



Health Reform Monitor

LTC 2.0: The 2017 reform of home- and community-based long-term care in Taiwan

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ABSTRACT

Taiwan planned to establish a social insurance-based long-term care system in 2016. However, due to the change in political parties that year, it was decided that Taiwan's long-term care policy would remain a tax-based financing scheme. The new policy focuses on providing home- and community-based service (HCBS); a three-layer HCBS service network within towns and districts was set to provide the 17 types of services in the HCBS spectrum, including preventive care. The reform was criticized as being too restrictive and lacking flexibility. However, the HCBS service spectrum has been widened, the target group has been enlarged, and thus HCBS utilization has increased. A rolling amendment has continued into 2018: the HCBS system requirement has been eased, and a new capitalized fee-for-service payment system has been launched. This paper discusses the analysis of the policy reform.

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1. Purpose of the policy

In 2007, a 10-year long-term care project (LTC 1.0) was implemented in Taiwan, with the goal of providing subsidies for long-term care users and introducing a care management system to local governments. Ten years later, a new long-term care policy, called LTC 2.0, was implemented [1]. The main purposes of the LTC 2.0 policy are to provide a human-oriented, community-based, and continuous care system, and to encourage the growth of the long-term care industry to respond to the future needs of formal services [2]. In addition, in this reform, the long-term care system was changed from a social-insurance system plan to a tax-based system. An outline of the recent policy reform was included in a recent paper [3], but no evidence of the impact of the recent reform was reported, nor was there any analysis of the dynamic amendment of the policy process or comparison with similar international experience. This paper, therefore, intends not only to add a description of the LTC 2.0 reform but also to provide a thorough analysis focusing on the dynamic process of home- and community-based policy reform, and discuss the lessons learned from comparing international LTC reforms.

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2. Political and economic backgrounds

The population in Taiwan, Republic of China, is 23.57 million [4]. The per capita GDP was \$25,893 in 2016. Dramatic population aging is occurring: the older (aged 65 or older) population comprised 7% of the total population in 1993 and 14.1% in 2017 [4]. The Nationalist Party (Kuomintang, KMT) was the primary political party in Taiwan after 1949. When martial law was lifted in 1987, the Democratic Progressive Party (DPP) was formally established. The KMT and the DPP became the two major political parties in Taiwan. In 2000, the DPP won the presidential election for the first time. Later, from 2008 to 2016, the KMT again reigned. In 2017, the DPP took dominated in both the presidential and congressional elections.

Traditional culture demands that family members care for older adults and disabled family members at home, and filial piety has been noted as the main reason that adult children have hesitated to use formal long-term care. However, people are becoming more aware of the needs for long-term care assistance, and more people have come to accept using long-term care services [2,5]. Nevertheless, due to a key 1992 labor policy, the most favored type of formal long-term care involves hiring foreign care workers to provide home care for disabled older adults, because the cost of hiring a foreign care worker is less and the disabled older adult can remain at home [6]. Institutional long-term care is also popular. Home- and community-based long-term care was introduced years ago but has not been widely utilized. Before the Ministry of Health and Welfare

Long-Term Care Policy Process

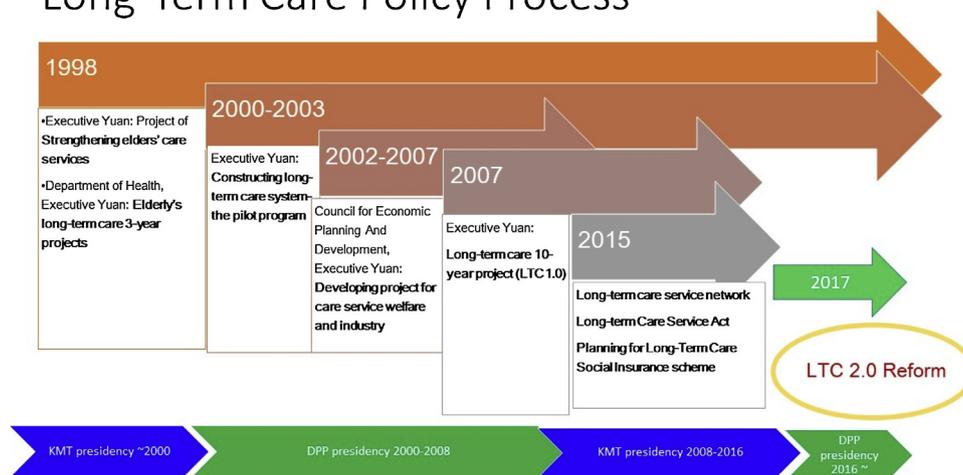


Fig. 1. The long-term care policy process.

Source: Ministry of Health and Welfare (2017).

was established, the long-term care policy was administered by the Department of Health and the social welfare department of the Ministry of the Interior.

3. Long-term care policy process

Planning for a public long-term care system began in the 1990s; lessons from both the tax-based welfare systems and social insurance systems were learned [7,8]. According to our observations, the long-term care policy in Taiwan was driven by political parties (Fig. 1).

Taiwan launched National Health Insurance in 1995, which was the most important policy initiated by the KMT. At the same time, the central government began planning formal long-term care financing in the public sector. Since 1998, the Strengthening Elders' Care Series project and the Elderly Long-Term-Care 3-year Project have been the central government's initial long-term care developments. Since National Health Insurance was successfully implemented, a social long-term care insurance system echoes the spirit of social solidarity, and serves as a stable source of financing, and a less expensive administrative cost system [9].

The vision of a national long-term care insurance scheme was one of the major political views of the KMT government in the years 2008–2016. A national long-term care insurance scheme had been planned with an expected implementation in 2016 [10]. The public also accepted long-term care financing by social insurance (agreement rate 68%–86% by age groups) [8] because the premium would be quite low and affordable, and because the existing National Health Insurance system was satisfactory.

Meanwhile, the DPP aimed to establish a welfare policy for long-term care. In 2000–2003, a pilot experimental program, titled “Constructing a long-term care system,” introduced new long-term care services and care management systems in experimental cities [11]. Later, the Council for Economic Planning and Development suggested the Developing Project for Care Service Welfare and Industry to encourage long-term care industries. Meanwhile, the surveillance, monitoring and accreditation of long-term care institutions became part of the regular administration of local governments.

In 2007, the first Long-Term Care 10-year project was implemented [12], whose main goal was to provide subsidies for long-term care users and introduce a care management system to local governments. Eligibility for the LTC 10-year project was

based on disability criteria and includes the following groups: older adults aged 65 and above, aboriginals aged 55 and more, physically/mentally impaired individuals aged 50 years and older, and older individuals who have disabilities of instrumental of activities of daily living and living alone. These potential users were transferred from hospitals and could apply directly for given services in an LTC management center at the local government level. Care managers performed the following tasks: assessing disability, health conditions and family situations at home, constructing care plans, and connecting to existing LTC resources, and then administering the LTC plan to users. The available LTC care included eight kinds of services: home help services, adult day care, family fostering, assisted devices and barrier-free housing modification, transportation, respite care, institutional care (low-income users only), and home (medical/nursing) care and home rehabilitation. National Health Insurance also paid for home medical care and hospice to an upper limit of twice a month; the other long-term care services were paid for out of the long-term care budget of the LTC project at the local government level.

There were many challenges during the first LTC 10-year project [1,13]: the LTC budget was insufficient; there was a shortage of care workers; the quantity and quality of care managers were insufficient; home-based and community-based LTC had deficit provisions; there was low awareness of various kinds of formal long-term care; the informational system was scattered; tsubsidies were not tailored to the needs of users; the application process for the long-term care process was rigid; and the long-term care system did not consider the needs of family caregivers.

When the DPP won the presidency and congressional election in 2016, a political atmosphere indicated that the implementation of a social insurance scheme for long-term care meant following the KMT political view. The DPP also estimated that much less funding was necessary than that estimated by the KMT [14], and tax-based funding would be enough. Under the strong will of the DPP government, long-term care policy planning was changed to tax-based financing, and the plan for social insurance was abandoned. A new long-term care policy, LTC 2.0, was launched in 2017.

4. LTC 2.0 reform

LTC 2.0 included the following aims: first, to construct a high-quality, fair-priced, and universal LTC care system; second, to put aging-in-place values into practice and to provide support for fam-

Table 1
Content of LTC 2.0 reform.

	Content of LTC 2.0 policy reform
Financing	Tax-based (tobacco tax, estate and gift tax, and general tax)
Eligibility	The disabled handicapped people (certified), disabled aboriginals aged 55 years old and more dementia patients aged 50 years old and more, older adults who are frail or living alone and in need of assistance, and disabled older adults in activities of daily living who are 65 years old and more
HCBS service types	Originally a three-layered 17 kinds of HCBS called ABC network was implemented. Later, the network rule has been loosened to 2-layered, and categorized as 4 types of care responding to the payment system: 1 Personal and professional care: home care, community-based care, professional care 2 Transportation (back and forth) to hospitals or rehabilitation clinics 3 Assisted devices purchase and renting, barrier-free home environment modification 4 Respite care for family caregivers
Application, delivery, and care management	The LTC application and delivery is a one-stop service by care managers: Personal contact /telephone line/ discharge plan of hospitals → assessment by care managers, confirmation of disability level and care problems, granted the budget → care plan discussion and planning → long-term care services delivery and copayment → feedback and adjustment
Payment	1 Personal and professional care: benefits by disability levels with copayment (\$334–\$1206/month) 2 Transportation: (\$56–\$80/month) 3 Assisted devices and home modification: (\$1333/month) 4 Respite care: (\$1078–\$1617/month)
Telephone line (#1966)	Application, consultation, or complaint of LTC services

Source: Ministry of Health and Welfare. A short version introduction of LTC 2.0 policy. 2018 December, <https://1966.gov.tw/LTC/lp-3648-201.html>.

ilies via multiple and continuous home- and community-based institutional types of care; third, to extend care to include primary preventive care; fourth, to integrate multipurpose supportive community services and to link discharge (from the hospital) preparation services with home-based medical care (see Table 1). LTC 2.0 eligibility is funded by public financing and is an expansion of LTC 1.0 [1]. Frail older adults and people living with dementia aged 50 years and more were also added.

LTC 2.0 covers 17 kinds of services. The following items were added: dementia care; aboriginal community integrated services; small-size multiple function centers (linking adult day care, respite care and others); multiple support services for family caregiver centers; a community-based integration care system (ABC system); community health preventive care; preventive and delaying disability programs; links to discharge plans from hospitals, and links to home-based medical care.

The delivery flow for accessing LTC in the LTC 2.0 system begins with a long-term care management center, which is a department of local governments. Users can access the LTC management center services by themselves or may be transferred to the center from hospitals or clinics. Then care managers at the management center assess care needs, formulate a care plan, and collaborate with the ABC network to communicate and negotiate with users, family and providers, and then implement the care plan.

The Community-Integrated Care system (a three-layered service network named the ABC network) is the core innovation in this LTC 2.0 reform (Fig. 2). The original design of the ABC network required ABC networking as a team. “A” is the network team leader, which functions as a community integration service center, and is in charge of the building delivery system for the service area and links LTC services from “B” and “C” within its respective network, in which transportation between points is within 30 min. “A” promotes service provisions and creates new kinds of LTC services; information, education and transportation are also provided among A–B–Cs. “B”, the composited service center, provides major community-based LTC services. Its mission is to increase community-based service quantity and to increase the utilization of multiple LTC services, as well as and to help the “C” spots develop LTC. “Cs” or alley LTC spots, are located within neighborhoods. The function of a “C” is to provide convenient care and temporary respite care, extend preventive disability-delyaing activities, and provide commune dining or meals on wheels for households.

Cs should be within walking distance of users. The ABC network is expected to provide all 17 types of LTC.

The payment system was also modified during the LTC 2.0 reform [15]. In 2018, the new payment system was introduced. In the past, fees for home-based care was based on service hours. The care service contents were not limited to the given hours. However, in the new system, payment is categorized into four parts: personal and professional care (\$334–\$1,206/month), transportation (\$56–\$80/month), assistive devices and home modification (\$1,333/month), and respite care for family caregivers (\$1078–\$1,617/month). Within each case with an upper limit, each type of service delivery is paid by fee-for-service. Users (and family) choose what they prefer to use from the menu of profession and personal care. Copayments are waived w for low income households users. If service usage exceeds the upper limit, users must pay for it.

5. Preliminary outcomes and policy amendment

Challenges within the original ABC network, from opinions collected from all stakeholders in a preliminary assessment in the demonstration stage, include the following [16]: first, governments, providers, and users found the system difficult to understand and implement. Second, LTC resources across cities/counties were very different, particularly in remote areas, and thus the demonstration of ABC network rules did not apply to all areas. In addition, the abilities of local government staff in LTC differed. Thus, the policy effectiveness couldn’t be assured. Third, the networking and management competence of “As” also differed, which determined the success of conduction. Fourth, financing rules and the information system were not well established. Fifth, the ABC design was criticized as being overly restrictive and lacking flexibility.

Since the original design of the ABC network did not work well, a rolling amendment followed in autumn of 2017. The ABC now does not have to provide all 17 types of LTC services at the same time, and the network does not have to follow the A–B–C structure; rather, the B–C only type is also allowed. The local government is expected to govern the ABC network, under the ruling of the central government. In 2018, the ABC network increased from groups comprising 17 As, 44Bs and 85Cs to those comprising 371 As, 2247 Bs and 1160 Cs [15]. However, the existing community-based LTC

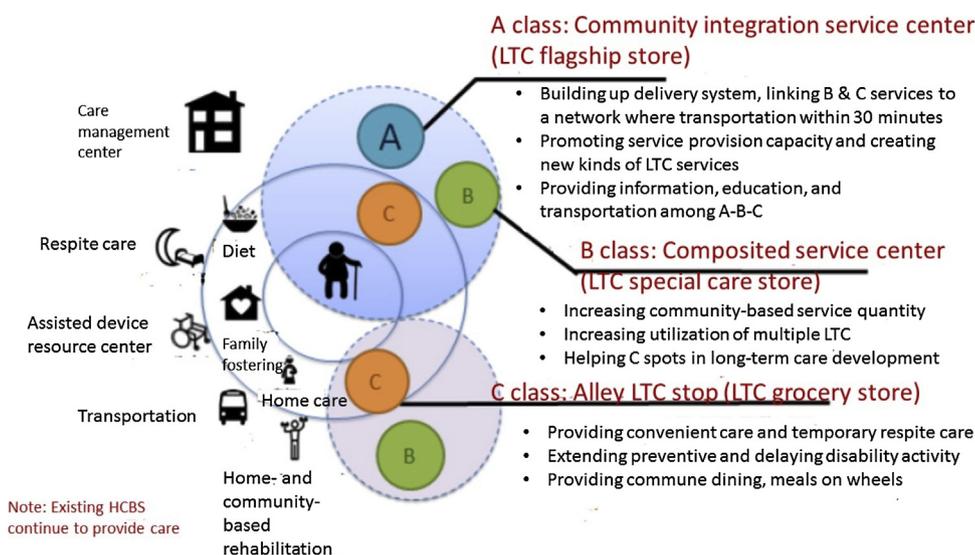


Fig. 2. The ABC HCBS network design.

Source: Ministry of Health and Welfare (2017).

service network may collapse due to policy incentives. *B* providers may leave the old network and set up a new network by themselves without *A* providers.

The announcement of the new payment system came within a very short time (1 month) before implementation, and the responses to the new payment system were as follows [17–19]. First, opinions from service organizations and scholars were unable to be considered because the Ministry of Health and Welfare decided to implement the new payment system immediately. Second, calculation in the new payment system is chaotic across different providers. Third, home care workers previously spent time providing personal care and emotional care by chatting with users. Now, care workers have time only to perform care tasks and have no time for social interaction. In addition, users feel they must pay for everything in the fee-for-service scheme. Users and family caregivers complain that care is insufficient. Fourth, issues with items of personal and professional care made available by fee-for-service within the capitation payment design have also been reported. Under such a payment design, users do not know how to choose what to pay for within a certain budget, particularly those who are unable to pay for the extra cost of home care, even though they are under the assistance of care managers at the beginning [19]. If users must remain under their existing care plans, the home care service costs typically are more than those in the previous service plan, and the family must either pay more or perform the care work themselves [19]. Furthermore, personal care and professional care are in the same category, making it difficult for users to decide how to distribute their budgeted funds in the same category due to information asymmetry. Fifth, under the new payment system, care workers usually feel more “professional” because everything is counted and the work boundary is “clear”. Sixth, providers must change the logistic of care from time-based to item-based. On the one hand, they may need to care for more users and deliver care in a relatively shorter time in one case, and on the other hand, they must provide for more cases simultaneously. This situation may be an advantage for providers because it allows them to earn more. However, because of the shrinking availability of time and items of paid home care, family caregivers may need to pay more and provide the rest of the unpaid care work themselves. In addition, the time during which home care is provided, which could be a respite hour for family caregivers, has shortened. Thus, the stress for family caregivers has increased.

There is little published quantitative evidence evaluating the LTC 2.0 reform. A quasi-experimental study before and after the new payment system was conducted to examine the satisfaction and quality of care according to the home care workers, users, and users’ families [20]. After the new payment system was implemented, the home care workers’ work satisfaction and care work achievement increased, user satisfaction towards home care and quality of care decreased, and family stress increased. The home care workers reported that their service hours increased, and 25% of them changed their method of care. More than 40% of users reported that they interacted less with care workers. Family caregivers reported that care items were appropriately delivered after the new payment system, but 27.5% of them increased the care work they provided themselves, and 45% of them reported increased fees. Overall satisfaction with the new payment policy for care workers, users, and family caregivers was 80%, 70%, and 75%, respectively.

Since the new payment system gives the impression of “every move costs” by the users, family caregivers, and HCBS providers [21], an amendment to the payment system was implemented in October 2018. Some of the service items were integrated into a larger unit. In addition, those who hired foreign care workers at home were not covered by the HCBS services at the beginning of implementation. However, by the end of year 2018, respite care was covered for the users of foreign care workers under the condition of disability level and living arrangement.

6. Discussion

The LTC 2.0 policy reform seeks to provide incentives to grow or expand the long-term care industry. Under LTC 2.0, the LTC services types and quantity of utilization have increased, and a new capitalized fee-for-service payment system has been launched.

There are some lessons from Taiwan’s recent LTC 2.0 reform that echo those of the reform experiences from other countries. First, politics affects policy directions and effectiveness. Instead of the original plan to reform the LTC system into a social insurance-based system, it was ultimately decided to keep a tax-based LTC system. Obviously the long-term care system design has been driven by political parties in recent decades. However, abandoning long-term policy planning not only causes social resource waste, but also makes policy implementation unfeasible. In democratic societies,

party alternation often leads to changes of policy reform. Nevertheless, continuity of the policy is still important. During the policy reform, there were voices from different stakeholders, including various service organizations, care workers, users, family caregivers, and diverse administrations, but the central government implemented the policy very quickly and left little time for local governments and these stakeholders to respond. Simultaneously, the central government was eager to prove their achievement by introducing dramatic reforms. When the policy was unfeasible, a rolling amendment had to be created, causing more confusions. A similar experience occurred in the Netherlands [22].

Second, expenditure of long-term care continues to rise over time, and thus the concern of sustainability would become the priority of a publicly financed long-term care system. LTC 2.0 reform adds the preventive care of the A-B-C strategy, echoing Japan's 2005 long-term care social-insurance reform, which introduced the delaying of disability through rehabilitative preventive care and the neighborhood-watch style scheme of Japan [23]. Furthermore, robust and stable financing is necessary. The current special tax may not be a sustainable financing source [24]. The source of financing will eventually be the next issue requiring reform.

Third, family caregivers are included in the formal long-term care system. Taiwan's recent reform also covers the benefits and services for family caregivers for the first time. Germany's social insurance system also covers an informal caregiver's social security premium and respite care [25]. The input of family caregivers is recognized and supported.

Fourth, long-term care services are encouraged to grow under the current policy direction. When incentives encourage the long-term care provision to be market-oriented, the public control of long-term care would be more difficult, as seen in the neoliberal long-term care experience in the U.S. [26]. In addition, when care expenditures grow and greater incentives limit the budget from public financing, the greater share of caregiving responsibilities will return to family caregivers.

To conclude, the LTC 2.0 reform has been conducted rapidly with many dramatic changes. Policy amendments are still being introduced to correct imperfections. Research on long-term care policy evaluation is suggested.

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