JOURNAL OF LONG-TERM CARE

Historical Changes and Cross-Country Comparisons of Long-Term Care Policy: A New Resource

PERSPECTIVES

LSE Press

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ABSTRACT

Context: Individual behaviour is influenced by the current policy environment, but many of the outcomes observed today are consequences of how people reacted to policies implemented in the past. However, understanding long-term care (LTC) policy at the time of a given survey is a challenge to cross-country research, since many longitudinal studies of ageing are conducted over a decade or longer.

Perspective: The Gateway to Global Aging Data's LTC Policy Explorer is a publicly available, open-access data and information platform that collects detailed, harmonised historical policy information across countries and US states to support researchers interested in studying policy. As of May 2026, the LTC Policy Series includes detailed LTC system information for 22 countries and 35 US states, documented from as early as 1992. It includes policies that affect the scope, coverage, and limitations of care, such as eligibility criteria, system financing, benefits provided, and costs to the beneficiary. We provide examples of major shifts and trends in policy as well as significant variation in LTC systems around the world that could be beneficial to researchers and may inform or guide future policy decisions.

Implications: This perspective highlights the complexities and differences in LTC benefit policy across countries and US states, revealing the importance of documented historical policy as a resource for the broader policy research community. The Long-Term Care Policy Explorer can be used with longitudinal studies that collect relevant information for identifying care needs and means to understand population-level effects of certain policies, particularly as they relate to public LTC benefit eligibility.

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KEYWORDS:
Long-term care; cross-country comparisons; policy research

TO CITE THIS ARTICLE:
Knapp, D., Lee, Y., Fransz-Myers, M. and Pasini, G. 2026. Historical Changes and Cross-Country Comparisons of Long-Term Care Policy: A New Resource. *Journal of Long-Term Care*, (2026), pp. 282–293. DOI: https://doi.org/10.31389/jltc.487

INTRODUCTION

In the past three decades, public spending on long-term care (LTC) has increased across the world. Spending in the United States was 1% of GDP in 2021, up from 0.6% in 2000 (OECD, 2025). Changes over the same period in high-income countries have varied, with some, including Japan, the Netherlands, and the Czech Republic, experiencing public LTC spending increases of one percentage point or more of their GDP, while others experienced limited or no change in their spending as a share of their GDP. Spending changes reflect both the growing share of older adults, which increases spending regardless of policy changes, and the evolution of public LTC policy, including differences in how countries provide care services to those with needs based on functional, cognitive, or other limitations requiring regular assistance. Publicly available information on cross-country differences in LTC systems tends to focus on system financing and aggregate funding levels. However, beyond cost and financing, public LTC policy has important implications for who receives care and how that care is provided. Countries differ significantly in the design of their public LTC systems, including who is covered, how eligibility for benefits is determined, and what benefits are available. This information has not been systematically collected in sufficient detail to assess LTC benefit eligibility within a given country based on individual and household characteristics. This level of detail is required to identify who is eligible conditional on a country's policy and is a prerequisite for the evaluation of current and alternative LTC policies.

In this perspective, we highlight a resource—the Gateway Policy Explorer—that systematically collects national-level public LTC policies across the world and state-level public LTC policies in the United States. This resource enables the determination of an individual's coverage, benefit eligibility, and the benefit amount based on their personal circumstances and how this information may change over time as a country's LTC policy evolves. We illustrate the utility of this resource by highlighting examples of cross-country and cross-state differences in LTC benefit eligibility based on means or needs and broad shifts in policy over the past thirty years. We conclude by discussing the prospects of this new resource for research on LTC, highlighting connections to nationally representative datasets that can inform prospective eligibility for care at the population level.

GATEWAY POLICY EXPLORER

The Gateway to Global Aging Data ('Gateway') (https://g2aging.org/) is a publicly available, open-access data and information platform developed to facilitate longitudinal and cross-country analysis on ageing, particularly those using the Health and Retirement Study (HRS) and its International Network of Studies (HRS-INS) (Lee *et al.*, 2021). Funded by the National Institute on Aging (NIA), the platform provides centralised resources for the research community, and its harmonised datasets have been widely used for cross-national research (Avendano *et al.*, 2026). One of the many resources available on the Gateway is the Policy Explorer (Gateway to Global Aging Data, 2025c). Seeking to capture the evolution of policies affecting older people around the world, the Gateway Policy Explorer captures historical policy changes over the time of the surveys covered by the Gateway. These policy areas include LTC policies, retirement policies, and education policies. The authors of this paper are members of the Gateway Policy Explorer team.

The HRS is over 30 years old, and many of the HRS-INS cover more than two decades. Because policies are constantly evolving, understanding the policy in place at the time a survey was conducted has become more demanding for researchers. Therefore, comprehensive, harmonised, country and state-level historical policy information has largely been missing as a resource for researchers using HRS and HRS-INS data. Where resources exist, they often provide insufficient detail to judge the applicability of a policy to a specific person (coverage). In the case of public benefit and insurance programmes, they may also lack sufficient information to determine benefit eligibility or entitlement amounts. The Gateway Policy Explorer fills these gaps, providing policy detail with the nationally representative HRS-INS data that can illuminate how policy affects relevant populations.

The Gateway Policy Explorer LTC Series includes detailed country- and US-state-level information across four policy types: cash benefits, in-kind benefits, 24-hour benefits, and service vouchers. For each policy type, a white paper is produced that provides an overview of the country or state's system, including how it is financed and who is covered. It also details the benefits provided, the requirements to receive benefits, care needs assessments and the evaluation process, limitations on receiving benefits, and any charges an individual incurs from LTC service use.

The Series is designed to map against the HRS-INS, enabling researchers to link policy variation with longitudinal survey data. Coverage is defined by three criteria: (1) policy scope, focusing on public care policies for persistent long-term care needs across the four policy types; (2) geographic selection, driven by the HRS-INS framework, including completed collections for several European countries (SHARE), England (ELSA), Ireland (TILDA), Korea (KLoSA), and Japan (JSTAR), alongside state-level data for the US; and (3) temporal selection, whereby each policy document begins in 1992 with the start of the HRS, or from the founding year of the country's main LTC programme or system (e.g., Korea's document begins in 2008, corresponding to the start of Korea's LTC

insurance system), to the present day, highlighting major shifts in health and social policy.[1] As of May 2026, the LTC Series has covered 22 countries and 35 US states for a total of 77 policy documents across the four policy types. Documentation for Finland, Northern Ireland, and Poland will be released in the near future, and documentation of LTC policies for US states is expected to be completed in full by Spring 2027. While new country collection has been paused, efforts are currently focused on updating documents completed at the initial launch of the LTC Explorer, bringing them up to date through 2026.

The policy collection and data harmonisation approach begins with a literature review of the policy, which informs the subsequent identification of key policy dimensions. We then developed a systematic collection protocol that is followed by each author of country and state policy documents. Country and U.S. state LTC policy is then collected and systematically documented following a four-step process. First, policy is collected using national legislation, or in the case of the U.S., through federal and state legislation. Due to the complexity of the U.S. system, we also source information from administrative manuals, federal programme application forms, and occasionally personal correspondence with state employees or experts. Each document includes a list of sources with the access date provided for each source. Then, policy documents are drafted following a standardised format, and each document is reviewed by the internal expert team before being sent for review by country or state system experts. After final review, documents are published to the Gateway website and are publicly available.

The documents use standardised terminology and organisation where possible, which allows for comparisons across different systems; researchers can compare across multiple countries or states at a point in time or within a country or state across time. Observing policy at this scale can uncover major shifts and trends in LTC policy, as well as highlight significant variation across systems, all of which may affect care trajectories or decision-making among older adults. In this perspective, we detail major shifts and comparisons across the world and within the United States to demonstrate the importance of historical policy collection and the usefulness of the Gateway Policy Explorer as a research resource.

CROSS-COUNTRY POLICY DIFFERENCES

Globally, countries exhibit considerable variation in LTC policy. To illustrate how the Gateway Policy Explorer can be used to identify and compare differences in LTC policy design, we selected the Netherlands and England as contrasting examples. These two countries represent distinct approaches to organising LTC: the Netherlands operates multiple parallel systems with differentiated eligibility criteria, while England relies on a single unified framework. Examining these differences highlights the Policy Explorer's utility for cross-national policy analysis.

At this time, the Netherlands provided in-kind benefits through three systems: the Zorgverzekeringswet (ZVW), Wet Maatschappelijke Ondersteuning (WMO), and Wet Langdurige Zorg (WLZ) (Gateway to Global Aging Data, 2024b). While all systems required residency in the Netherlands, each system had different eligibility criteria. To qualify for ZVW, individuals also had to pay a health insurance premium and an income-related contribution, while WLZ eligibility required an income-related premium. WMO eligibility was solely based on residency. In contrast, during this same year, England had only one system that provided in-kind benefits through the Care Act (Gateway to Global Aging Data, 2025a; UK Parliament, 2014). To be eligible for care coverage, individuals had to reside within the geographical area of the local authority where they were applying to receive benefits.

The benefits provided in both countries varied widely, particularly in how they were organised and delivered. As shown in Figure 1, each system in the Netherlands provided different benefits. ZVW provided home care services, WMO offered home and community care, and WLZ provided 24-hour home care and residential care. Conversely, in England, local authorities provided in-kind benefits through personal budgets, which allocated funding to individuals but were typically managed on their behalf—either by the local authority or a third party (e.g., a service provider)—to arrange care. In some cases, individuals could receive the budget directly to arrange their own care, provided they met certain requirements, such as having the mental capacity to manage payments.

Lastly, regulations on user costs (e.g., copayments, deductibles) also differed significantly between the two countries. These include copayments, which are fixed amounts that an individual pays for covered services, and deductibles, which are set amounts an individual must pay before the public system begins to cover costs. In the Netherlands, user costs were characterised by a mix of fixed and income-based fees. Under ZVW, there were no additional fees for LTC services, as these were covered by the health insurance premium for basic insurance. Under WMO, individuals paid a fixed copayment, which was the same for everyone regardless of income or assets (€19 per month in 2020). Under WLZ, there were two types of copayments: low and high. Married individuals whose spouses did not reside in an institution, along with single individuals or couples both staying in an institution for the first four months, were required to pay a low copayment. All other individuals paid a high copayment. In 2020, the low copayment was calculated as 10% of the assessed annual income, divided by 12, and could not exceed €881.60 per month. The high copayment was calculated by dividing the assessed annual income by 12, with a maximum limit of €2,419.40 per month.

In England, user costs were based on a beneficiary's income and capital (e.g., assets), known as means testing. Individuals with capital above the upper threshold paid the full cost of care services. Those with capital below the lower threshold had a contribution based solely on their income. In 2020, the nationally set lower capital threshold was £14,250, and the upper capital threshold was £23,250. For individuals with capital between the thresholds, a 'tariff income' was added to the income considered in their financial assessment. The tariff income was £1 per week for every £250 of capital above the lower threshold. For example, an individual with £123,250 in assets and no income would have their copayment determined as if they had an income of £400 per week.

CROSS-COUNTRY SHIFTS

The Gateway Policy Explorer also allows users to identify cross-country shifts, such as the introduction of LTC insurance systems in several countries globally. Many countries around the world have established LTC insurance systems—for example, Germany in 1995, Japan in 2000, Korea in 2008, and, more recently, Slovenia in 2023 (Gateway to Global Aging Data, 2023d; Gateway to Global Aging Data, 2023e; Gateway to Global Aging Data, 2024d; Gateway to Global Aging Data, 2024e). While many countries provide LTC benefits through their health and social welfare systems, the implementation of LTC insurance often results in an expanded scope of benefits and more comprehensive assessments of care needs.

Before 2008, LTC for older adults in Korea was characterised by family-based care or services provided by local governments to those with financial need (Gateway to Global Aging Data, 2024d). The only officially recognised home-based support in the Elderly Welfare Act, which regulated LTC services before 2008, was the 'Family Volunteer Dispatch Project', which sent volunteers to assist with daily tasks. In 2008, LTC insurance established universal access to a broader range of services, especially home care, including personal care, domestic assistance, home nursing, and equipment such as reclining beds. LTC insurance also introduced clearer guidelines for assessing care needs. Previously, the Elderly Welfare Act did not specify the criteria for assessing care needs. Under LTC insurance, eligibility is determined through a structured 52-item questionnaire covering five domains with decision trees used to calculate each individual's score and assign them a corresponding dependence level.

Similarly, in Slovenia, before LTC insurance was introduced, home and residential care were provided through the social security and healthcare systems (Gateway to Global Aging Data, 2024e). Established in 2023, LTC insurance initially covered community and residential care services, with home care, e-care, and services to strengthen and maintain independence (e.g., occupational therapy) set to be introduced on July 1, 2025. E-care refers to telecare services that help older adults remain independent by providing rapid emergency assistance in the event of falls or accidents. Independence programmes provide psychosocial support, dementia care, and counselling to prevent decline. Similar to Korea, Slovenia's LTC insurance system established clearer,

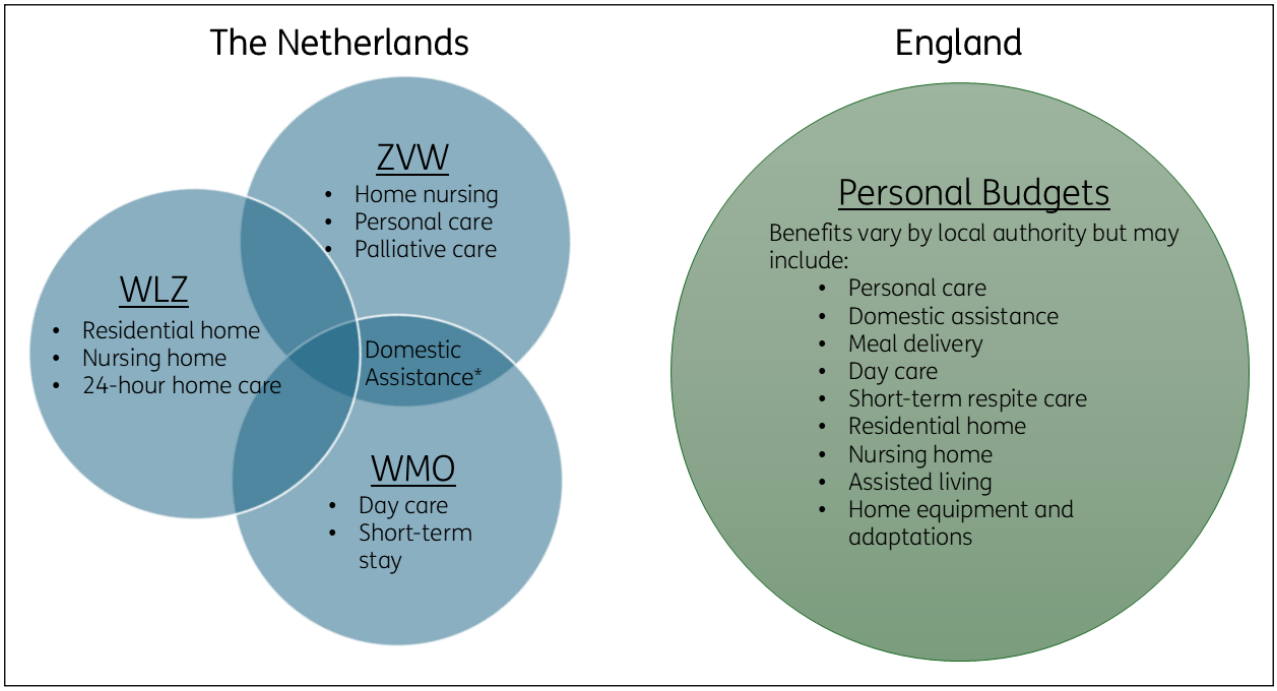

Figure 1 In-kind benefit delivery: The Netherlands vs. England.

Notes: (*) Only provided under ZVW when combined with nursing care. WMO domestic assistance services vary by municipality.

more detailed criteria for assessing care needs. Before LTC insurance was introduced, there was no statutory framework, and service access was determined at the discretion of assessment teams. In contrast, LTC insurance uses a 75-item, 8-module assessment with a weighted scoring system to determine dependency levels.

Another notable cross-country trend is the growing focus on cognitive factors (e.g., orientation, memory, communication) in care needs assessments. Many countries and US states limit assessments to functional limitations, and this approach may overlook individuals with cognitive impairments, potentially leading to unmet care needs and restricted access to appropriate services. Countries such as Austria, Germany, Japan, and Korea have incorporated these cognitive factors into their assessment frameworks. As shown in Figure 2, Austria's care needs assessment estimates the monthly caregiving hours required for various activities (Gateway to Global Aging Data, 2023a). For example, taking medication is estimated to require 3 hours of care per month. To be eligible for benefits, individuals must meet at least Care Level 1, which corresponds to 60+ hours of care per month (65+ hours starting in 2016). A cognitive impairment category was introduced in 2009 with 25 assigned caregiving hours per month, increasing to 45 hours in 2023. This 45-hour allocation is the highest among all assessed activities, followed by 30 hours per month for meal preparation, eating, and toileting. This change demonstrates the growing recognition of how cognitive factors impact care needs, often interacting with functional limitations in Activities of Daily Living (ADLs) such as difficulty bathing, transferring, and eating, to increase the overall level of support required. Similarly, in Germany, cognitive components were added into the care needs assessment in 2016 as part of a major LTC reform (Gateway to Global Aging Data, 2023d). Prior to this reform, Germany used an assessment framework based on four modules: personal care, nutrition, mobility,

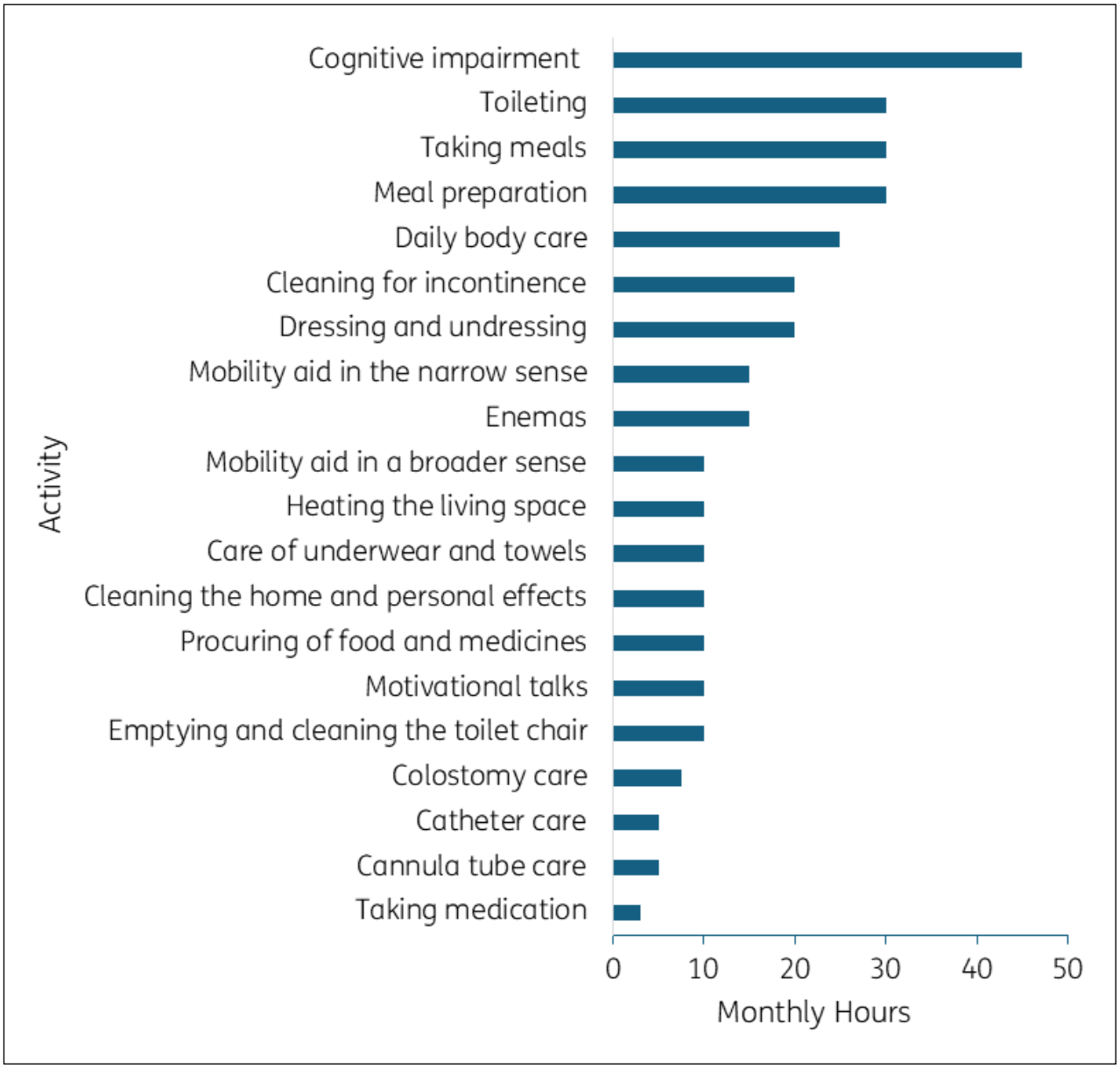

Figure 2 Monthly care hours by activity – Austria assessment (2023).

and Instrumental Activities of Daily Living (IADLs). In 2016, the reform introduced a more comprehensive assessment that incorporated additional domains, including cognitive and communication skills. The cognitive and communication skills domain includes key cognitive items that influence the level of support required, such as recognising people, decision-making, and awareness of danger.

U.S. STATE-LEVEL POLICY DIFFERENCES

Public LTC benefits in the United States are provided through Medicaid, a public health insurance programme for low-income individuals. Unlike most international LTC systems, the United States does not have a national LTC policy. Rather, individual states have substantial authority to manage and administer their Medicaid programmes as long as they operate within broad federal parameters. This flexibility creates significant variation across the country in eligible populations, benefits provided, and user costs. To capture this variation, the Gateway Policy Explorer documents United States LTC policy at the state level. Through the Gateway's collection of 35 states and counting, marked differences have been identified across the U.S., reflecting substantial variation in state governments' interpretations of federal policy.

The administrative federal-state partnership affects every aspect of the Medicaid programme. The federal government sets requirements and guidelines for states to follow, as well as several options that states may adopt (Gateway to Global Aging Data, 2023h). One example is coverage for alternative groups, which the Gateway refers to as 'eligibility tracks' (see Table 1) in order to concisely summarise the relevant pathways for older people from the more than 50 available legal pathways (Centers for Medicare & Medicaid Services, 2012). Federal law requires state Medicaid programmes to cover certain groups called the 'mandatory categorically needy'. These include low-income pregnant women, children, and most importantly, related to LTC, Supplemental Security Income (SSI) recipients. States have the option to extend coverage to additional populations, called the 'optional categorically needy'. Such populations include aged and disabled individuals at higher income levels and the Affordable Care Act (ACA) adult expansion group. Finally, states may choose to cover individuals with higher incomes if they 'spend down' by incurring valid medical expenses until the state-specific income limit is reached. This group is referred to as the 'medically needy'.

Substantial variation across states exists because most coverage groups are optional, as shown in Table 2. For example, California has implemented four

ELIGIBILITY TRACK	COVERAGE GROUP	DEFINITION
1. Mandatory Categorically Needy	1a. SSI Recipients	Individuals receiving (or, in some states, who are eligible for but not receiving) Supplemental Security Income (SSI) programme cash assistance. The applicant must be aged (65+), blind, or disabled, as determined by the Social Security Administration.
	1b. 209(b) States	An alternative to track 1a states imposing more restrictive eligibility criteria than those of the SSI programme. It may not be more restrictive than on January 1, 1972. This group must be aged (65+), blind, or disabled but may use more restrictive criteria to determine this status than the Social Security Administration.
2. Optional Categorically Needy	2a. Institutional Rules	Individuals residing in an institution (and/or, in some states, individuals who would be institutionalised if not for home and community-based services) at a higher income level. Most states set the income level for this track at 300% of SSI and count the income and assets of the couple separately.
	2b. FPL Aged & Disabled	Aged (65+) and disabled individuals at a higher income level. The income level for this track is usually 100% of the Federal Poverty Level (FPL). If the state also has track 2a, individuals under this track will typically not be institutionalised or receiving institutional-level care.
	2c. ACA Expansion Adults	Established under the Affordable Care Act (ACA), this track became an option officially in 2014 and extends coverage to single and childless adults without a disability up to 138% of the FPL.
3. Medically Needy	3a. Aged, Blind, and Disabled	Provides Medicaid coverage to aged (65+), blind, and disabled individuals with incomes higher than the other existing eligibility tracks. Individuals must spend down their income (typically on a monthly or six-month basis) by incurring valid medical expenses to meet the state-set medically needy income limit. This limit is usually very low.

Table 1 Breakdown of LTC-related eligibility tracks.

Source: Gateway to Global Aging Data (2023h).

STATE	TRACK 1a			TRACK 1b			TRACK 2a			TRACK 2b			TRACK 2c		TRACK 3a		
	1992	2000	2025	1992	2000	2025	1992	2000	2025	1992	2000	2025	1992/ 2000	2025	1992	2000	2025
Alabama	●	●	●				●	●	●				—				
Arizona*	●	●	●				●	●	●			●	—	●			●
Arkansas	●	●	●				●	●	●				—				
California	●	●	●							●	●	●	—	●	●	●	●
Colorado*	●	●	●				●	●	●				—	●			
Connecticut				●	●	●	●	●	●				—	●	●	●	●
Florida	●	●	●				●	●	●		●	●	—				
Georgia	●	●	●				●	●	●				—	●	●	●	●
Illinois				●	●	●					●	●	—	●	●	●	●
Iowa	●	●	●				●	●	●				—	●	●	●	●
Indiana			●	●	●				●		●	●	—	●	●	●	
Kansas	●	●	●				●	●	●				—		●	●	●
Kentucky	●	●	●				●	●	●				—	●	●	●	●
Louisiana	●	●	●				●	●	●				—	●	●	●	●
Maryland	●	●	●					●	●				—	●	●	●	●
Massachusetts	●	●	●					●	●	●	●	●	—	●		●	●
Michigan	●	●	●				●	●	●		●	●	—	●	●	●	●
Minnesota				●	●	●	●	●	●				—	●	●	●	●
Mississippi	●	●	●				●	●	●	●	●		—				
Missouri*				●	●	●		●	●				—	●	●	●	●
Nebraska	●	●	●							●	●	●	—	●	●	●	●
New Hampshire				●	●	●	●	●	●				—	●	●	●	●
New Jersey	●	●	●				●	●	●	●	●	●	—	●	●	●	●
New York	●	●	●										—	●	●	●	●
North Carolina		●	●	●							●	●	—	●	●	●	●
Oregon	●	●	●				●	●	●				—	●	●	●	
Ohio			●	●	●		●	●	●				—	●			
Pennsylvania	●	●	●				●	●	●		●	●	—	●	●	●	●
South Carolina	●	●	●				●	●	●		●	●	—				
Tennessee	●	●	●				●	●	●				—		●	●	●
Texas	●	●	●				●	●	●				—				
Virginia*				●	●	●	●	●	●		●	●	—	●	●	●	●
Washington	●	●	●				●	●	●				—	●	●	●	●
West Virginia	●	●	●				●	●	●				—	●	●	●	●
Wisconsin	●	●	●				●	●	●				—		●	●	●

Table 2 State variation in eligibility tracks covered in the Gateway Policy Explorer (1992–2025).

Notes: All 50 states have not yet been completed. Eligibility track 2c (ACA Expansion Adults) was not implemented in any state until 2014 and therefore would not be present in 1992 or 2000.

AZ: In 2011, AZ closed enrolment for aged, blind, and disabled individuals; only previously eligible individuals could retain coverage this way.

CO: Authors could not verify when this track was implemented. It has been in use since at least 1996.

MO: 209(b) states that do not have a separate Medically Needy track for Aged, Blind, and Disabled individuals must allow their 209(b) group to spend down to the 209(b) income limit. To account for this, we list MO as having track 3a, although it is just the spend down amount for track 1b.

VA: VA's track 2b income limit is 80% of the FPL, rather than the typical 100% FPL.

LTC-related eligibility tracks: 1a (SSI recipients), 2b (100% Federal Poverty Level – FPL aged and disabled), 2c (ACA expansion adults), and 3a (medically needy aged, blind, and disabled) (Gateway to Global Aging Data, 2023b). Crucially, California's medically needy track essentially allows anyone to become eligible as long as they 'spend down' their monthly income to meet the state limit (as of 2026, the limit is $600 for individuals and $934 for couples). California also offers several pathways to eligibility regardless of health status. Texas, comparatively, covers track 1a (SSI recipients) and track 2a (institutional rules). While Texas does cover the 'Institutional rules' group, which has a higher income limit than any existing California track, it requires all applicants to need institutional-level care (Gateway to Global Aging Data, 2023g).

Other major differences across states are the LTC services offered, the mechanisms for providing them, and the care needs criteria that must be met before accessing those services. States are required to provide institutional care, which is expensive, both for recipients and the Medicaid programme, and requires individuals to contribute all their income to the cost of care aside from a small personal needs allowance. Applicants for institutional care must also meet a high medical dependence threshold, known as a Nursing Facility Level of Care, NFLOC (United States Congress, 2025). An NFLOC is a standard level of care used in the U.S. Medicaid system that is meant to be comparable to a nursing facility. However, this standard is not defined at the federal level. Instead, states have discretion in how an NFLOC is defined and assessed. The only required home care benefit under Medicaid is home health services, which provides home health aide and skilled nursing services in the home. However, specific eligibility thresholds vary by state, and physician's orders for care must be recertified every 60 days. Because of these limitations, home health is most often used as a short-term rehabilitative benefit (e.g., after an acute hospital stay), and the vast majority of states use other avenues to provide long-term home care.

States have the option to provide home and community-based services, such as personal care, adult day care, and respite care. These are either provided as state plan services (personal care is the most common) or through waiver programmes. State plan benefits cannot be limited to specific groups; they are an entitlement and must be provided to any Medicaid beneficiary that meets the medical eligibility criteria. Waiver programmes can be limited based on age (e.g., 65+ only), location (e.g., only available in specific counties), and capacity (e.g., states may use waitlists). The most common types of waivers are referred to as Section 1915(c) waivers, which provide expanded home and community-based services to individuals that meet an NFLOC. The next most common are Section 1115 waivers, which allow the Secretary of Health and Human Services to approve any programme that 'assist[s] in promoting the objectives of the Medicaid programme'. As it relates to LTC, our research has found that most states use this mechanism to implement managed care.

The state of Michigan uses both the state plan mechanism and a 1915(c) waiver to provide home and community-based services (Gateway to Global Aging Data, 2023f). The Home Help Program, started in 1981, provides state-plan personal care services to individuals that require physical assistance or the use of an assistive aid to perform at least one ADL. Michigan Choice, a 1915(c) waiver programme established in 1992, provides various home and community-based services, including domestic or chore services (e.g., household chores, yard maintenance), personal care, and skilled nursing, to individuals who meet the state-set criteria for an NFLOC. There are several pathways to NFLOC eligibility under this programme, ranging from functional limitations to cognitive impairments. The functional limitation pathway generally requires hands-on assistance with at least two ADLs. The important distinction is that all NFLOC pathways have a higher medical threshold than the Home Help Program. The state of Ohio, which borders Michigan, does not have a state plan personal care programme (Gateway to Global Aging Data, 2024c). Their 1915(c) waiver programme, called PASSPORT, also has several NFLOC pathways, with the functional limitation pathway requiring hands-on assistance with at least two ADLs. While Michigan's and Ohio's functional pathway criteria are the same, Michigan's personal care entitlement programme is a substantial expansion of access to care.

NFLOC programmes are restrictive; even if they are not limited by age, location, or capacity, reaching an NFLOC is very difficult. To emphasise the variation in NFLOC definitions, the state of Virginia's 1915(c) home and community-based services programme's functional limitation NFLOC pathway requires the individual to have a limitation with at least five ADLs (Gateway to Global Aging Data, 2024f). The ADLs included in a state's NFLOC assessment can also differ, as shown in Table 3. While Michigan, Ohio, and Virginia have an NFLOC requirement, they have different ways of defining what that means. This creates the opportunity for a scenario where someone might be eligible for care in one state, but an individual with the same level of care would be ineligible, the only reason being that they reside in a more restrictive state.

STATE	DRESSING	BATHING	TRANSFERRING	WALKING	EATING	TOILETING
Michigan	No	No	Yes	No	Yes	Yes
Ohio	Yes	Yes	Yes	Yes	Yes	Yes
Virginia	Yes	Yes	Yes	No	Yes	Yes

Table 3 ADLs included in state NFLOC assessments – Michigan, Ohio, and Virginia (2025).

U.S. STATE-LEVEL SHIFTS

As discussed, states have the option to provide personal care as a state plan option to all medically eligible beneficiaries or as a waiver service to a targeted group. Because 1915(c) waiver programmes require individuals to meet an NFLOC, state plan personal care programmes typically have a lower medical eligibility threshold (as shown through Michigan's Home Help Program), making them a more accessible option and a means of expanding access to care. Out of the 35 states covered in the Gateway Policy Explorer, 16 have had a state plan personal care programme in operation since at least 1992. Four states have implemented a state plan personal care programme since 1992: California (1993), Colorado (2025), Florida (2013), and Louisiana (2004) (Gateway to Global Aging Data, 2023b; Gateway to Global Aging Data, 2023c; Gateway to Global Aging Data, 2024a; Gateway to Global Aging Data, 2025b). However, two of these states (Colorado and Florida) still only provide the service to individuals that meet an NFLOC. While more accessible as a state plan service, it is still difficult to access personal care with such a high medical threshold. The remaining 13 states only provide personal care through a 1915(c) waiver.

Overall, while just under half of the Gateway Policy Explorer states provided state plan personal care before 1992, only four of the remaining 14 have chosen to implement this option since, with two still requiring an NFLOC. The remaining states only provide personal care through waivers and have not made efforts to change their policies. There has been a slow shift toward state-plan personal care, but it could accelerate in the future. Before the establishment of 1915(c) waivers in 1981, the vast majority of LTC was institutional. These waivers were created as an option to deinstitutionalise care and are significantly less expensive than care in institutional settings. By diverting individuals who would otherwise be receiving costly institutional care to a home or community-based setting, states could save money and still allocate resources to the most critical cases. Section 1915(c) waivers became an extremely popular option. Today, 47 out of 50 states provide home care through a 1915(c) waiver (KFF, 2025). Personal care, which provides assistance to individuals with less critical needs, could be an additional approach to potentially catch beneficiaries before they decline into a more intensive (and expensive) level of care.

CONCLUSIONS

Policies regulating LTC services for those with care needs have changed substantially over the last thirty years. The Gateway Policy Explorer's LTC Policy Series was created to enable research on LTC access and use by detailing differences in policies across and within countries and states over time. These policy details can be used in combination with longitudinal data that includes person-level information, such as measures of care needs, social support, income and assets, to understand population-level relationships between policy and critical outcomes of interest in LTC research, including:

- LTC benefit eligibility based on care needs and/or means,
- characteristics associated with non-take-up of LTC benefits,
- the inter-relationship between family caregiving and public LTC provision, and
- changes in access to LTC services arising from changes in eligibility criteria.

Such data exist from the biannual surveys collected by HRS-INS, including the Health and Retirement Study in the United States (hrs.isr.umich.edu), the Survey of Health, Ageing, and Retirement in Europe (share-eric.eu), the English Longitudinal Study of Ageing (elsa-project.ac.uk), the Korean Longitudinal Study of Aging (survey.keis.or.kr), the Japanese Study on Aging and Retirement (rieti.go.jp/en/projects/jstar), the Irish Longitudinal Study on Ageing (tilda.tcd.ie), the Northern Ireland Cohort for the Longitudinal Study of Ageing (nicola.qub.ac.uk), the Mexican Health and Aging Study (mhasweb.org), as well as other studies in the US and Europe, including the National Health and Aging Trends Study in the US (nhats.org) and the British cohort studies (cls.ucl.ac.uk/cls-studies). Most studies in the HRS-INS have harmonised data produced by the Gateway, including additional resources and guidance to support researchers in accessing and appropriately using the data (see g2aging.org).

GLOSSARY OF TERMS

ACRONYM	TERM	DEFINITION
ACA	Affordable Care Act	The Patient Protection and Affordable Care Act of 2010 was a landmark health reform in the United States that made a number of changes to Medicaid. Implemented in 2014, the most notable change was the expansion of eligibility to adults with incomes up to 138% of the federal poverty level. Originally a requirement, a 2012 Supreme Court ruling made the Medicaid expansion a state option. To date, over three-quarters of states have opted to expand.
ADL	Activity of Daily Living	Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).
FPL	Federal Poverty Level	Poverty threshold established by the U.S. Department of Health and Human Services for administrative purposes, such as determining financial eligibility for federal programs. The FPL is determined annually for different household sizes, and financial eligibility for a programme is generally a percentage of the FPL (e.g., 100% of the FPL, meaning households with annual/monthly income at or below this amount would qualify based on financial eligibility).
HCBS	Home and Community-based Services	Services designed to assist individuals in a home or community setting, such as an adult day centre. HCBS are often designed to enable people to stay in their homes in lieu of nursing facility admission.
HRS-INS	Health and Retirement Study and its International Network of Studies	The Health and Retirement Study is a longitudinal panel study that surveys a representative sample of approximately 20,000 Americans over the age of 50 every two years. Beginning in 1992, the study has collected a range of information, including income, work, physical health and functioning, and health care expenditures. Since its launch, similar studies have developed in other countries, including Europe (SHARE), Korea (KLoSA), and Japan (JSTAR). These international studies make up the HRS international network.
IADL	Instrumental Activity of Daily Living	Tasks related to independent living, including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.
NFLOC	Nursing Facility Level of Care	Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programmes in the United States under Medicaid. However, there are no federal criteria that determine an NFLOC, and how it is defined and assessed is at the discretion of the state.
SSI	Supplemental Security Income	The U.S. old-age cash assistance programme for aged, blind, and disabled persons with low income and assets.
WLZ	Wet Langdurige Zorg	In the Netherlands, the Long Term Care Act provides LTC to older adults with intensive care needs and is organised at the national level by the Ministry of Health, Welfare, and Sport and at the regional level by regional care offices and health insurers. It was created in 2015 to provide a new policy framework for residential care after the General Special Medical Expenses Act was repealed. It also introduced 24-hour care at home.
WMO	Wet Maatschappelijke Ondersteuning	Created in 2007 in the Netherlands, the Social Support Act provides home care benefits that support an individual in maintaining their living environment and daily domestic tasks (domestic assistance). It is organised at the municipal level.
ZVW	Zorgverzekeringswet	The Health Insurance Act in the Netherlands organised by health insurers that provides personal care and home nursing services to older adults with care needs since 2015, when the General Special Medical Expenses Act was repealed.

NOTE

1 Harmonised data updates are announced on the Gateway website (https://g2aging.org/additional-resources/announcements-and-data-updates) and sent to users via email, while updates to policy documents are tracked within the document in a dedicated version history section to capture all major revisions as systems evolve.

ACKNOWLEDGEMENTS

The authors thank the Gateway Long-Term Care Team, including Ludovico Carrino, Drystan Phillips, Sterling Couts, Maya Wedemeyer, Eden Wetzel, Chrys Xie, Sarah Gao, Rinaldo Naci, Maha Gasim, Heber Dávila, José Carlos Ortega-Regaldo, Beatrice Fabiani, Silvia Matalone, Afriem Belete, Wei Yang, and Courtney Van Houtven, as well as Ava Bindas and Jinkook Lee for their feedback.

FUNDING INFORMATION

The Gateway to Global Aging Data is funded by the National Institute on Aging (NIA), R01 AG030153.

COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

DK conceptualised the paper and led the overall development of the Gateway Policy Explorer. YL led the international LTC policy analysis sections and country policy document data collection. MFM led the US LTC policy analysis sections and US policy document data collection. GP led the overall development of the LTC Policy Explorer. DK, YL, and MFM drafted the original manuscript, and all authors contributed to critical revision and editing. All authors read and approved the final manuscript.

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TO CITE THIS ARTICLE:
Knapp, D., Lee, Y., Fransz-Myers, M. and Pasini, G. 2026. Historical Changes and Cross-Country Comparisons of Long-Term Care Policy: A New Resource. *Journal of Long-Term Care*, (2026), pp. 282–293. DOI: https://doi.org/10.31389/jltc.487

Submitted: 25 September 2025 **Accepted:** 12 June 2026 **Published:** 24 August 2026