of LTC services
- Example two: Foster private sector participation
- Example three: Carry out sector-wide budgeting reform
- Example four: Develop an information system for the LTC sector

Example 1: Implement the basic package of LTC services

- The guidelines on the basic package of LTC services were developed, implemented and kept updating

- The basic package of LTC services covers social and health care services to support the elderly living independently and ageing in place
  - Primarily focus on the ADL and IALD functional limitations or disability
  - Care and social services: Personal care, home health care, nursing care, rehabilitative care, respite care, housekeeping, meals-on-wheels, transport, shopping, social support, equipment and home modifications

- Eligibility criteria
  - Degree of functional limitations based on the functional ability and needs screening and assessment
  - Household income (means-test)

- Coordination between social and health sectors
  - Coordination between health and LTC basic packages
  - Coordination on the functional ability and needs assessment
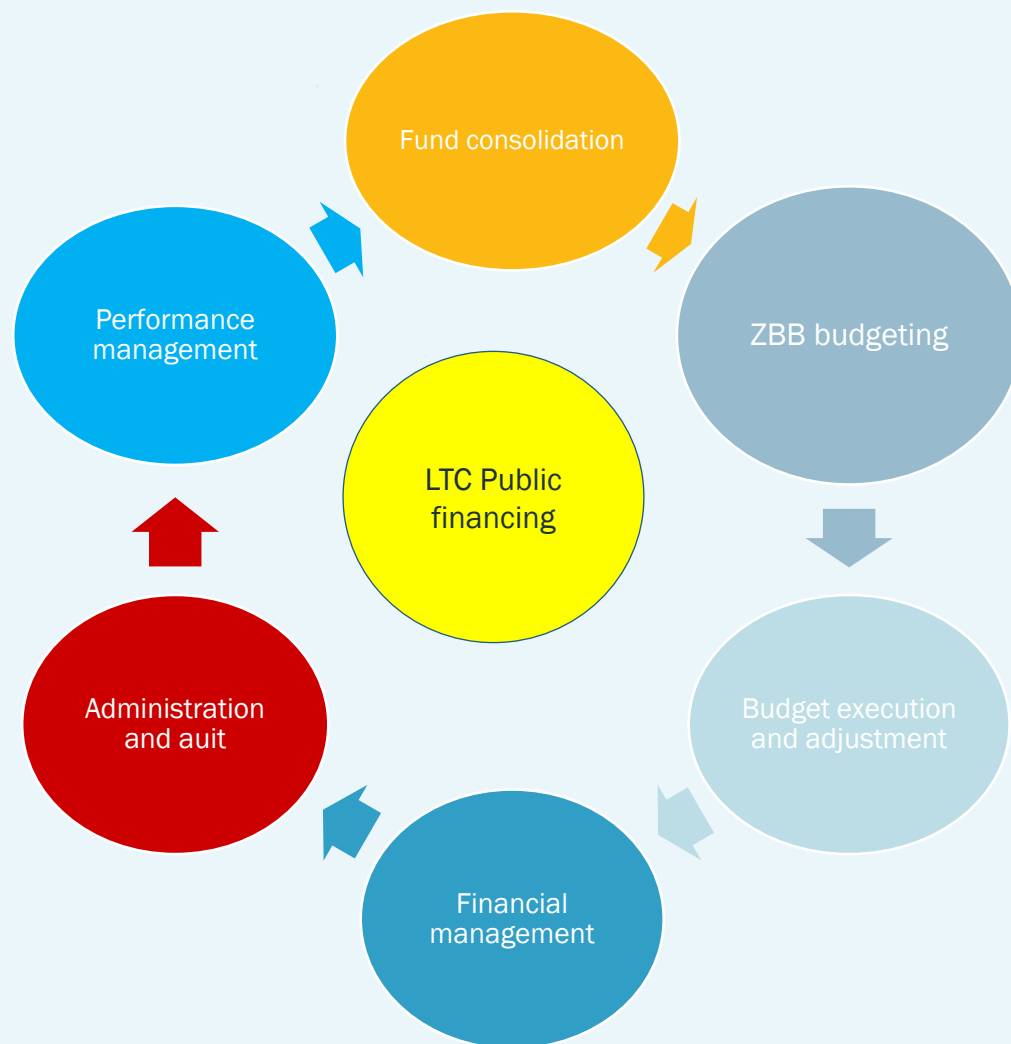 - Coordination on care plan and care management for service delivery

Example 2: Foster private sector participation

Targeted beneficiaries

Basic package of LTC services

Service pricing

Procurement management

Quality assurance

Contract management

Financial management
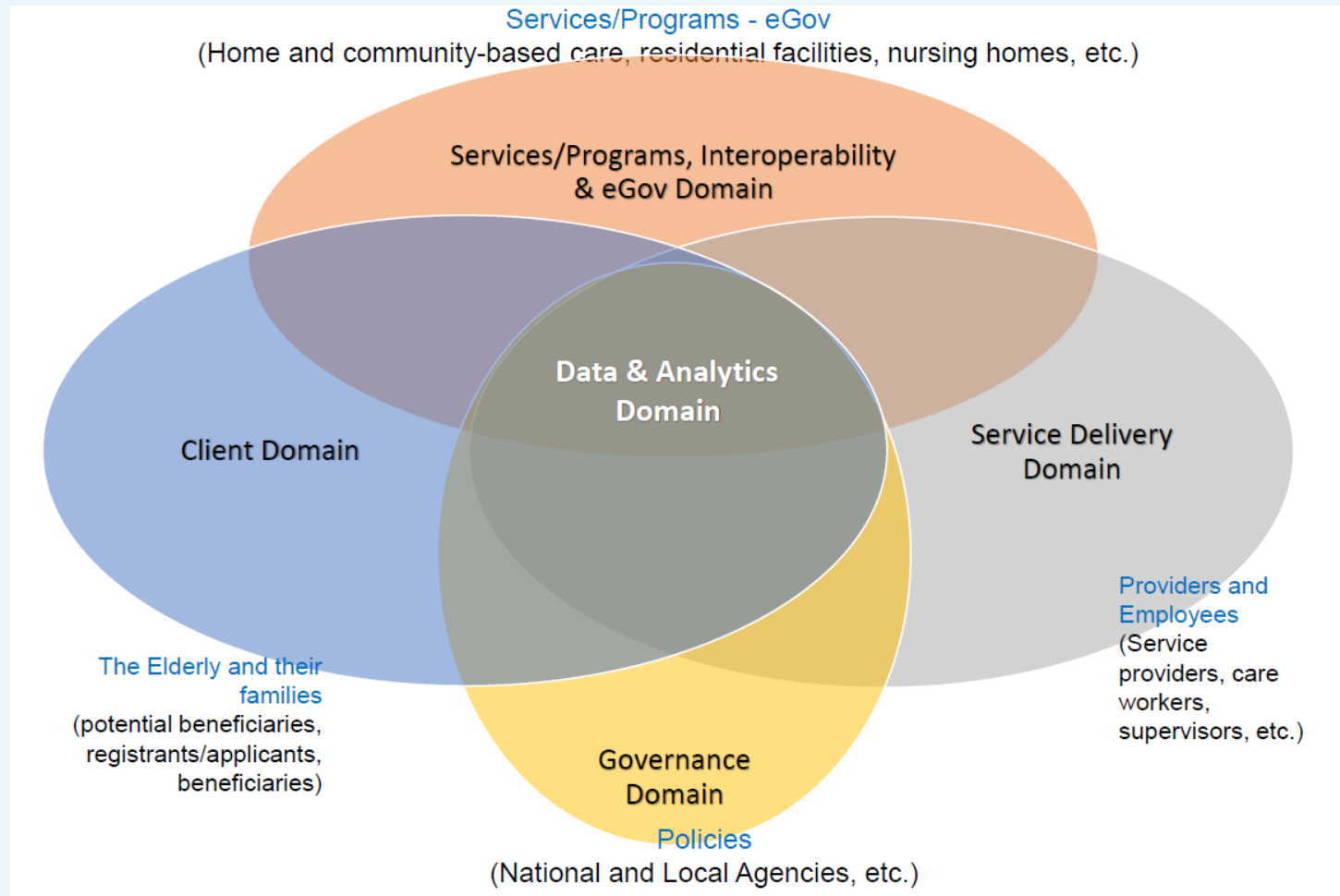
Performance management

- The Guidelines on government purchase were developed to streamline and standardize the process and procedures of government purchase

- The Guidelines are kept updating from edition 1 to edition 2 to reflect lessons learned and policy changes

- Similarly, the guidelines on contracting public facilities out to private operators and the guidelines on publicly operated facilities were also put in place to improve the efficiency and effectiveness of public facilities

Example 3: Carry out sector-wide budget reform on LTC

Fund consolidation

ZBB budgeting

Performance management

LTC Public financing

Administration and auit

Budget execution and adjustment

Financial management

- Context: LTC funds were fragmented and formulated based on incremental increase of budget allocation at the previous year

- A zero-based budget (ZBB) reform was initiated and implemented under the Guizhou Aged Care Program

- ZBB reform refers that LTC funds from various sources will be consolidated and allocated based on the actual needs and gaps identified

- An accounting ledger has been introduced and put in place to monitor and evaluate the reform progress

- The performance of public spending will be incorporated into the future fund allocation

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Example 4: Develop an information system for the LTC sector

Services/Programs - eGov
(Home and community-based care, residential facilities, nursing homes, etc.)

Services/Programs, Interoperability & eGov Domain

Data & Analytics Domain

Client Domain

Service Delivery Domain

The Elderly and their families
(potential beneficiaries, registrants/applicants, beneficiaries)

Providers and Employees
(Service providers, care workers, supervisors, etc.)

Governance Domain

Policies
(National and Local Agencies, etc.)

- The information system is a powerful tool to help the governments regulate the LTC sector effectively and efficiently and promote innovations

- Objectives: an integrated information system aims to facilitate service delivery, enhance quality assurance and public financial management, and inform evidence-based policy making

- Steps
  - Conduct LTC business requirements analysis
  - Develop a high-level conceptual design
  - Develop the core information system (data, middleware, application systems, hardware, network, security)
  - Pilot and scale up the information system

The Case for North Macedonia

Sarah Coll-Black

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North Macedonia: emerging agenda around LTC

- Well established SP system, with some care benefits and services for elderly

- 2019 reform introduced new approach to social services, supported by WB project

- 85% of grants for in-home care for elderly

- MLSP: *in the face of growing demand for care, how to establish a fiscally affordable system*

- MoH: more recent request for support on NCD and LTC

Pragmatic use of multiple WB instruments

- Regional ASA on promoting jobs and care economy

- In North Macedonia, focus on LTC:
  - Private sector:
    - Assess market and players
    - Identify barriers to entry and expansion
    - Willingness to pay for services (TBD)
  - Financing:
    - Current expenditure across MLSP, MoH
    - Projecting future needs and costs to inform options for government expenditure
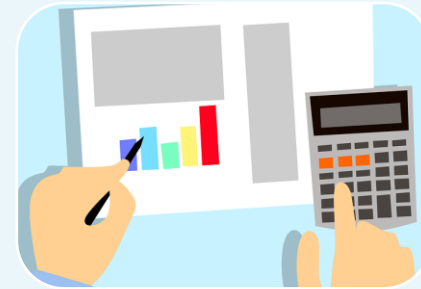
Governance and Financing

Market analysis and regulatory framework

Attitudes and willingness to pay for services

Workforce review and training needs

Second Social Services Improvement Project

Access and eligibility

- Improve needs assessment for in-home care
- Introduce eligibility criteria and targeting mechanism

Services and benefits

- Extend coverage of publicly financed in-home care & day centers
- Introduce incentives for private provision of these services

Governance and organization

- Improve quality of publicly-financed services
- Introduce more oversight of private market
- Establish operational linkages with health system

Human resources

- Training of social workers, family doctors
- Improve caregiver licensing
- Pilot: activation of GMA beneficiaries into care work

Mirrored by a new Health Project (to be designed)

Access and eligibility	Services and benefits	Governance and organization	Human resources

• Improve needs assessment for in-home care in coordination with SP
 	
• Upon discharge from hospital, refer patients to SP's care system
	• Extending coverage of publicly-financed medical services (i.e. nurse patronage program)	• Strengthen health MIS:
		  • referrals from/to SP;
		  • Referrals across health
		  • Monitor service quality
			• Review current use of nursing staff within health system & empowering GPs

Early Lessons

- While entry into LTC may be through one sector, the use of multiple WB instruments can:
  - Enable an integrated approach across SP and Health, which in turn allows LTC to be considered as a "system"
  - Allow for direct considerations of the role of the private market and the "stewardship" function of the Government
- However, moving this approach forward requires:
  - Establishing a common language on LTC across Ministries (and GPs)
  - Recognition of the strengths, roles, and comparative advantages of each sector
  - Strong dedication by the WB team to work cross-GP based on a common framework, understanding of issues, and objectives
  - Resources, time and motivation – and a fun team!

Likely future areas for engagement:

Stewardship:
- Moving away from provision as a "last resort"; that is, moving away from providing services for the poor" to facilitating care for all in need across LIMCs

Financing :
- *Revenue mobilization*: Tax-based and/or insurance-based, even with cost-sharing.
- *Expenditures*: Improving eligibility and basket of services; prioritizing home- and community-based care; employ demand- and supply-side mechanisms to facilitate care and incentivize quality care

Provision:
- Care continuum (including preventative care); coordination and integration across sectors
- Optimal ways to engage private providers – outsourcing, contracting in/out, etc.

Quality
- Developing, enforcing and monitoring
- Providers' incentives

Technology
- Assistive devices
- Quality

Workforce
- Professionalization (gender plays key role)
- Support for familial caregivers

Managed migration

Silver economy

Thank you!